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SENATE

SELECT COMMITTEE ON MENS HEALTH

Reference: Availability and effectiveness of education, supports and services for men's health

TUESDAY, 7 APRIL 2009

SYDNEY

BY AUTHORITY OF THE SENATE

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SENATE SELECT COMMITTEE ON

MEN'S HEALTH

Tuesday, 7 April 2009

Members: Senator Bernardi *(Chair)*, Senators Cash, Lundy, Sterle, Troeth and Williams

Senators in attendance: Senators Bernardi, Heffernan, Lundy and Williams

Participating members: Senators Abetz, Back, Barnett, Bilyk, Birmingham, Bishop, Boswell, Boyce, Brandis, Carol Brown, Bushby, Cameron, Colbeck, Jacinta Collins, Coonan, Cormann, Crossin, Eggleston, Farrell, Feeney, Ferguson, Fierravanti-Wells, Fifield, Fisher, Forshaw, Furner, Heffernan, Humphries, Hurley, Hutchins, Johnston, Joyce, Kroger, Macdonald, McEwen, McGauran, Marshall, Mason, Minchin, Moore, Nash, O'Brien, Payne, Polley, Pratt, Ronaldson, Ryan, Scullion, Trood and Wortley

Terms of reference for the inquiry:

To inquire into and report on:

General issues related to the availability and effectiveness of education, supports and services for men's health, including but not limited to:

(i) level of Commonwealth, state and other funding addressing men's health, particularly prostate cancer, testicular cancer, and depression,

(ii) adequacy of existing education and awareness campaigns regarding men's health for both men and the wider community,

(iii) prevailing attitudes of men towards their own health and sense of wellbeing and how these are affecting men's health in general, and

(iv) the extent, funding and adequacy for treatment services and general support programs for men's health in metropolitan, rural, regional and remote areas.

WITNESSES

Committee met at 9.00 am

WOODWARD, Mr Alan Roger, General Manager National Services, Lifeline Australia

CHAIR (Senator Bernardi)—I declare open this public meeting of the Senate Select Committee's inquiry into men's health. The committee's proceedings today will follow the program as circulated. These are public proceedings and the committee may also agree to a request to have evidence heard in camera or may determine that certain evidence should be heard in camera. I remind all witnesses that in giving evidence to the committee they are protected by parliamentary privilege. It is unlawful for anyone to threaten or disadvantage a witness on account of evidence given to a committee and such action may be treated by the Senate as a contempt. It is also a contempt to give false or misleading evidence to the committee.

If a witness objects to answering a question, the witness should state the ground upon which the objection is to be taken and the committee will determine whether it will insist on an answer, having regard to the ground which is claimed. If the committee determines to insist on an answer, a witness may request that the answer be given in camera. Such a request may, of course, also be made at any other time. A witness called to answer a question for the first time should state their full name and the capacity in which they appear and witnesses should speak clearly and into microphones to assist Hansard to record proceedings. Mobile phones should be switched off.

With the formalities over, I welcome everyone here today. In particular, I welcome Mr Woodward from Lifeline Australia. Thank you for talking to us today and thank you for your submission, which we received as No. 89. Do you wish to make any amendments or alterations to the submission as received?

Mr Woodward—No.

CHAIR—Thank you. Do you wish to make a brief opening statement before we go to questions?

Mr Woodward—Yes, a brief statement. Lifeline believes that suicide should be a major issue in the consideration of men's health, noting that men have a four times greater death rate by suicide than women in Australia. To put that another way, 80 per cent of the deaths by suicide in Australia are males. Lifeline believes that suicide is preventable, noting that suicide may occur when a person is experiencing grave emotional distress that is also likely to incur ambivalence at the time towards considering suicide.

I would like to read a short story of a man, John Kevin Hines, who, pacing for about 40 minutes in anguish on the Golden Gate Bridge some years ago, was thinking to himself, 'If one person asks me what is wrong, I won't go through with this.' He thought that over and over. Eventually a woman wearing giant sunglasses approached him. 'Would you take my picture?' she asked. The 19-year-old John Kevin Hines accepted the camera from her and clicked it five times. Then he snapped. The moment Hines released his hold on the four-foot high railing, he regained his grip on reality. During the four seconds between the jump and splashdown, he could think clearly. All the problems that had made him want to die moments earlier seemed less overwhelming than a 220-foot plunge into the San Francisco Bay.

'Oh my God,' he thought. 'I don't want to die. What have I done? God, please save me,' in a prayer that was seldom answered. Since the bridge was opened in 1937, someone has jumped from it every two weeks on average and, out of the roughly 2,000 attempts, only 20 people have lived.

The psychologist Ed Schneidman in the US is a pioneer in suicide research. He once said, 'It's a bad idea to kill yourself when you're feeling suicidal.' That is no joke. When you are feeling suicidal, you are not solving problems well. You are unable to step outside of your troubled mind. Those things make for a very dangerous situation. The realisation of the risk of suicide can come too late for many people—men notably in Australia—from those whose lives and achievements seem worthy of celebration considering suicide, through to people who are struggling with life at all times. The final act of suicide perplexes family and friends, leaving behind a legacy of loss and bereavement. It is estimated that, for every death by suicide, 10 people are significantly impacted by that death.

That story illustrates part of the reality of suicide—that is, that there is an ambivalence and often a cry for help. Lifeline is an organisation that, since its inception in 1963 in this very city Sydney, by this very mission, the Wesley Mission, commenced work to reach out to people who are feeling suicidal so that they would have somebody who would be there for them and support them. We also know that encouraging help seeking and making help available and accessible, such as through 24-hour, seven-day-a-week crisis lines such as the Lifeline 131114 service, can make a difference. We know that, in the case of men particularly, building protective factors—where they have support from friends, family and the community—building the capacity to problem solve and address issues in their life and building coping strategies will make a difference. We also know that social inclusion will facilitate both the access to support and the building of protective factors.

In this sense, suicide is an issue that remains loaded with stigma in Australian society. That stigma, or the sense of shame at feeling suicidal, the inability to talk in a community about suicide and to educate people to be aware of the potential for people feeling suicidal and knowing how to issue frontline support, all go together as barriers to people accessing help.

Lifeline believes, particularly at this time—where we are facing economic difficulties; where there is the experience of drought and drying in the continent and massive structural adjustment in rural and regional areas; where unemployment is likely to rise, by all projections, and many households are facing financial difficulty—that suicide and men's health should be taken as a serious issue for this country. Lifeline, as an organisation experienced in suicide prevention, is concerned that, with the current economic crisis and social pressures, we could see an increase in suicide deaths in Australia unless preventative measures are taken. Thank you.

CHAIR—You mentioned in your opening statement that 80 per cent of people who suicide are men. It has been put to us that more women actually attempt suicide than men do and they are perhaps just not as successful at it. Is that information correct?

Mr Woodward—I am not sure I am in a position to express a clear view on that, in that the data around suicide attempters in Australia would not be definitive. There is some data that indicates presentations at places like accident and emergency in hospitals, but it is unlikely to pick up all attempters. So it is not something that I could really comment on in detail.

CHAIR—Does Lifeline keep a record of calls that are made to you of people who have actually attempted suicide or are just contemplating it? Do you differentiate between them?

Mr Woodward—Yes, we can give you some data along those lines. This is data collected from a profile of calls to our 131114 service in 2007. We take around 450,000 calls a year to that service and around 3½ per cent are where suicide is a significant or key issue in the call. Our telecounsellors are trained to identify suicide ideation and the risk of suicide. That translates into around 45 calls a day where suicide is a significant issue in that person's life. Just over one call per day is where a suicide attempt is in progress.

Senator HEFFERNAN—I have to say that I get a few of them. A male prostitute who used to service some of the people around town here rang me one day, and I would like to get the break-up between the call for help and the suicide—that is, on the path to suicide—but I have found through my own experience with a series of traumatised people that the phone call is for help, like the man on the bridge. This guy was making a choking noise. He was actually hanging himself by swinging off a motorbike in the bush. The long and short of it was, he really just wanted to talk to someone but no-one would talk to him so he had stretched his neck. I just said, 'Hang on, mate, swing back onto the motorbike, because I want to have a yarn to you.'

We eventually got the police out in the bush at Bargo. He lived in a double-decker bus there. We took him to Camden Hospital, to Waratah House there. Do you know what they did with him? This is how inefficient the system is. They wanted to know if I was his partner, for a start, and I said, 'No, I've got a slightly different profile to that.' He was still alive, this bloke, stretching his neck. To the government's credit, I was able to get him housing instead of a double-decker bus to live in. They said, 'All we can do with him is give him a pill, sit him in the sun for a few hours and send him home.' That is all the care they could give him.

If you talk about being efficient, Lifeline is a wonderful organisation. A lot of these people just need someone to talk to. It is just bloody dreadful! I have endless examples of people who just need someone to talk to. Once you get a reputation for talking to anyone, they ring you, which is good. Thank you, Mr Chairman.

CHAIR—Thank you.

Senator HEFFERNAN—As the chairman said, women may well make more calls for help by way of the threat of suicide, which is really a call for help. World wars start because people stop talking to one another. I know when I get the shits myself, it is handy to talk to someone.

CHAIR—Did you want to respond to any of that, Mr Woodward?

Mr Woodward—No, other than to say that, broadly speaking, one-third of the calls to 131114 are from men and two-thirds are from women. I am happy to try and get further details for the inquiry.

CHAIR—I am intrigued by that. One of the challenges that men's health seems to be facing is effective communication targeted towards men, dealing with both physical and mental health problems that may be there. What steps does Lifeline take in this regard to target men specifically, if any?

Mr Woodward—We have done a number of things. At one level our broad approach to encouraging people to phone the national helpline, 131114, is part of our ongoing outreach in communities. Through our network of 42 Lifeline centres in all states and territories, we undertake community outreach which, broadly speaking, encourages people from all walks of life to seek help, to phone and talk to someone when they need support.

In more specific outreach, we have undertaken a number of programs that target messages to men. One example of that would be through the motor trade industry, where we worked with the industry association for a whole campaign under the banner of 'Read the signs'. We produced communication and education material and also ran awareness-raising workshops, particularly with young apprentices in the motor trade industry. We found that to be an effective approach to getting those messages through, suggesting that people seek help and also encouraging peers, friends and family members to realise when a person is struggling and to be there to support and encourage them. We also have a partnership arrangement with the NRL, with a program under the banner of 'Help a mate stay in the game', which again is largely directed towards males.

Through our partnership with LivingWorks, which is an international organisation that produces suicide awareness and suicide prevention, education and training materials, we have operated in Australia for more than 10 years to educate individuals and communities around being alert for suicide—to see the signs with a friend or family member and to know how to—

Senator HEFFERNAN—Do you think there is some way of picking up those signs?

Mr Woodward—Yes, there are indeed.

Senator HEFFERNAN—Would you like to articulate some of those signs.

Mr Woodward—I would refer the inquiry to one of the attachments to our submission which relates to identifying and supporting people who may be feeling suicidal. I will summarise some of the key points. A noticeable change in a person's outlook may be a sign. A person may start to talk in ways that are not typical or are suggestive of an underlying deep distress, such as, 'I don't know when things are going to end. I don't know how I'm going to get out of this. I don't feel I can go on any more.' Sometimes the signs can be more overt—that is, people may be giving away their possessions or making statements that indicate some finality.

However, it is also important to note that there are life situations or changes in life situations that might trigger suicide ideation, and in that sense it is a matter of being responsive to a person who is in need, say through a relationship breakdown, loss of work or another form of loss or grief.

Senator HEFFERNAN—Is there a break-up between economic trauma and social trauma on the path to suicide? Is it more economic or more social—having a blue with your girlfriend, or the wife has walked out, or the husband has walked out, or whatever?

Mr Woodward—I am not sure that I can quantify it. However, I would note that there are two factors that men are known to seek help for. Relationship breakdown is a significant issue for many men in Australia. Around one-third of the men that call our service are divorced or separated and one of the top three issues that are the focus of a call to 131114 is family and

relationships, which may not include an actual relationship breakdown or separation. So relationships and family are a very key part of the social determinants.

Senator HEFFERNAN—Yes, it gets pretty hard even for the police to deal with, because when people get to that point they become irrational. If you talk to police that go to domestics, they are pretty scary scenes sometimes.

Mr Woodward—That is another example where preventative work can be so much more powerful. Lifeline has participated in the Family Court mental health program in the last couple of years. That program sought to particularly promote the use of services such as the Lifeline telephone counselling service to clients of the court who were going through difficult times and to train Family Court officers in identifying where a client might benefit from that. Lifeline was pleased to participate in that initiative.

Senator HEFFERNAN—Have you identified people who tend to suicide because have been done over by the system? By that I mean where they are in the right but the interpretation of the law says they are in the wrong. As we all know, the courts are not about the truth; the courts are driven by the law. You can get a smart lawyer not to tell a lie but to avoid the truth in court and, if he is a smart enough lawyer to use precedent, he can get you out even though you are guilty. On the other side of that equation there are people who are telling the truth or who are innocent who get done over by the same law. It is nothing to do with the truth. Lawyers and judges do not like to own up to that, but it is true.

Recently—and this was not given any publicity—I had a great trauma to deal with in relation to a certain Comcar driver. He was involved in something that brought some notoriety to me, which basically was true. He actually hanged himself on Christmas Day, because he was having trouble, I believe, dealing with the fact that, despite the truth, he got done over.

Mr Woodward—The onset of suicide ideation can involve many complex factors in a person's life. Some of those factors may be obvious to friends, family and associates and some may not. But through training and awareness raising, it is more likely that those signals and signs can be picked up.

Senator HEFFERNAN—You might not be able to get the code, because in that particular instance of the Comcar driver, which everyone has hidden away and pretended did not happen, I spoke to the family and they could not pick up any signs. It is just a great tragedy.

CHAIR—That prompts a question, Mr Woodward. In your experience, is the mental health issue attached to suicide generally a short-term aberration, if I can describe it like that, or a long-term medical condition that needs extended treatment? Do you have any information in regard to the prevalence of suicide amongst those with just a short-term issue and those with a longer term mental illness?

Mr Woodward—It could be either. The desire to end one's life can be an episodic and sudden experience, and there is some research evidence that shows that shortly after, if the person lives, their ideation dissipates and, with a profusion of support, is unlikely to return. It is, however, the case that an underlying mental health disorder can bring on suicide ideation and create a more chronic situation, and there is some evidence that indicates that the experience of clinical

depression can be related to suicide ideation and death by suicide. So it is a both/and situation rather than an either/or situation.

CHAIR—I accept that, of course. For those that are experiencing circumstances that seem to push them over the edge, how effective is talking and counselling? Senator Heffernan said that a lot of these people just want someone to talk to. Is there a measurement of effectiveness that you can talk about?

Mr Woodward—Yes. We believe that a crisis line such as Lifeline's 131114 service is effective. In the last couple of years seminal research has been undertaken in the US with our cousin service there, the National Suicide Prevention Lifeline. What that has shown is that helplines are effective in, firstly, relieving emotional distress, which clouds the mind and leaves a person unable to draw on their coping skills, and, secondly, in actually building coping skills. It also shows that suicidal people will phone a service such as a 24/7 helpline and, in that sense, it paves the way for risk assessment to be undertaken for support for those callers, including the possibility of a request for emergency intervention where life and safety are at risk.

The research in the US further showed that there was a lasting impact for some weeks thereafter to the call. So it is our belief that a helpline service literally can save lives. In that sense Lifeline views its service as an essential national service in Australia.

CHAIR—As such, with the evidence pointing that way, do you receive government funding and, if so, how much?

Mr Woodward—Yes, we do receive government funding in a number of ways, both federal government funding, which has been used to support our infrastructure and capabilities, and funding from some but not all state and territory governments to support the operation of the service through Lifeline centres. We also raise funds ourselves through our business activities, such as shops and fundraising, and through the call for donations, and we have an annual campaign.

CHAIR—How much money do you get from the federal government?

Mr Woodward—I could take that on notice overall, as it does vary around the country.

CHAIR—Thank you, I would appreciate that. Also, if you are happy to, could you provide us with the annual cost of the entire service that you run.

Senator HEFFERNAN—In southern New South Wales this year, if it does not rain this winter, we are going to face our fourth failure. Northern Victoria and South Australia have a 30 per cent chance of average winter rainfall. You blokes in the north are facing 70. I know, just from driving around, that there are a whole lot of farmers who are 60-odd years old who feel that in their economic circumstances they are back where they were before they started life as a farmer and who are seriously depressed. Are you aware of that and would you be prepared to place more ads? The average cocky would not know anything about Lifeline, I would not think. Would it be possible—it is good enough to put pink batts in bloody roofs, and that is supposed to be a Snowy scheme, allegedly, according to the paper the other day—to get some extra advertising into rural areas, especially the drought-affected areas of the south, because I can

assure you that everyone has the wobbles up down there. If we get another winter failure and the Murray River system fails and the Goulburn River system fails—and there is a 50 per cent chance that the general allocation of water in the Murrumbidgee River will fail—it is going to be very traumatic.

Mr Woodward—We would be pleased to undertake any community outreach we can. We have previously run television and radio advertisements, using community service spots, to encourage help seeking and to promote the Lifeline service. Some of the centres in those areas that you refer to have been involved in outreach activities on the ground. Occasionally there have been specific initiatives for suicide awareness training. I am aware of one in New South Wales which receives some support from the AMA, I believe. We are keen to undertake any initiatives on the ground that can encourage help seeking.

Senator HEFFERNAN—I think there is a hot spot coming up, having dealt with a few people who have lost someone suddenly, with no prior indication. Most farmers are pretty independent old codgers and they do not like to show signs of weakness. It gets to the stage sometimes—and I will not use the 's' word again; once is enough on *Hansard*—when you really get beside yourself with whatever the issue is, you can see that it always helps to talk to someone.

Mr Woodward—Yes.

Senator HEFFERNAN—But these people, because they live in an isolated situation—much the same as domestic violence—become trapped by their isolation.

Senator WILLIAMS—Mr Woodward, in your submission you are saying—and I agree with you totally—'Get help early.' I am going along the same line of thinking as Senator Heffernan, being in the bush and seeing people go through droughts and tough times, and many of these farmers think they are 10-foot tall and bulletproof. They are not; they are human. How can we encourage these people to get help early, when some of them are so locked up in themselves and do not want to talk to anyone? Have you any ideas on that?

Mr Woodward—You are hitting on a key issue relating to men's health, which is the notion of stoicism—that is, a reluctance to seek help from others and a belief that problems should be endured rather than solved. That is a cultural or attitudinal factor that can affect men's health, both physically and mentally. How do we address that? Part of it is through community education and outreach, to encourage a different way of looking at things. Some of it is through men-appropriate services, where men are encouraged to talk with other men or interact with other men. I do note in your inquiry agenda that you will be hearing from Men's Sheds groups and so on.

Some of it is about equipping the people who are around those men to be caregivers or supporters and to actively ask questions about how they are travelling. Those are all ways in which that issue can be addressed.

Senator WILLIAMS—I have been working with New England Health up home, and we had a good session in Bundarra last Monday week to which about 15 people came along. Its topic was, 'Mates helping mates in tough times.' We are trying to sell a message. I know the radio

have been doing that for the last week in the north of New South Wales, saying, 'Look, men are not bulletproof. There's plenty of people to help.' This is the amazing thing. Centrelink has something like 37 programs available for people in rural areas that are doing it tough. We have Centacare; we have lots of groups out there. Some of the advice GPs are giving includes, 'If you are feeling down, talk to your GP.'

How can we promote this more? Senator Heffernan has touched on it. Should we be saying to the government, 'Look, give us $10 million for an advertising campaign, where we can run these adverts through rural communities especially, because of the drought and the tough times et cetera.' Would you see that as good help, with some federal funding to actually run campaigns with some iconic Australian in the advert?

Mr Woodward—It could possibly be, particularly if it were linked in with promoting help seeking to something like a national helpline or other help services. Lifeline's experience is that, when there is government-led national advertising of a general nature, that can bring forward people who will seek help. So there is certainly a role for broadly based community outreach of that nature.

Senator WILLIAMS—We were told the other night, just like on a slippery dip, if you get a cold and you do not take action, the next thing is you have the flu; if you do not take action, the next thing is you have pneumonia; the next thing is you are dead. Mental health can be the same. At the first sign of feeling down, if you do not get help, you can go down till you get into anxiety and then depression and then death. How do you identify this? How do you identify people when they are just in the early stages? Would you be able to answer that question through your experience in Lifeline?

Mr Woodward—Yes. One of the answers to that question is the concept of transitional zones or transitional times in a person's life. Where change occurs or in critical times of transition in a person's life, that is where attention to the provision of care and support is particularly important. In relation to young people, some of those transition points might be, for example, movement between primary and secondary school or movement from school into the workforce. In adult life, some of those transition points can be getting married or forming a long-term relationship, possibly the breakdown of a relationship, career outset and possibly issues such as job loss. Physical health issues may mark a transition point in a person's life. I note that the prevalence of major physical illness amongst men is greater than women and we might anticipate that that has some bearing.

If I could reflect a little on some of the profiles of callers to Lifeline services, you will see some of these themes. Of the caller profile that was provided to the inquiry—a slice of data of calls to our service in 2006—the age profile for most calls was generally in the 41- to 60-year age category, which, from our thinking, reflects that it is often in those middle years of life that major change or transition can occur that suddenly put a person in need of support. Fifty-one per cent of the callers were not in a relationship at the time of calling. One-third were divorced or separated.

As I mentioned earlier, family and relationship issues, in particular, are major reasons for people calling us. A quarter of the calls related to the caller's health or disability, often physical health issues or experiencing a change in employment or life situation as a result of illness. Just

under a quarter—24 per cent—of callers phoned about what we call self in community, which relates to how people sees themselves in the community, possibly experiencing difficulties relating to that community, including loneliness and a lack of social support.

Those are the factors that give us some indication of when a person may consciously need to seek support, and therefore help-seeking messages, programs and access points can be created around those transitional points.

CHAIR—There are a number of submissions that talk about family breakdown and things of that nature, and you said that roughly a third of the men that call Lifeline are divorced or separated.

Mr Woodward—To clarify, that is one-third of the callers.

CHAIR—One-third of the total callers? Do you keep data relating to children and custody issues?

Mr Woodward—We do not keep information at that level of detail, no.

CHAIR—If someone calls up, the immediate issue is to stabilise the situation—is that right?—and then to find the root cause. How does the process work for Lifeline?

Mr Woodward—The process will be guided by the situation of the caller. However, in a general sense the first part of our call is to establish a trusting connection with the caller. Lifeline's values are to provide a respectful interaction and non-judgemental approach. The second part of the process will involve the exploration of the emotional impact that a caller is experiencing, and that will vary with every caller. For many callers it might be a time of high emotion, and the need to express that to somebody is important.

The call will also explore what are the opportunities to address the particular issue at that point in time, with the focus of the call being around what in the here and now can be talked about and addressed, with an understanding that sometimes addressing one small thing can assist in building the coping and problem-solving capacity of a person. It may be a very simple thing—as simple as working out what they are going to have for their evening meal—to perhaps a focus that is more ongoing, and then looking at what people and support structures are around the person that they can reach out to to receive further support. We do not view our service as an ongoing support mechanism but, rather, a response at a point in time, and we seek to equip people with information about where they might obtain ongoing support.

CHAIR—Is it normal for a person to repeatedly ring your service and request to speak to the same individual?

Mr Woodward—There are a number of callers who phone our service repeatedly, yes. Over the last couple of years we have made changes in our delivery, so we operate as a complete national pool of telecounsellors across the locations. It is now very unlikely that a caller phoning repeatedly will talk to the same telecounsellor on each occasion.

CHAIR—You mentioned that you try and refer them out to other services to obtain help. What is your experience and understanding about the availability of those services, particularly in some of the rural and remote communities? Are there enough to fulfil the need?

Mr Woodward—Could I clarify firstly that, while we might be suggesting other services, such as specialist mental health services or other community services which may also work with a caller around seeing which family and friends they can rely on and what other supports there are in the community, it is not a service referral per se. Having said that, in some areas of the country there are not immediate services available. You touched on rural and regional areas: again, in the profile we submitted to the inquiry, which focused particularly on the needs of rural and regional male callers, we did note that some callers may have been using the Lifeline service because they could not access other services in those areas. We think there is an issue around after-hours access to support, and the Lifeline telephone counselling service operates 24/7 so that people can phone in at any time of the day on any day of the week.

CHAIR—Going back to your service again, you are receiving 450,000 calls.

Mr Woodward—Yes.

CHAIR—That is an extraordinary volume of calls. I know you are going to get the funding information for us, but are your telephone counsellors principally remunerated or are they volunteers?

Mr Woodward—Almost all of the telephone counsellors are volunteers.

CHAIR—Do you have difficulty in attracting people to volunteer within the organisation?

Mr Woodward—As with, I think, many organisations that utilise volunteers, we experience difficulties. Pleasingly, we have a workforce of around 3,500 to 4,000 volunteers nationally. With government funding support that we are grateful for, we are presently undertaking national recruitment exercises and looking at ways of further increasing our volunteer numbers. But Lifeline, as with other community based organisations that seek to utilise volunteers, does struggle to attract and retain volunteers.

CHAIR—Is there any opportunity for those who have benefited from Lifeline counselling to step up to the plate and become volunteers themselves, through their own experiences, or is that not something you have investigated?

Mr Woodward—I am not sure I understand the question.

CHAIR—If someone has contacted Lifeline, gone through suicide prevention and benefited from the services, quite often they have a unique insight into the conditions that led them to where they were at that point in time and recognise the benefit of those discussions; that has been my experience with other organisations. Have you had any success in getting those people involved in your organisation as volunteers? Do you see that as a potential benefit, or is it a greater risk?

Mr Woodward—We believe that many of the people who volunteer as telecounsellors are people who have used the service in the past or have simply had a life experience which has created some difficulty for them. Some of the underlying traits we are looking for in telecounsellors are empathy and the ability to relate and connect with other people in times of difficulty. Often the people who can do that best are those who have experienced difficulty themselves. One of the qualifications I would put is that a person who is currently going through a critical time in their life may not be well suited to going on the phones and supporting others, but we recognise that many people in the community have had difficult patches in their lives and they come to a point where they then want to put something back and are often very suited to the work.

CHAIR—What is your interaction like with medical professionals and general practitioners? I will not ask if they refer patients to you, but do they make people aware that your facility is available and help promote it? Do you see that there could be some beneficial greater interaction?

Mr Woodward—We do know that many medical practitioners and health professionals, such as psychologists, psychiatrists, community health workers, mental health teams and other community service workers, will consciously promote the Lifeline telephone counselling service for after-hours support to their clients. We do have some interaction with those organisations, both nationally with peak bodies and regionally with those on the ground.

Our goal is to try and form constructive partnering relationships, where we think we can offer something. We also think that more could be done there. We think that there could be greater use of collaboration and partnership models between the formal or specialist services and a not-for-profit, non-government organisation such as ourselves.

CHAIR—Thank you very much for coming along today. In conclusion, if there was a single measure that we could introduce or enact that would reduce the number of suicides in Australia, which is in excess of 2,000 per annum, what would it be?

Mr Woodward—The single measure would be to secure a sustainable follow-up service for people who are identified at high risk of suicide. Over the last couple of years we have, on a pilot or developmental basis, offered that service to people identified through the 131114 service as at high risk of suicide and have then offered and provided call-back contacts and follow-through. The same could be done for people who are identified, through accident and emergency, in hospitals as at risk of suicide or through GP surgeries or through other services.

We believe there is a sound evidence base that that follow-up support is effective and also facilitates longer term action around the underlying causes or conditions for a person. That would be one single measure that Lifeline believes could be introduced into the overall service mix in Australia on a sustainable and appropriately funded basis.

CHAIR—Okay. Thank you, Mr Woodward. Senator Williams, did you have anything further?

Senator WILLIAMS—No. That is it for me, thanks, Chair.

CHAIR—Mr Woodward, would you like to add anything before we complete this part of the proceedings?

Mr Woodward—No, thank you.

CHAIR—Thank you very much for your evidence today.

[9.44 am]

MARSH, Mr Warwick, Chief Executive Officer, Dads4Kids Fatherhood Foundation

O'NEILL, Dr Tim, Medical Policy Adviser, Dads4Kids Fatherhood Foundation

BROOKMAN, Mr Ron, Relationships Policy Adviser, Dads4Kids Fatherhood Foundation

CHAIR—Welcome, gentlemen. I did make an opening statement in regard to these proceedings today, but I noticed you were not here. I will remind you that a witness called to answer a question for the first time should state their full name and the capacity in which they appear. Please speak clearly into the microphones to assist Hansard in their recordings. I would ask you to have your mobile phones switched off. Thank you for coming along today and thank you for your submission. We received it as No. 69. Do you wish to make any amendments or alterations to the submission as it has been tabled?

Mr Marsh—There are just a couple of cosmetic adjustments and we also want to list the series of documents we want to table today.

CHAIR—Thank you. Mr Marsh, are you going to be the spokesman for this group?

Mr Marsh—If we could have a few minutes to speak, we will be as brief as we possibly can, because we know you want to focus on questions.

CHAIR—I will invite you to make a brief opening statement, if you would care to.

Mr Marsh—Wonderful. I am the founder of the Fatherhood Foundation. It is a great privilege to be here. I should mention that I just had a call from Tony Miller and he is stuck at Taree. He hopes to be here at 10.45, but he is on his way.

Firstly, I would like to thank the Senate for agreeing by a majority vote to appoint a Senate select committee. Congratulations! Secondly, I would like to thank the chair for the invitation, and I really appreciate this. I would like to make a few brief comments and then ask Ron Brookman, who conducts the relational restoration and educational counselling service and is very much involved in the many problems associated with fatherlessness, to make a few brief comments. I would also like to ask Dr Tim O'Neill here on my right-hand side, a GP from Canberra, to make a few comments. Dr Tim is the medical policy adviser to the Fatherhood Foundation and has a deep interest in men's health.

I would like to table a corrected version of my original submission, which includes the PDF research documents as listed which directly support our submission, highlighting the importance of successful fatherhood, strong marriages, positive family relationships, good friendships and caring communities as the major social determinants of men's health and wellbeing. We are excited that the government is using the broader World Health Organisation definition of health—that is, complete physical, mental and social wellbeing, not merely the absence of disease and infirmity. I would like to quote Mr David Learmonth, Deputy Secretary of the

Department of Health and Ageing, because I thought his comments made on 26 March were brilliant. He said:

... there is a genuine desire for the government to address men's health holistically and to look at psychosocial wellbeing as well as their physical needs. There is an emphasis on the importance of the social determinants of health—in particular, education—for boys and men.

I congratulate Mr Learmonth again, and the government. We congratulate the government on their direction. We want to point out that a holistic approach to men's health forms the basis of our submission. We request that the items which I will mention be uploaded as supporting documents to the corrected version of our original submission which we sent down to Mr Reid yesterday and provided to the senators today.

I am going to ask my associate to give a package to each of the senators and also I will provide a pack for Senator Lundy. Please give her my commiserations that she could not be here today. As a previous member of the Building Workers Industrial Union, I thought it would be nice to say, 'Hello, comrade.' But all the best, Senator Lundy, and sorry we cannot meet up today.

I will briefly table these documents and then I am going to hand over to Ron: *Fathers and Families*, which documents the high cost of fatherlessness and the subsequent cost to our health as a nation, published by the Fatherhood Foundation; *21 Reasons why Marriage Matters*, which documents the health benefits of a strong, sustainable marriage to men and women, published by the Fatherhood Foundation; *16 Reasons for Sexual Integrity*, which documents the benefits of promoting quality relationships between men and women and shows that the practice of sexual integrity safeguards human health, published by the Fatherhood Foundation; *21 Reasons why Gender Matters*, which documents the gender differences between men and women and the need to celebrate our 'complementarity' and outlines the health benefits that come from positive family relationships, published by the Fatherhood Foundation; a report called *Mortality over 20th Century*, a great reference tool for analysis of mortality in Australia, which is by the team at Western Sydney University; and, lastly, *The Roseto Effect*, an independent reference article on the powerful effects of positive relationships for good health, which of course is the key story of our submission. Over to you, Ron.

Mr Brookman—Thank you. I am from the Fatherhood Foundation and I am a pastor at Ramsgate Uniting Church. In our submission 'Healthy Men, Healthy Families, Healthy Nation', *The Roseto Effect*, as described by Malcolm Gladwell, is mentioned. The originator of the Roseto study, Dr Stewart Wolf said, 'People are nourished by other people.' A large measure of human health comes from the quality of relationships that we have in our families and in the broader community. When the town of Roseto in the United States was first studied in 1966, the cardiac mortality traced a unique graph. Death from heart attack for men goes up with age but in Roseto, a town in the USA known for its strong community, strong families, strong marriages and strong spiritual life, it dropped to near zero for men aged between 55 and 64. For men over 65 the local death rate was half the national average.

It has been shown in numerous scientific studies that having friends increases your life span. The ALSA study—that is, the Australian Longitudinal Study of Ageing—by the University of Adelaide in March 2001 showed that people with extensive networks of good friends and

confidantes outlived those with fewer friends by up to 22 per cent. The single greatest predictor of good health and longevity is marriage. Married men enjoy better health than unmarried men. Figures from the Australian Bureau of Statistics show that the median age of death for non-married men in 1992 was 52.2 years, but the figure leaps to 72.5 years for those who are married.

Males between 20 and 69 years of age who had never married experienced death rates two to four times higher than those who were married. All this information is referenced in our document *21 Reasons why Marriage Matters*, which you have in your packet there. Another key indicator for health in our community across all genders is fatherlessness. Fatherlessness increases poverty, which is a recognised breeding ground for poor health. Fatherlessness lowers educational performance, which is directly linked to poor health for all genders.

Fatherlessness increases levels of drug abuse and violent crime, which contributes to higher levels of poor health, injury and morbidity amongst men. All these comments and many more are documented in our submission 'Healthy Men, Healthy Families, Healthy Nation'. Over to you, Tim.

Dr O'Neill—Thank you very much, Senator Bernardi and other senators and staff. I am a medical practitioner in Canberra, counsellor and medical adviser to the Fatherhood Foundation. In relation to the current health status of men, over the last 50 years we have done very well with Australian health outcomes. Life expectancy for men is 79 years, a little more than a year behind the world's best, and life expectancy for women is 83.7 years, the highest in the world. So why are men worried about the state of their health?

Putting it simply, as I see a steady stream of men pass through my office, many men are hurting and hurting badly. As Henry Thoreau once said, 'Most men live lives of quiet desperation.' I would like to invite you to look at men's health through two different lenses. The first one is looking at men's health by the decades of life, from zero to 70-plus. I have a list of those. The improvers over the last 50 years are coronary artery disease, motor vehicle accidents, cancer survivors, infectious diseases, including pneumonia, smoking for those aged over 30, and other accidents.

The increasing problem areas are abortion, family breakdown, lone parenting and underfathering, depression, suicide—which is underreported because of the failure to report alcohol and drug overdose deaths as suicide—and single car accidents. Drugs and alcohol and hepatitis C are rising. There is smoking amongst those less than 30; homelessness; sexual integrity issues; obesity, including childhood obesity and diabetes; cancer of the colon, prostate and skin; work related stress; renal failure; dementia and dependency; and the loneliness of old age.

When one looks at this list, it is clear that the physically orientated issues are all improving, with the exception of those which emerge later in life as the result of older age and effective treatment of former killers. Diabetes is an exception, though one may argue that many of its antecedents are sociologically determined and are related to excess nutrition and inadequate exercise. Those conditions which are becoming more prominent and costly are largely sociologically determined and are the conditions of quiet desperation.

The second lens is that of race and social status. This includes the unborn, indigenes, migrants and refugees, mentally ill, disabled, the elderly and those with a criminal record. These are those men who bear a particular burden of disease, mental illness and social disaffection. The outstanding common factor amongst these—and, using both of these perspectives, it is clear that one dominant factor stands out—is the increasing poverty of family formation and breakdown in Australia. The harm done to the emerging Australian male through the absence or underperformance of fathers and the lack of fathering skill being passed on to sons is now shaping Australian men's health more than any other single factor.

That the majority of households in Australia are single-adult households—so says social researcher Hugh McKay—indicates the resulting breakdown in social order. The failure of the Family Court of Australia and Australian law to recognise the presumption of shared parenting perpetuates the deprivation of many Australian fathers of their deepest needs and responsibilities: to father their growing children effectively. Is it any wonder that quiet desperation stalks the minds of an increasing number of Australian men and their lost voice?

What shall be the government's response? The answers sought by men for this growing despair are multifactorial: spiritual, social, psychological and physical. They are not quick-fix answers. No government can effectively work in this area without a considered response and such a response must outlast the term of any one parliament. More than a decade ago, the Office of the Status of Women championed the cause of suffering women. It is now time for an Office for the Status of Men and Fathers to be formed to serve and advise the current and future governments in this critical task.

CHAIR—Thank you.

Senator WILLIAMS—Dr O'Neill, there are some very interesting statistics there, especially in relation to the whole presentation about the country town Roseto and that friendliness obviously is good for people's health. One of my big concerns is the breaking up of families where children are involved. I know prior to the last election I had a lot of calls from men in Victoria who had split up from their partners and did not have access to their children. One man who rang me had an AVO taken out against him. He had gone to the football to watch his son play sport and he was spotted being within 200 metres of his son, or whatever the AVO regulations were, and actually got gaoled for two days. There must be enormous pressure on these fathers when they cannot have access to their children. What can be done about it?

Dr O'Neill—The recognition of a presumption of equal parenting, shared parenting, must come. At the moment, a disaffected woman—

Senator WILLIAMS—So that is not the situation now, obviously?

Dr O'Neill—No.

Senator WILLIAMS—I am not familiar with the law.

Dr O'Neill—At the moment a disaffected woman may take out an AVO upon a man for vexatious reasons and he is cut out of the action for a prolonged period of time. Yesterday I spoke to a man in a similar situation, where his partner had an affair with another man. He was

unable to cope with the situation. He walked out of the house. She sold his business, which he had worked very hard in for 10 years. He has been unable to have access to his children over the Christmas holidays, over the Easter holidays, it looks like, and she is now blackening his character and saying that he is unable to father his children.

Senator WILLIAMS—She had the affair?

Dr O'Neill—Exactly. Men are the losers in this. There is no doubt about that, and nobody wants to make women the losers but we must have shared parenting and it must be possible to have that done quickly, not after nine or 12 months of court hearings and negotiations at great expense.

Senator WILLIAMS—Is this message getting through to the political leaders in our country? Is that message being spelt out to ministers and members of the government and opposition?

Mr Marsh—We have been working very hard in that area with many different groups across Australia. In our submission is a 12-point plan which was brought together in 2003. A lot of the things in our documentation are not necessarily our policies but those of large groups of people. Our facility is to work with others and coordinate policy development from the grass roots. So we have been part of a campaign to see a presumption of shared and equal parenting.

I have to say here that Mr Howard, I believe, let us down. He had the opportunity to do it; he had the political mileage to do it; and he had the will of the people, because 80 or 90 per cent of Australians want shared parenting after divorce. But what we got was shared responsibility, and it is a pathetic excuse. If you do not like me saying this, please forgive me for my clarity or rudeness. The bottom line is, we do not have what we need to have to make a level playing field for men and women in Australia today.

Senator WILLIAMS—Okay, Mr Howard is not in government any more, as you would be aware. What is the current government doing?

Mr Marsh—It would seem that they are actually going backwards, from my estimation. Talking with guys in the men's movement, the fatherhood movement, the present government is retracting from even a shared responsibility, and it is a concern for me. The laws are set in place. Thankfully, here has been a change in the culture of the Family Law Court, but that change is still very slow. I am not a separated father and neither is Tim, so we have no axe to grind on this issue. I heard the other day that a father was put in gaol for 10 days for sending a card to his daughter. That a man who sent a card to his daughter could get put in gaol for 10 days is a national disgrace. If a mother got put in gaol for 10 days for sending a card to her daughter, that would go around the world 10 times—

Senator WILLIAMS—Headlines in the paper.

Mr Marsh—and there would be a commission of inquiry and that Family Court judge would be sacked. But I believe we need to see a change. The pendulum has swung that way, across that side of the fence, and it has got to come back to the middle, and that is exactly why we are here talking about some of these issues.

Senator WILLIAMS—I am a father of three. No doubt these fathers who do not have access to their children have a lot of mental stress, perhaps depression, perhaps leading to suicide et cetera. Eighty per cent of suicides in Australia are carried out by males, so no doubt the ramifications of not having access to their children could be catastrophic.

Mr Marsh—Yes. I think you will find that the greatest level of suicide is between the ages of 25 and 45 and I think 70 or 80 per cent of those are fathers. I believe that suicide in Australia is driven to a great extent—and has been driven—by the Family Court, and the Child Support Agency, which in many ways acts as a handmaiden for the Family Court and has been very harsh in its rulings. To be fair, there has been some improvement there. We have to be honest: with that legislation there has been some improvement, but certainly there is a long way to go.

Senator WILLIAMS—So your recommendations to the government would be?

Mr Marsh—I am confident, as Tim has said, that we need a presumption of shared and equal parenting, because that puts a mother and a father at equal value to a child. A child is brought into this world by a mother and a father.

Senator WILLIAMS—Yes.

Mr Marsh—Indeed, a child needs a mother and a father. Unfortunately, divorces do happen, but the other thing is that we have to find a way to encourage marriage and to prevent divorce, and that is what we are about. The Fatherhood Foundation is not so much a single dads group. We do support single dads, but we are about putting a rail around the top of the cliff before people fall over, because once they fall over the cliff it is very difficult to put them back together again.

CHAIR—I congratulate you on your submission. I found it fascinating. It explored a range of areas outside what most people think about in relation to men's health. It did not deal specifically with physical ailments. There is a societal context there, and I thought it was terrific.

I would like to ask you a few questions, if you do not mind, in regard to some of the statements that are in your submission. What alarmed me was the reference to the fact that men suffer inordinately. A prevalence of suicide and depression starts at boyhood. One of the statements that I highlighted is:

... more boys than girls have mental health problems, including conduct disorder, disruptive or anti-social behaviours.

That is, I guess, the gestation for some of the serious problems that men experience later in life. What do you put that down to? Is it simply a lack of fatherhood experience or fatherhood skills, which you kind of suggest in some of the other areas of your submission?

Mr Marsh—The other guys might like to comment on this, because it is a very good point, Senator Bernardi. The Fatherhood Foundation has always tried to work across party lines and be bipartisan. We had the pleasure of working with Mark Latham, who, as you know, was the Leader of the Opposition a few years back. Mark was quite passionate about these issues of fatherhood. You might remember he made a speech at the National Press Club, 'The crisis of masculinity', and I think he was hitting the nail on the head. In fact, at that point—if I can make

this observation—he could have gone to power. It was only as he went on and he seemed to forget about the crisis of masculinity that he ultimately lost the election.

I think this an issue of huge interest to people. It is an issue of huge interest to a lot of women. Some of our greatest supporters are women. Yes, there is a crisis, and I believe it is a crisis that starts with boys' education. In our sincere zealotry to help young girls—and I applaud the women's movement for their gains over the last 30 or 40 years—we have helped girls, but boys have fallen 20 per cent behind in HSC score at 18 years of age. Their entrance into university is 55 to 45. Surely we should be seeing a level playing field. We have made it better for women and young girls, who are naturally happy to sit and be very placid and learn, but boys are active. Boys need experience. Boys need a whole different approach to education.

You might be aware that the House of Representatives did a very good bipartisan examination of education, and it had a lot of very good recommendations. It would be great to see some of those recommendations re-earthed. Do you have any comments, Dr Tim or Ron?

CHAIR—Just before you do, Dr O'Neill, can I ask you another question, Mr Marsh. You have described a crisis in boys' education. Is there an extension of the crisis in masculinity? The other reference you made was to a restoration of fatherhood. Those things sound fantastic, and I am interested in what we can do. You have talked about some educational issues. If Dr O'Neill is going to respond as well, I would be interested in exploring that a bit further.

Mr Marsh—That is why we are saying that we need some very strong direction from the government and that is why we need an office for the status of men and fathers. We have a problem which is across several different areas: it is in education; it is in family breakdown. It is a loss of masculinity. There is a crisis of masculinity. Young boys are growing up not knowing who they are, because womanhood and femininity is applauded, but to be a male is to be almost despised. That might sound funny to you, but in certain sectors of society that is how it works, and that is how men often feel.

We have to find a way to holistically address the problem. I am not trying to evade your question, because it is a very good question, but it is such a big issue that we have to tackle it holistically. I believe it starts with the family, not so much education, and it starts with empowering fathers. How many children do you have?

CHAIR—Two.

Mr Marsh—What ages?

CHAIR—Nine and seven. I'm meant to be asking the questions!

Mr Marsh—I know. You are a father and you have learnt from your father. I found—and you will too—that some of the good things I have learnt from my dad I will impose on this generation, but also the mistakes and the weaknesses. Oftentimes I found myself even smacking my kids when they were younger, for things that I was doing wrong, and I had to pull myself up.

There is a need to encourage men, which is what we are passionate about. Our core issue is fatherhood, so our goal is to restore fatherhood and to help men—to encourage them as fathers:

'Yes, you've made mistakes, but you can do it. Yes, your dad might not have been that fantastic, but learn from the good things and go on.' It needs development in the education area, it needs development in human services and it needs development in the Family Court. Any comments from you, Dr Tim?

Dr O'Neill—I agree with that. I think to a certain extent men are their own worst enemies. Men do behave badly at times and they reap the consequences. But I think we have got to the point now where fatherhood skills and awareness are at an all-time low and the sense of transmitting those skills to one's child is depleted. The social capital of fatherhood is now at an all-time low. I think that most people would understand that intuitively, but when asked they would say, 'All that a kid needs is a mother, some sperm and a house.'

Senator HEFFERNAN—That's bullshit! I am sorry, Mr Chairman—and he's no pansy, let me tell you—but, with great respect, one of the problems is they are plain bloody lazy. Some parents are deadset either dysfunctional or lazy and, as we all know, the first child is always a bit of an experiment because you do not go to tech to learn to be a parent. One of the serious problems is that some parents leave it up to the bloody schools to do the parenting.

Mr Marsh—I could not agree more with your first comment, but I would not repeat the words exactly. Yes, what you said is correct.

CHAIR—Dr O'Neill, would you like to finish your statement?

Senator WILLIAMS—How were your parents, Senator Heffernan?

Senator HEFFERNAN—We used to get a kick up the—

Senator WILLIAMS—Not enough!

Dr O'Neill—The sentiments that Senator Heffernan has expressed are essentially that we have handed over the expertise of parenting to the experts, but they are never there, they are not the parents and they do not take the responsibility. They might have ideas about that. We really do need to go a long way to strengthen parents, to give them the authority and the responsibility in every aspect of their children's lives, particularly fathers, to restore them to a situation where they feel proud of what they know about being a father and a husband and a man.

Senator HEFFERNAN—Mr Chairman, I have some pretty strong views about this, in case you haven't noticed! The world's most important vocation without a doubt is parenthood.

Mr Marsh—I agree.

Senator HEFFERNAN—The world's most difficult vocation, by the way, is the priesthood, because they ought to get married, because they wake up like all other men. I will not go any further than that. The greatest reward in being a nurse or a teacher is to see the results of your care and professionalism, whether it is the recovery of a patient or the career advancement of someone you taught as a kid.

With parenthood, one of the great rewards, which the tide of life sweeps away for a lot of people, is understanding not what your parents mean to you but what you mean to your parents. You cannot do that unless you have your own kids. That is a hidden reward.

Now we have 7,000 kids in the Northern Territory with no access to a high school, which is a complete national disgrace. We have a place the size of Victoria called Cape York Peninsula with 4,000 people that live off the coast and we expect the Indigenous people up there—under what they are proposing there now politically with the wild rivers legislation—to just be didgeridoo makers and spear holders.

People need to understand the responsibility of parenthood, and if you are a third generation unemployed person that lives out the back of Liverpool or somewhere, parenting becomes an inconvenience. Parenting is the world's most precious vocation and we have to have people understand that certain responsibilities go with that, which you do not pass up when you put them on the school bus in the morning, then get the teachers to pull them into gear when they get to school. Parents need jerking into gear. A lot of parents are deadset irresponsible and lazy and want to spend their time anywhere but caring for their kids. Understanding what you mean to your parents is part of the solution to that.

Dr O'Neill—That is one of the great tasks lying before an office of the status of men and fathers. It would be to promote the skills and vision to inspire parents to see the value of their parenting.

Mr Marsh—Particularly as fathers.

Dr O'Neill—Yes.

CHAIR—There is talk about the office of the status of men, and, Dr O'Neill, you referred to men being their own worst enemies. You mention in the submission that there is apathy and self-inflicted harm through substance abuse and so on. There is also a call for what you call a male-friendly health service. Can you tell me what you mean by a male-friendly health service and what is actually wrong with the existing health service that is not catering for men?

Mr Marsh—I will hand that to Dr Tim, because he knows a lot more about medicine than I do.

Dr O'Neill—The health service is mostly male-friendly. The willingness of men to access it and be aware of their health needs, particularly their mental health needs, is important. On the physical side, the government has done well with the 45- to 49-year-old health check. That is a great thing. On the mental side, I cannot help but commend the beyondblue initiative as something that has opened the path for people, for men, to talk about depression and so on. We have had some great examples of people like that: Geoff Gallop, and Jeff Kennett in his role as the chairman of beyond blue, have done great work. People are aware of beyondblue. They phone them up and they look at the practitioners on their website and they approach them. We have done pretty well with that and I would hesitate to think that the health service is not that men-friendly.

Certainly the future of general medical practice, which is the doorway to health, is under threat. The majority of people going into that profession are women, part-time women, and may not understand entirely how to relate to men and their health. The future of general practice in Australia is extraordinarily threatened at the moment. In Canberra, we have the worst statistics in terms of the availability of general practice. The average age of general practitioners in Canberra is 56 and they are not going to be there for that much longer, so we have a crisis.

CHAIR—Is part of the crisis getting men to go to their GP?

Dr O'Neill—That is a reasonable thing, and particularly to discuss the issues of mental health.

CHAIR—Is it then the suggestion that a number of the mental health issues that surround men are brought about by this crisis in masculinity or these conflicting messages that you are suggesting men are receiving about what they are meant to be as fathers, role models, providers, sensitive new age types and those sorts of things?

Mr Marsh—I would applaud medicine in general for the advances, but there is a way of approaching men and getting at men. If you scold men and tell them they are naughty and they do not do this and they do not do that, it is not going to work. Yes, there is a need for men to go to the doctor more regularly. A very practical example I can give to you is that we do a 10-week fatherhood course called Good to Great. When I first started doing this course in 2004, men's health was not on the list. It has been a gradual involvement for me because I have looked more and more at men's health. It is shocking. A dead father is no good to any family or any child, so we have included men's health as part of our core curriculum for being a great father. It is just core business for the Fatherhood Foundation.

Men's health is core business, because men are dying five years younger than women. Unfortunately, I have had many friends die at 49, 48, 45, so there are children left fatherless. We see that fatherlessness is a core issue and we need to find ways to get messages out, so when I say male-friendly, it is a case of needing better marketing of medical services. We see that women are going to the doctor more often. They go for pap smears, to hospital et cetera, but that is after 10, 20, 30 or 40 years of working at marketing and addressing the needs of women, which has been part of the call of the women's movement.

Women's health has been a core issue for the women's movement, so we are excited that here in 2009, 20 years after the national health policy for women, the government is considering a men's health policy and that this committee is inquiring into a men's health policy. We see some desperate needs, but we are excited about the progress, that you are here today and that there are people recording these statements, and many other great people who will be coming after us to talk about these issues, aren't we, Tim?

Dr O'Neill—You will hear submissions from people like Men's Sheds and Dads in Distress. The Men's Sheds movement is a fantastic example of giving men an opportunity to talk together. Dads in Distress is about—

CHAIR—The same sort of thing?

Dr O'Neill—Yes—getting people who are in difficult situations to talk together. From my perspective, it is not necessarily how the health system is working but how the networks that are provided for men are working. There are issues of loneliness and quiet desperation, and any promotion of those sorts of organisations is going to go a lot further than just spending thousands of dollars on the health system. I notice that the movement Dads in Distress is facing an axing of its funding. This is absolutely tragic. We had that example of a father in Melbourne a few months ago throwing his kid off the bridge. Where were the people that he could have called? That is the real issue.

CHAIR—In your submission you highlight that there is 34 per cent higher health expenditure on women than men. That is, I presume, a reference directly to hospital funding and treatment of illness. Is that correct?

Mr Marsh—That is a government figure and I think you will find it in the Labor Party's health discussion paper. Just for the record, in my estimation that is pretty generous. I think the expenditure on women's and men's health has a far greater discrepancy than 34 per cent, but that is a figure that has been admitted to by government. I think that is a very fair figure.

CHAIR—Is it then fair to say that you are suggesting that you want to see an increased expenditure on men's health and not specifically on, say, the diagnosis and treatment of physical ailments, which is progressing at some reasonable levels, but outside of the general medical fraternity, or what most people would consider is health spending, such as supporting these smaller groups like Fatherhood, Dads in Distress and so on?

Dr O'Neill—Particularly because much of the health expenditure for women is about reproductive health, going to child-bearing and so on. Of course they need much more involvement with the medical profession during those times. Young men do not come to the doctor and they do not need to come to the doctor for physical complaints most of the time. On the other hand, young men's needs are huge when it comes to their sense of connectedness in the community, and that is where I would be putting my dollar.

CHAIR—But not just young men?

Dr O'Neill—Certainly. As we said, those groups of people who are alienated, and particularly those men who are suffering from family breakdown, must be the greatest area of need that we have.

Senator WILLIAMS—But you are saying they are cutting funding for some of these programs. Is that state or federal funding?

Mr Marsh—That is federal funding for Dads in Distress. If I understand correctly, Tony Miller from Dads in Distress will be here and you could ask him those questions, but certainly the Fatherhood Foundation is a strong supporter of Dads in Distress. It is criminal that here we are talking about having an inquiry into men's health, the government is about to release a men's health policy, and one of the most grassroots organisations in Australia that is dealing with the problem which is probably most easily fixed—the suicide rate; a reduction in the suicide rate—is basically going to be shut down on 30 June. We need to see Dads in Distress funded, because their work is so important. Just like the Men's Sheds, they gather men together.

I have been to their meetings. They get a bunch of guys around a table like this and they can talk. They can say things they have never said before. They can be listened to. That group and that listening and talking actually saves their lives. I have referred many men to Dads in Distress and I know their lives have been saved. Yes, that is a recommendation that would be great to see out of this committee: I would certainly put it to the chair and to the rest of the committee that you put it strongly to the government that Dads in Distress should continue to be funded and not defunded on 30 June.

CHAIR—Mr Brookman, did you have something you wanted to say?

Mr Brookman—I think a strategy to follow would be to look at ways of investing into community groups that already exist—football clubs, other sporting organisations and so forth. Access men at places where they gather and bring messages about the need for doing something more than just barracking for their son or playing football. In training, coaching, look at ways of getting some good psycho-emotional things happening as a way of enhancing the sporting stuff. Just look at the community as it exists, where men actually meet, and inject funding and ideas into getting men to relate to one another.

Steve Biddulph wrote a book on Australian manhood and said that, essentially, we are competitive, isolated and emotionally shut down. That is a picture of Australian manhood, really. Competition can be great, but it can be overdone, of course. The isolation, the loneliness, is the big problem, which stems probably from the fact that we do not give boys and men an emotional language. We need to be working on ways to give men and boys, as they are growing, a language to be able to express what is happening in the heart, in the feelings that are there.

A really important outcome of this inquiry would be to look at ways of funding what is happening in the community where men are meeting, seeking to address those particular issues. That then gets to the root problem of many physical ailments and then, later, depression and mental ailments.

CHAIR—Mr Brookman, is this what you are suggesting an office of fatherhood should be? That is how you have described it. Other submissions have described it as an office of men or a department of men or whatever. Is that what you are suggesting an office of fatherhood should be doing: coordinating an overall approach to communicating matters of health and wellbeing with men?

Mr Brookman—Yes. As the government, the parliament, develops such an incentive, look at ways of getting to the grassroots, where men are meeting now, and bring that positive message.

CHAIR—Are you suggesting that we should be teaching men how to be men or how to be better men or better fathers?

Mr Brookman—Yes. I do not know whether 'teaching' is the right word, but certainly encouraging, mentoring and giving that opportunity. The only way that men can grow to be men is—

Mr Marsh—Through other men.

Mr Brookman—as we encourage one another. It is a relational thing. That is the key area.

CHAIR—So there are not enough positive role models?

Mr Marsh—I think men learn from other men and, as Tim so eloquently said, we have a lack of social capital when it comes to fathering. The world wars knocked a whole slice of guys off and children grew up fatherless and now we are in a situation where between 20 and 25 per cent of children grow up in a fatherless home. All the studies that are coming out around the world, thousands of studies from around the world, show that if you take men and fathers out of the family, the family self-destructs. I will say it again: if you take men and fathers out of families, the family self-destructs.

You might have heard this story. In Africa there was a problem in a game reserve. Wild bull elephants were coming in and destroying all the villages. They were killing other animals and doing horrible things. There was a meeting called to work out what they were going to do, and they were going to shoot them all, but one of the rangers said, 'I've got the answer for you,' and they brought these two older bull elephants into this group of elephants. All these young elephants that were running riot quietened down.

You hit it on the head when you talked about mentoring. It is about finding mentors. We have mentors in Australia. We have great fathers. We have great men. It is a way of accessing those mentors in the community and finding opportunities to encourage this next generation and to put a premium on fathers. I am not saying that fathers are better than mothers. A child needs a father and a mother equally. But something unique happens when a father does something with his child.

Just last Wednesday I took a young boy to the Socceroos. He is 14 years of age. His father is drinking and he has basically grown up fatherless. I took him to the Socceroos and we hung out with my son, another young fellow, and just to be there, to be loved and appreciated by an older man who is not out there to take advantage of him or to do anything wrong, but just to love and appreciate him as a young man, is going to make his week. It is going to make his month. We should multiply those sorts of things by the tens of thousands across Australia.

Many of those things are happening already. Do not get me wrong; it is not all doom and gloom. But what is happening is that society is basically self-destructing. We are losing relationships and marriage, we are losing family, and, as we do that, these ties in our social fabric are fragmenting and, as they are fragmenting, we have fewer and fewer male role models. You can see what is happening in America: there are these massive gangs. People need role models, so they go to gangs. Young people go to gangs.

CHAIR—Mr Marsh, Mr Brook and Dr O'Neill, thank you for coming along and providing the evidence you have today.

Dr O'Neill—Thanks for the opportunity.

Proceedings suspended from 10.31 am to 10.45 am

MILLER, Mr Tony, Founder, Dads in Distress Inc.

CHAIR—Welcome. Thank you for coming along today, Mr Miller. The committee has received your submission. Do you intend to make any alterations to the submission as received?

Mr Miller—No, I do not.

CHAIR—If you wish to make a brief opening statement, please do so.

Mr Miller—I want to thank you for the opportunity of putting a submission in and for inviting me here today to present. I do not want to come with all the facts and figures. You have them in front of you and I am sure you have heard a lot already in regard to facts and figures around suicide. The reality is that we are losing five males every day to suicide in this country. That is through our ABS stats. If you talk to people at the coalface, people that are working in the field, the figure is much higher—the deaths by drowning, misadventure, single-vehicle accidents. We all understand that, and it is simply a case of how many. We know that the coroner is reluctant to put 'suicide' on the death certificate because of the implications of that: it may be insurance; it may be stigma. There are a number of reasons. But everybody that works in the field understands that the suicide rate is much higher amongst males than is actually reported.

Certainly going through divorce or separation is an added reason for men to suicide. I do not know how to explain it. It is simply that, for men, losing their children through a divorce or separation is absolutely gutting. For decades, we men have been asked to fight wars on behalf of our country. We have been asked to go to war and defend our country, defend our families, defend our children; yet, in a divorce scenario today, we are asked to simply walk away. I find that very sad.

Most of the men that we see simply want to see their children. They want to have time with their kids. Regardless of what is happening in the divorce or separation, they just want time with their kids, and it is one of the reasons—a big reason—why we have a large suicide rate amongst those men that are going through divorce or separation.

I would like to address some of the issues that were raised in the previous one, if that is possible. Do I do that now?

CHAIR—I would invite you to address them briefly now, but, so that we have a reasonable time for questions, they can be explored further then.

Mr Miller—On the presumption of equal shared parenting, obviously that is the goal that everyone would like, because it means that we all start on a level playing field and, when going through a divorce or separation, both parties at least have an equal go at things. At the present time it is not that way and it is a big struggle for men.

An equal shared parenting bill would certainly change things. We ask for it. We would like that to happen. At least it would stop the fighting, and that is what we are about. You get into a court scenario. One party wants the kids for so much of the time, the other party wants the kids

for so much of the time, and it just creates conflict. If we could at least start on a fair and equal basis, that would be wonderful.

The biggest issue we have is around enforcement of the court orders. The Family Law Council has recommended that an agency be established to enforce court orders. Most of the problems that we see are where men have court orders to see their children and have been refused that access to their kids. That is when it all goes belly up. That is when the fighting starts between mum and dad, the kids are dragged into the middle of it, the whole scenario ends up in a disaster, and they end up on our doorstep. We would like to see that enforcement agency happen. We have recommended to the Attorney-General that the Child Support Agency take on that role and certainly the Child Support Agency has been receptive in wanting to do that. I think it would reduce a lot of conflict and just might change everyone's opinion or perception that the Child Support Agency is biased. That is certainly the perception out there amongst most people. I think the rest I can leave for when we talk.

CHAIR—Thank you, Mr Miller.

Senator WILLIAMS—Mr Miller, thank you for coming along and for your submission. I want to put a hypothetical case to you. Imagine that tomorrow you were the sole dictator in Australia and you could make the rules. What would be the first four or five things you would do?

Mr Miller—I would certainly like to see 'relationships' being taught in schools. You need geography and history and everything else, but we could bring relationships back into the school system and teach our kids before it all goes belly up. Unfortunately, we see men at the other end of the scale.

Senator HEFFERNAN—What does that mean?

Mr Miller—Just relationships.

Senator HEFFERNAN—What does that mean, though?

Mr Miller—How to get on with your partner. What a relationship is all about.

Senator HEFFERNAN—Hang on. We are at school, we have got schoolkids, and we are teaching them how to get on with their partner?

Mr Miller—How to get on with each other, be it male or female. The trouble is, we do not know how. The people we see do not know how. They struggle with it. I think if it were taught in schools at a young age, when those kids got to an older age—

Senator HEFFERNAN—I think it ought to be taught in the family.

Mr Miller—True.

Senator HEFFERNAN—Bloody school is half the trouble.

Mr Miller—I agree, Bill, but the problem is that the families are already breaking up. We have got a huge divorce rate in this country. Nearly 50 per cent of the population are going through this. If we could teach them now, in school, before they hit the skids, that would be great. It would be wonderful.

Senator HEFFERNAN—As you know—and this is probably blasphemous—single kids tend to be spoilt in a lot of circumstances. They do not have to share their toys with their brothers and sisters et cetera. But when they go to school, part of what school is supposed to be about is learning to get on with the rest of the kids. Surely just being there does that. Would you have a course?

Mr Miller—I do not think it would hurt to have a course and to teach them how to get on.

Senator HEFFERNAN—I think it is hooey. If you have a robust social situation in a school, where you can do all the things that kids do, everything from having a blue with one another to playing cards with one another, that is part of the interaction, of learning to get on and not get on with the mob. I learnt a long time ago that if someone tells you to go and get well and truly knotted—

Senator WILLIAMS—I am surprised to hear this!

Senator HEFFERNAN—you say to them, 'I'm so pleased you've had the opportunity to tell me to get knotted. Now what can I do to help you?' rather than punch him in the head.

CHAIR—Could we go back to Senator Williams's question.

Senator HEFFERNAN—Yes. But, Mr Miller, you are actually saying there ought to be a course, a registrable course in schools, teaching people to get on with one another.

Mr Miller—There should be something that is brought into schools at a young age to teach kids how to get on—how to be human. We are not doing it.

Senator HEFFERNAN—That is like the UN. In my view, the UN is the largest, most corrupt body on the planet. How would you measure a course that taught kids how to get on with one another, given human nature? The more you know about human nature, the more you worry about it.

Mr Miller—That is true. I would agree. I do not know how you do it, as I am not an expert in that field, but it is something that needs to be done.

Senator WILLIAMS—Let's put the education aside, because I think life is a learning experience in itself. I have a lot of arguments and problems with education systems, but surely at a young age children are taught to play with each other and befriend each other et cetera. Let's go back to the law side of things, the family law court matters. As I said, imagine you are the dictator of Australia and you have the power to do everything. What would you do in relation to the law and the way it is currently?

Mr Miller—A presumption of equal shared parenting would be ideal, but also an enforcement of court orders. At the present time, court orders from a family law court are not worth the paper they are written on. They are absolutely not. It is an absolute joke. We have got people that have 200 or 300 breaches. These people are actually breaking the law. They have been given a court order where the father has access to his children and they are being refused that and no-one is doing anything about it—no-one. Yet, if that man misses his child support, watch out, they will come after him with a big stick very quickly.

Senator HEFFERNAN—That is, of course, because the courts are about the law and not the truth.

Senator WILLIAMS—This is a message that has been quite clear today and it was a message that was made very clear to me before the last federal election, when I had single men ringing me up and telling me their stories and how wrong the law was that they could not get access to their children. This obviously goes on to have huge mental ramifications for these men, leading to depression, leading to suicide et cetera.

Mr Miller—It certainly does. As I say, there is nothing more gutting than not being able to see your children—your flesh and blood.

Senator HEFFERNAN—It goes a step worse, though, in some situations. Where a male is refused access and at the same time the law is giving consideration to same sex adoption for the kid, the kid becomes the convenience factor of the so-called parenting couple. It is sort of a double whammy in some circumstances.

Mr Miller—It is, and that is unfortunate.

Senator HEFFERNAN—I will shut up.

CHAIR—You've got the floor now, Senator Heffernan! Senator Williams, would you like to continue with your line of questioning?

Senator WILLIAMS—No, I am fine with that, Chair. I know you have some questions to ask.

CHAIR—I do, and they go, Mr Miller, to the general nature of Dads in Distress. How many people are involved in Dads in Distress from an operational perspective?

Mr Miller—We have about 200 volunteers nationally. There are six of us that are full time and we have a number of part-time people that work in the office and throughout the areas that we are funded in. Unfortunately, we were funded in the past under FaCSIA—I should not say 'unfortunately' because it has been good—under the Local Answers funding, which was not quite the fit for us, but at the time, with the previous government, that was all there was. That was the only basket they could find to fit us into, and one of the big issues for us and for all men's groups in this country is that the funding issues are just non-existent. What is there is normally seeding money. You get a program up and going and the minute you get it going the funding is pulled from under you and you have got nowhere to go.

CHAIR—We will come to funding in a moment if you do not mind.

Mr Miller—Sure.

CHAIR—Let's just go back to the organisational structure. You have 200 volunteers.

Mr Miller—We have 200 volunteers around the country. We operate 45 groups nationally.

CHAIR—How do they operate? How does it work?

Mr Miller—We do a weekly meeting out of these groups. We offer a safe place for these guys to come and talk about how they are feeling—to come and vent, if you like. In some cases they are possibly angry at the time. Most of them I would say are hurt more so than angry, but we certainly do get some angry people. We give them a safe place to come and talk about how they are feeling to other blokes that may have gone through a similar thing. By doing that, it gets it off their chest. One of the biggest problems we have with guys is that they keep it inside and, by keeping it inside, it eats away at them and kills them eventually. The idea of a group is simply that these guys can come in and talk about how they are feeling, where they are going, and we try and guide them about where their future lies, by understanding where they have come from in their past.

CHAIR—How do these people in distress find you?

Mr Miller—We are pretty well known now. We have a website that we have over 10 million hits on per annum. We win awards all the time with our website. We have a 1300 number, where they can call in from all over the country. The groups are word of mouth. It is pretty well known that we are there to help. We are the hospital ship of the men's movement, if you like. We are simply there to put these guys back together—helping them to navigate the future by understanding their past.

CHAIR—You mentioned funding. You previously received some funding under FaCSIA.

Mr Miller—Yes.

CHAIR—How much was that?

Mr Miller—We have been funded over three years. Our last funding round was nearly $800,000 for two years. We are also funded through the CSA, through the CSNSEG group—the stakeholders engagement group. So we have been able to do what we have done very well with what we have had over the last couple of years, but it has never been anything that has fitted what we actually do. As I said, it was just on the basis of, 'This is where some money is at the moment. We can throw you into that basket. It doesn't really fit you, but it'll do.'

CHAIR—We heard evidence earlier that your funding is going to stop as at 30 June.

Mr Miller—Yes. We have about six weeks to go on our funding. We are waiting to hear back from the minister's office. I am confident that we will get funded again in some way. I do not know how. It might only be emergency money.

It is interesting to note—and I will tell the committee here now—that they are saying that we need to go down the mental health road. 'It's a mental health issue, Tony. Put it under that basket and you'll get funding.' I have to say I have difficulty with that. Because a man is divorced or separated does not mean he has a mental health problem. It means maybe his wife fell in love with somebody else and left or maybe he fell in love with somebody else and left. Just because he is a divorced or separated male does not mean he has a mental health problem. What it is is separation grief. He is separated from his kids. That hurts, and he struggles with that. He once had a happy home that he called the family home, he had a bunch of kids, he was working, he was doing his day-to-day thing, and suddenly that is all gone and so is his life. 'Where do I go from here?' He does not know what to do or where to go next. That is where we come in, to try and keep him on that road instead of going down the road of abusing, whether it be alcohol, drugs or whatever. We just try and keep him on the straight and narrow and try and get him back to his kids. We call it 'delivering dad back to his kids'.

It is not a mental health issue. Now we are told, if we want funding, that we have to say that these guys have got a mental health problem. Well, I'm sorry, they haven't! It is not a mental health problem.

CHAIR—There is a link. There is separation anxiety or distress that has been there for families, to substance abuse, to going into clinical depression quite often. Is that accurate?

Mr Miller—Yes, of course. Of course, if you went down that road, that would happen. Maybe we are there before all that happens. But I take offence at people saying that there is a mental health issue with these guys that are suicidal because their kids have been stripped away from them, because they have lost their house, because they have lost their job, because they do not know where to go next. I find that difficult. These guys are just normal human beings, normal males, trying to get on with their lives. They may have been right in the relationship, they may have been wrong, who knows? I am not there to judge them; I am simply there to help them continue on.

CHAIR—When someone goes to one of your groups, you said it is just an opportunity for them to talk and to open up about the issues that they have experienced. What is the outcome? How long do they stay generally?

Mr Miller—It varies. We have guys in there that have been coming for years. In that case, they have stayed for years because we have helped them. They got back on the road. Often they come back and say, 'Look, I'm now talking to mum. I'm seeing my kids more. I'm happier. It is not the perfect arrangement, but it's a lot better than what it was when I walked in the door here. I was ready to neck myself.'

Over a period of time these guys have worked through it. A lot of those guys have put their hands up and said, 'Look, we want to stay on and help the next bloke that comes through, because there was no-one there for us.' That is what it is all about to us. It is about mateship. This country was once famous for its mateship and somewhere along the line we have lost it. I hope that DIDS has resurrected that mateship. It is about a bloke giving another bloke a hand up and saying, 'Hey, you're doing it tough. I'm here to help you. I'm here to listen.' That is what it is about, simply.

CHAIR—If we accept that you and your volunteers are there helping tens of thousands of other men—is that a reasonable characterisation?

Mr Miller—Certainly.

CHAIR—Who is helping you?

Mr Miller—No-one. No, we get a lot of help and support from the other groups that are around. Financially it is tough. We do not have the dollars to do what we would like to do, but we do what we can. I made that analogy when we did the roundtable. That is men's health in this country. It is like holding the bloke up that has just suicided. He has just thrown a rope over the beam of his shed and he is hanging there and we are underneath him holding him up, stopping him from choking to death. He is gasping and he is kicking and he is dying. While we are doing that, we are waiting for somebody to come and help us, and they are just not there.

CHAIR—I am not being the devil's advocate at all, but there are programs that are targeted to suicide prevention and depression and things of that nature that are mass media programs.

Mr Miller—Certainly.

CHAIR—Some of them are very effective. We heard from some of them today and earlier.

Mr Miller—Of course.

CHAIR—I refer to Dads in Distress as a smaller group because it is targeted towards small group interactions. Is that a more effective means of dealing with some of the issues that men are facing in regard to mental health? I say 'mental health' because that is their frame of mind when they are calling you.

Mr Miller—It is certainly important for people who are going through a divorce or separation. I know when I went through it, that is what I was looking for. I needed to talk to somebody who felt my pain, who understood how I felt. I had gone around and told everybody that wanted to listen where I was at and what I was going through, until the point where I would knock on the doors and the blinds would come down, the door would shut and the lights would go out. You join a leper colony: no-one wants to catch what you have got. The benefit of a group like ours is simply to be able to say, 'Look, we understand where you're at. We've been there. We understand your pain. We have felt it,' and we are able to guide those guys back through the maze. And we are not anti-women. In fact, our supporters are mostly women. We have more calls from women than from men, surprisingly.

The calls are very often from second wives, saying, 'Look, I don't know how to deal with this. My husband is depressed, he's lonely. We've got a great relationship, but he can't see his kids from the previous relationship, and we're struggling with that. He can't handle that. How do I help him?' We get that every day of the week.

CHAIR—How many calls would Dads in Distress get annually?

Mr Miller—Around 20,000.

CHAIR—How many men come to your groups regularly?

Mr Miller—That varies greatly. It depends on the group, on what area it is. I do not have the figures in front of me here, but I can certainly get them for you.

CHAIR—Yes. I would be interested in how many people access your services in that small group environment.

Mr Miller—Yes, certainly.

Senator WILLIAMS—Mr Miller, you were saying—and I agree with you totally—that because a man gets divorced, separates or whatever, it does not mean to say there is a mental problem or mental illness or whatever, but surely when he loses the house and has no access to the kids, that all can weigh on him and then cause a mental problem such as anxiety, depression or whatever. Would you agree with that?

Mr Miller—Most definitely.

Senator WILLIAMS—Those things can add up.

Mr Miller—Most definitely, yes.

Senator WILLIAMS—They would be the recipe for a mental problem, yes.

Mr Miller—I would agree.

CHAIR—Mr Miller, earlier we had a submission that there should be an office of fatherhood. You have suggested there should be a department of men and their children. Do you see that the earlier submissions—and you would have picked up on some of the discussion in the evidence—are consistent with what you are seeking to get out of a department of men and children, as you characterise it?

Mr Miller—Most definitely. All we would like to see is something set up—a peak body, if you like; a clearing house or whatever, as we have put in our submission—to collate, collect and disseminate any funding relating to men and their children. At the moment there is no body. It is something that has been raised ever since I have been doing this: 'How come there's an office for the status of women and there's not for men? Does there need to be?'

CHAIR—What is the answer to that? Why is there an office for the status of women and not for men?

Mr Miller—I do not know. It amazes me. It amazes me that the Prime Minister has a minister responsible for women that is an adviser to the Prime Minister, yet there is none for men. It may be because he is a man; I do not know. Maybe he does not need it, but I think he does.

CHAIR—If there an office for the status of men or for fatherhood were established, is there a risk that it might institutionalise some sort of conflict process: 'They're getting this. We want this'?

Mr Miller—I do not think so. At the present time, funding for women's programs is way out of bounds. And, rightly so, they should be funded, but at the moment even a women's refuge in a single town is funded more than men's funding for the New South Wales state. It is crazy. New South Wales state funding was $300,000 last year. Unbelievable. There are a lot of women's refuges—and rightly so; I am not saying there should not be—but there should be some equality or at least some money thrown back into men's programs. There is very little thrown into men's programs. That is the problem.

Senator HEFFERNAN—There is an inherent convention in traditional thinking that the maternal instinct for a child is more important than the paternal instinct and therefore there is a bias towards the mother.

Mr Miller—Certainly. That is the way we feel, and that is what you are presented with when you go into a family law court today, most definitely: 'Mum's the primary carer.' If you want to see your child, you need to fight for it, and you will get every second weekend and half the holidays if you are lucky; and that is only if, when you turn up, the mum says you can have them. If mum says, 'No, you're not having them,' then you have to go back through the court system again and again and again until you run out of money or the emotional strain is just too much and you give up and walk away, and unfortunately we have far too many kids in this country without fathers, because they have walked away. Is that right or wrong? Have they just walked away or is it just too much to bear?

Senator HEFFERNAN—I meet a lot of fair dinkum fathers and I could name a bloke in Junee right now whose son is a good guy who works in a garage in Junee. He married a girl who ran away with a drug addict. The drug addict has been convicted and sentenced to jail, but she has the right to the child, and the drug addict who is in jail—the foster parent or whatever you would call him—has more rights than the father of the child.

Mr Miller—That is right. That is often the case.

Senator HEFFERNAN—It is just bloody crazy.

Mr Miller—It is often the case. If mum picks up with another boyfriend or husband or whatever, he has more rights to your children than you do, and that is one of the big worries.

Senator HEFFERNAN—The grandfather has taken all this to court, I might say, and just cannot believe that we have got these weird, sterile people in the court system who obviously do not understand what the link is with kids, because they probably have not got any kids of their own. I get into a lot of trouble for exploring that area of society, and I will not explore it here today, but there are some natural instincts in human beings that get ignored in the court system.

Mr Miller—And grandparents are the forgotten ones in this battle, unfortunately—very much so.

Senator HEFFERNAN—This is too touchy for me, I have to admit.

CHAIR—You gather your thoughts there, Senator Heffernan, and we will come back to you perhaps. Mr Miller, this is for my clarification: in your submission under 'Fast facts' you have said:

... research indicates that age standardised rates for suicide have been decreasing slowly since 1997 ...

Mr Miller—Yes.

CHAIR—Does that mean that more people are committing suicide at an earlier age?

Mr Miller—I think so.

CHAIR—That is what it means?

Mr Miller—Yes.

CHAIR—Do you have any idea why that is?

Mr Miller—Certainly the divorce and separation scenario in today's society is not helping. I am not an expert in that field, I am simply putting blokes back together again, but I would think it would be as a result of either divorce or separations and the family breakdowns that we are experiencing in today's society.

CHAIR—In your own experience with Dads in Distress, do you find that there is a younger generation of men seeking help?

Mr Miller—There certainly is, yes.

CHAIR—What is the average age, or what age brackets do your clients fall into?

Mr Miller—We see them from 18 up, but we see them a lot in their early 20s, with a couple of kids and a big mess, and they do not know where to go or what to do. It has all gone belly up. They have married very young and it did not work out. Now they are in a heap of debt and paying child support for the next however many years and struggling to make ends meet.

CHAIR—In your submission you have also made a couple of points about the process and about what could be done to alleviate the stress upon some fathers. One of the points you made was that domestic violence is not a gender specific issue.

Mr Miller—That is right.

CHAIR—And I gather you are being critical of the current advertising of domestic violence.

Mr Miller—The campaign that is out there at the moment is a deficit male model program, really, and does little to engender any confidence amongst males. When I sit in a movie theatre with my 10-year-old son and they put an ad up on the screen there, I have to tell you, I slink down in my seat and so does he. There is nothing in that about women not hitting men, as well,

and we see many men that have had domestic violence perpetrated upon them. It is unheard of or not spoken about—taboo—in this country, but it is coming out now and more and more people are talking about it. Statistics are certainly proving that it is vastly different to what has been propagated in the past. We are saying that the program is right, but why not have it up there with both sides? Why is it always a deficit model that is shown? It does not do anything for us at all.

CHAIR—Are there any other issues in regard to domestic violence—other avenues apart from public awareness—that you think we should be pursuing as a nation?

Mr Miller—As I said, you should put a campaign out there to show that it is non-gender specific, that it happens on both sides of the fence. You should be showing that it is not right for females to hit men or vice versa; it is the same. It does happen. I have seen men come into our groups with iron marks on their backs. You can actually see where an iron has been stamped into their back. It happens. People do not want to speak about it. If you go to a police station or you go to report domestic violence perpetrated on a male, they do not want to know. They laugh at you—'You're a male. You're this high and she's that high. Are you kidding me?' These guys come to our meeting and in fact they do not walk in the door; they crawl in the door often. It takes a lot for them to admit in front of other men that, 'I didn't perpetrate violence on her. She actually did it to me. This is what happened, but who's going to believe me? So I just shut up and I cop it and, as a result, I don't get to see my kids any more'—this happens, that happens. It is a nightmare, it is an absolute nightmare.

CHAIR—But where domestic violence is occurring, we encourage women to walk away and seek help in shelters and things, which is another point that you have made in your submission.

Mr Miller—Yes.

CHAIR—But men do not have the same opportunity to seek external support mechanisms when confronted with that, or when confronted with being kicked out of the marital home for whatever reason.

Mr Miller—Yes. There is nowhere to go. Where do they go? There are no refuges for men. There is nothing set up for men.

CHAIR—There are men's shelters. In Adelaide where I am from there are specifically shelters for men, I guess, or homeless men.

Mr Miller—Homeless men, yes.

CHAIR—I guess they are targeted, so it is a different—

Mr Miller—Different, yes. If a bloke is going through a divorce or separation, trying to get somewhere suitable to be able to see his kids for a start is a struggle, especially if he has just lost the family home through a bitter divorce, the whole deal, or he has had to move out—she may have put on an AVO, and the only way he can get to see the children is to have suitable accommodation. Often men end up in caravan parks and those sorts of places, and then the court denies them access to their kids because they are not in suitable accommodation. It is just like a

merry-go-round. It just goes around and around in circles. These blokes are struggling. They are dads and they just want to see their kids, regardless of what has happened in the past.

I understand that certainly the law has to err on the side of protection of the children. If there is an AVO issue that has been brought up, then rightly so, they have to err on the side of caution to protect the children, but often the AVO system is absolutely absurd. We have got numerous people that have approached us over unbelievable orders that have happened over AVO scenarios. It is ludicrous. I have spoken to the Family Law Practitioners Association many times. There is a peak at the moment. If you look at the contact centres—if there is an abuse issue or anything, the kids are ordered into a contact centre, to be able to see dad through a contact centre—there is an eight-month waiting list. So there is a big peak all of a sudden. There are lots of people trying to get into contact centres to see their kids.

We have been told that it is a little bit of a thing they are using at the present time. It is one way of bypassing the FRCs now. Instead of going to a family relationship centre, you can bypass that. You get a free ticket straight into court, which the lawyers love, if there is an AVO. We are told that they are encouraging people to go for an AVO, bypass the FRCs and go straight to court. It is a done deal.

CHAIR—It was suggested by an individual that he went to court to fight an AVO. A number of outrageous claims were made against him—such as that he had murdered 15 people and various other things—by his wife, all of which were unsubstantiated. The AVO was still upheld, simply on the basis that the former spouse was worried about the circumstances. Is that a common occurrence? Is there a perception that there is a complete lack of justification in the granting of an AVO?

Mr Miller—Certainly. It is so easy. They are handed out like lollies these days, they really are. It is unbelievable. We hear case after case in regard to the AVO situation. It is incredible.

CHAIR—You have mentioned that the agencies currently are dealing with things as 'the horse has already bolted and they are shutting the stable door'.

Mr Miller—Yes.

CHAIR—Prevention is often much easier and less expensive and less cumbersome than any cure.

Mr Miller—Certainly.

CHAIR—I do not want to put words into your mouth. Is the cure for the dads in distress—or the prevention, I should say—the acceptance that there should be equal rights for sharing of time with children? Is that the fundamental issue?

Mr Miller—It would be a big jump, a huge jump and a huge change in the way men perceive the system at the moment. They perceive the system as simply being unjust. Many men walk away from the system because they are tired of the merry-go-round. They run out of money or they run out of emotion to be able to continue with the fight to see their kids.

CHAIR—The consequences of that are increased levels of substance abuse; perhaps a slip into mental illness.

Mr Miller—Yes.

CHAIR—And other associated problems that go with it.

Mr Miller—Yes, definitely.

CHAIR—A high level.

Mr Miller—There was one thing that I was going to say: I noticed yesterday—and I unfortunately did not bring it with me because I rushed through this morning—on a court order from a gentleman who has just approached me that Legal Aid has refused to take his case on a merit base, which is understandable—I have no argument with that. But I noticed on the second page that there was the statement, 'Due to the economic restraints of the times, New South Wales Legal Aid will no longer enforce orders.' They will not go to court and enforce any orders. That to me is amazing, and I am about to take this up with the media, certainly push this out to the media, because it is just gobsmacking to me that Legal Aid in New South Wales pull back any help for guys that want to simply see their children. They are trying to enforce orders—court orders, mind you. Somebody is breaking the law here; normally the custodial parent is breaking the law by not allowing the non-custodial parent access to their children, and they are getting away with it. Now it seems that Legal Aid in New South Wales agrees—'Just go away. Do it'—the same as the Family Court turn their head and do not want to know either. It is just amazing. All this has repercussion in men's health, separated and divorced men's health. because where do they go from here? It is just amazing.

CHAIR—Thank you, Mr Miller, for attending today. I wish you continuing success for Dads in Distress.

[11.24 am]

FLETCHER, Dr Richard, Senior Lecturer and Team Leader, Fathers and Family Research Program, Family Action Centre, Faculty of Health, University of Newcastle

CHAIR—Welcome. Thank you for taking the time to come and join us today. In an earlier statement I mentioned if you could, for the benefit of Hansard and other witnesses, state your name and whom you are representing before making your opening remarks. I asked whether there were any amendments or alterations to your submission. You have indicated that there was some additional material. Has that been tabled now?

Dr Fletcher—Yes.

CHAIR—It has? Are there any other amendments or alterations that you wish to make?

Dr Fletcher—No.

CHAIR—Do you wish to make a brief opening statement?

Dr Fletcher—Yes.

CHAIR—Please do so.

Dr Fletcher—I am speaking on behalf of the Family Action Centre at the University of Newcastle, part of the Faculty of Health. If you would turn over the first page, that would give me a chance to walk through some of these documents that you have in the attachments.

CHAIR—These are the new ones that you just tabled?

Dr Fletcher—Yes. I would like to make some points before getting to the point of postnatal depression and fathers. This first document is a document from 1993 that we put out from the University of Newcastle. It had a major effect in Australia because it was the first time that those graphs—like the one that is over the page for cause of death for 15- to 24-year-olds—had been presented in a way that anybody could grasp.

So in 1993 there was a lot of interest from health workers around Australia about how you might prevent the evidence that was in front of them. Many of those health workers who called us after that were women. The nurses at Cairns Base Hospital, the women at the women's health centre in Kalgoorlie, for example, contacted us and said, 'We notice that the men here have terrible health. How can we fix that?' I am pointing that out to you to make some general points about the nature of the way men's health has developed in Australia just from my own experience from, say, the nineties.

The next document, 'Testosterone poisoning or terminal neglect?', is a research paper I did for the parliamentary research service in 1995. That was because the Proudfoot case had caused a lot of publicity and controversy around the nature of men's health and whether there was a men's

health movement that was pushing men's health like the women's health movement of the seventies; and there was not. Basically, I would argue, there still is not. The push for men's health does not come from a men's health movement, although they would be important people to identify. The push for men's health comes from the men's families, so all the women who work in the health service, for example, have husbands, brothers, fathers who have bad health or poor health. They are the ones who have been pushing.

I have included an executive summary in there, but if you turn over to the report on men's health services that I did for the New South Wales government in 1997, that lists lots of examples, such as testicular cancer, where the prime mover for attention to testicular cancer before Apex took it up was a woman who worked at Mona Vale Hospital. Her son was identified with cancer. He recovered, but she noticed that there was nothing in the health promotion unit, where she worked, around testicular cancer, so she advocated and eventually got some money to do the first pamphlets and health promotion. That is a common story: that the way men's health has evolved has not been a group of angry men saying, 'We don't like the way the GP talks to us. We want men's health.' The way men's health has developed has been by community concern, I would say, and in many cases women with community concern.

I noticed in your discussions that are in the transcripts from Canberra, for example, a good deal of discussion about men not accessing services. I want to put the view to you that that is in fact a small part of the problem and that a bigger part of the problem is the services not accessing men. So instead of saying, 'Why won't the men go to the service?' you would say, 'What is that service doing wrong that the men don't appear at the door?' When I was working for the New South Wales government at one stage, they looked at community health centres. They would say, 'The community health centre at Cabramatta has a high proportion of Vietnamese families but they are only 20 per cent of the people who come into the community health centre.' They did not say, 'There is something wrong with the Vietnamese. They don't need health.' What they said to the community health centre was, 'You're doing something wrong here. If a large proportion of your population is Vietnamese and they don't come in the door, what aren't you doing?' I think we should apply the same logic to men.

If you turn over the next page, there are five pictures there from a PowerPoint presentation, a small study which I am offering as an illustration. We looked at pharmacies. As you would know, these are places where anybody is free to go. They are nearly all owned by male pharmacists. The counter staff are nearly all females and they are typical in the sense that men and women can go there and get health advice and products. We did an observation study. We selected 10 pharmacies randomly. We put observers in there to count what people did when they went in. If you look at the table on the right, it tells you that for every 100 males that walked in, 170 females walked in, so women attend those pharmacies more frequently.

But the really big difference, if you look at the bottom, is the way they behaved once they got in the pharmacy. The women pick things up. They open things. They smell things. You can see that it is their territory. The observation bears out what you might know from your own experience—that is, if you go into a pharmacy, men behave differently. They go to the counter, get the business done and get out. When we asked people why that would be, they said, 'Well, it's the men. The men are the problem because they're busy being macho. They don't want to touch anything. They're busy, or they think their time is important, so they don't want to muck around like the women.' All the discussion was around the men.

What we did then was measure the surface area in the pharmacies and coded it. Is this talking to men? Is this talking to women? Or is it neutral, like talking to babies or analgesics, which talk to both? When you code it like that and you look at the surface area—you can see those two pictures there—the coding was not difficult to do. It is pretty obvious who they are talking to in the displays, the one on the left being for women and the one on the right being for men.

When you look at those 10 pharmacies, there are 30 square metres talking to the men and 331 square metres talking to the women. So when you see men behave in a pharmacy like it is not their territory and they do not belong there, it is not, we would say, a problem in the mental health of the men. We would say that the pharmacy is telling them, 'Mate, you jump along here. This is a place for women.' You can see the same thing operating in baby health centres and community health centres. When we interviewed young Aboriginal fathers, for example, about having their first baby, one of the things they said to us—and they were talking about the AMS as well as the hospital—was, 'You go in there and there's stuff on the walls against rape, against stalking, against drugs and alcohol.' They said, 'Where's the picture of us that's about us having our kids? Where's the positive picture of us? Where's something that we'd like to be? All we see are these messages about how terrible we are.' They said, 'That's not me. How come that's all there is?'

This idea that it is in the men's heads that they will not go to services and that it is the men's problem is not borne out by our own experience or research and is not an effective strategy. You are missing at least half the problem if all you do is worry about what the men are thinking and you do not change what the services are doing. I just want to make those brief points.

I also want to point out that the other policy developments that are happening at the same time as this one are relevant and I have included—not that I want to talk to it—the submission that we put to the early childhood inquiry, because in that area they talk about 'parents' and 'how many families'. They do not talk about fathers, and that is a way of masking inadvertently what is not happening for fathers. I just draw your attention to the overlap between your own inquiry and ongoing policy development.

The submission I put in, however, was about postnatal depression and about the dire situation and complete lack of services for fathers when they have depression or when their wives have depression. While the beyondblue initiative has done a fantastic job in general, it is doing absolutely nothing about this issue and there are no plans to do anything, which ought to be of concern.

CHAIR—Thank you, Dr Fletcher. In regard to your submission which deals with postnatal depression, as a layman I understood that postnatal depression in women was often caused by hormonal imbalances. Is that an inaccurate statement? You are shaking your head.

Dr Fletcher—There are the mood swings that happen immediately after birth in the first few days. They are thought to be a rebalancing of hormones. About 80 per cent of women have that, so it is very common. Depression that is ongoing, and can last up to the first two years, is not a hormonal imbalance. That is thought to be a psychosocial effect. For example, they have looked really hard to find a hormonal trigger for that depression, because you can imagine it would be a good answer, but they have not found any. The National Health and Medical Research Council reports, for example, identify that it is not going to be solved by a hormonal rebalance. It is

going to be solved by, and the first line of treatment is usually for, the woman going to a group and talking to other women, with a facilitator like a midwife or a nurse; talking to other women about how she can get out of this mess of feelings: that she is hopeless, that she is no good as a mother and so on.

CHAIR—Most brand-new parents would feel at some point that they have stumbled onto something that is completely overwhelming in dealing with children.

Dr Fletcher—Yes.

CHAIR—You are suggesting that this is quite widespread amongst new fathers, too?

Dr Fletcher—There are two sides to it. The depression is one thing, and I think your previous speaker made a good point: that you do not want to characterise everybody who is in a bit of strife as having a mental health problem. However, the new evidence we have had in the last decade addresses Senator Heffernan's question. The old model was that the mother's job was to bond with the baby and the father's job was to support her while she did that. All the health workers that are in Australia now were trained on that model. The research over the last decade says that that is no longer the case—'We don't see it that way'—and that the father has an impact by his direct relationship with the baby, not just by supporting the mother. Of course he should do that, but he also has an impact.

In 2005 the *Lancet* published a study of 10,000 fathers and mothers. They measured their depression at two months after the birth and then they followed the children up. When those children were 3½ years old, if the father was depressed at two months after the birth, then the child had twice the chance of having behaviour problems—three times if it was a boy—and that was irrespective of whether the mother was depressed. A father not engaging with the child has long-term effects. There are the same effects, as we know, with mothers. That is why we pay such attention to postnatal depression in mothers. It is not just that the mum is depressed and miserable and having a terrible time—of course you want to do something about that—but we pay so much attention to postnatal depression because the child is not getting the attachment that it needs and therefore will have behaviour issues and deficiencies in the social skills area in the future. Now we know that the same thing happens with fathers. That is quite a shift in our approach, I think.

CHAIR—There are no new services for fathers planned at a national level.

Dr Fletcher—That is right.

CHAIR—You have referenced two things. The first is:

The 2008-2010 Perinatal Mental Health National Action Plan states that the focus of services as the "well-being of women and their relationship with their infant".

The second is from beyondblue:

... the ... wellbeing of fathers is relegated to a "long-term goal"

Neither of those initiatives recognise what you have just said, do they?

Dr Fletcher—No. That is my complaint—not mine alone, of course. That is my point as a researcher in this field: that the knowledge I am talking about, the papers I am referring to—and the *Lancet* is not a secret little journal; it is public knowledge—are not being taken account of. Because the impetus has been so strongly on the mother and the infant, as other speakers I am sure have mentioned, the role of the father is minimised, and not in any antagonistic way. This is not like the post-divorce antagonism between individuals. This is just not recognising how important the fathers are and the services not being provided.

CHAIR—Dr Fletcher, you may have heard some of the earlier evidence that there should be an office for the status of men. It has been called 10 different things, I would think, in the submissions; but, effectively, an office that examines policies in regard to men, similar to what the Office of the Status of Women does. Do you have a view on whether that would be the right path to go down?

Dr Fletcher—Not in that form. I have a view that there need to be adjustments in policy to recognise fathers and the effects on men's health, and in the research area, where my heart is, I am concerned that there is so little specified money for fathers, for example, but whether that would be solved by having an office for the status of men I am not sure.

CHAIR—If there were additional money flowing into the system—and there were some suggestions that men's health issues had received 34 per cent less funding than women's—where should that money be targeted?

Dr Fletcher—Can I first comment that I think it is an awkward argument to make, because in areas that are major health issues, like heart disease, we have had an enormous amount of funding, and that has been of benefit to men. When those comparisons are made between men's funding and women's funding, it is usually for the specific—cancer, for example; breast cancer versus prostate—but, if you look at the overall health budget, plenty goes to male health issues. It is not right and it is too simple to characterise it as dollars for women/dollars for men.

Nevertheless, in terms of the guidelines for where money for research goes, for example, if it is a biomedical issue—so if you are talking about sodium transfer across membranes in the brain—it is going to affect everybody and should be funded. When it comes to doing research into, say, mothers or fathers who have depression, there is no money earmarked for fathers. The researchers for mothers—who are more established, understandably—obviously take the large portion of the cake. Unless there is dedicated funding for fathers, that is not going to change very much.

CHAIR—You did say there was some research—I will call it research; a successful pilot program for fathers, where the mother is depressed—being conducted in the Hunter.

Dr Fletcher—Yes.

CHAIR—What were the results of that?

Dr Fletcher—That was a pilot where I set up a service for fathers whose wives were in trouble—that is how I described it—and said, 'Call this number.' We were just seeing if anybody would call and, if they did call, what would work. What I offered them was home visiting and I visited the homes of these dads with a video camera. It is based on STEEP—Steps Towards Effective Enjoyable Parenting—and Watch, Wait and Wonder, which is a psychodynamically based program that I had done some training in. The model is that you are interested in the attachment between the father and the baby, and I went into the home on that basis, whereas the usual model, of course, is that you are there to tell the dad he should be supporting the mum while she bonds with the baby.

I was doing the other side of it, and what I noticed was that fathers would often be unclear about how important it might be for them to play. For example, I would be in a home with a bloke who has got an office in the house, and we are playing with the baby on the carpet and I am filming him. The model was that I video him doing whatever he normally does and then we both look at the video the next time. When you look at a video of what you have just done, you can see things happening. When we are watching the video, I could say, 'What did you do that for? Why did you move the baby there?' and then he could say, 'Well, I thought, from the way she looked at me, she wanted a change.' He can articulate that. So that is the model.

What I noticed was that I would say to a father, 'If I wasn't here now with the video camera, what would you do?' and he would look at the baby and say, 'Well, she looks happy. I'd duck into the office and check my emails or I'd finish the washing up. I'd get something done,' and not really register that the interaction he is having with the baby is what is going to affect the neural pathways with the baby. We know from the brain research now that you build your baby's brain by that interaction, and I think fathers are not well informed about their role.

In the case of depression, by me continually asking dads, 'What do you think the baby is thinking now?' they started to ask their partner that, and so the partner who had been depressed, and who was off medication by the time I would come into the picture, would start to think, 'What's the baby thinking now?' and it helped change her attitude too. Instead of seeing the baby in terms of, 'It's very tiring and I'm exhausted,' they would start to think about what the baby is thinking and see the baby more as a person and less as a task.

The results of the pilot were promising but it is a small pilot; you cannot run a program on that. It needs research money to see how it would work if we did it across Adelaide or Sydney or somewhere, and how we would train people up and so on, in the normal way of things.

CHAIR—That is dealing with the development of babies and men's interaction with them?

Dr Fletcher—Yes, as a way of addressing the 15 to 20 per cent of women who have postnatal depression.

CHAIR—What about the men? How does it help the men deal with it?

Dr Fletcher—Whether that would help the men or not, I do not know, because it was not targeted at those men. It is not like we do not know what to do with depression; we do. But we do not ask men, for example. We do not give them the same screening tools. We have a standard screening tool for depression called the Edinburgh depression scale. It is very widely used. A

home visiting nurse was talking to me about something that happened recently. She said, 'I took one and I gave it to the dad, because when I got it out of the bag, he said, "What's that?" and I said, "Oh, here, fill it in," and he filled it in and the mum filled it in.' She was visiting the mum shortly after the baby was born for this initial visit to see if she was okay. On that scale, you score everything 1 to 3, and a score over 12 for a woman means she is supposed to be seen to. The father scored 18 and the mother scored 6, so the mother was below the cut-off and the father was way over the cut-off. I said, 'What did you do?' She said, 'I didn't do anything.' I said, 'He scored 18 and you didn't do anything?'

She said, 'Who am I going to send him to? She's the client of the hospital, he's not, so I can't send him to social work. Who would I send him to in the community? They're all busy. They've got long waiting lists in mental health, so I didn't do anything.' That example crystallises that there is no systemic way for fathers to be asked early on, 'How are you going?' Fathers come in late. They are busy. Men are working overtime usually when the baby is born, trying to catch up, so we do not have any systemic way to do it. Beyondblue is perfectly positioned to do that, in that they are a competent national organisation, but it is not on their agenda.

CHAIR—Dr Fletcher, it seems that a lot of the evidence that we have received—and, it is fair to say, what you are presenting to us too—is that a lot of the issues that men face in regard to health, be it mental or physical health, stem from societal attitudes to men's role or indeed men's attitudes to their own role. Is that a reasonable characterisation?

Dr Fletcher—It is, except I would put the emphasis on the society as evidenced by the services' attitudes to men rather than the men's attitudes. There is automatic thinking, where you say, 'The men aren't accessing the service. The problems must be the men.' If the men are not accessing the service, I would say, 'What is the service not doing?' We have seen services change. GP attendance has changed, because GPs have been doing things differently, so it is not impossible. It is not because they changed the upbringing of all those men. I think they changed the service.

CHAIR—I agree with you, but I am suggesting that the societal attitudes shape the men and how they deal with things when they are confronted with issues.

Dr Fletcher—Yes.

CHAIR—Men may know instinctively that something is not right but they tend not to seek help about it.

Dr Fletcher—I also think that there is an information gap rather than an attitude gap. For example, in the Adelaide area where they have done a lot of work on incontinence, they were looking at older men and why they did not access the incontinence nurse. They assumed it was something to do with their attitudes but, after extensive research, they identified that it was that men did not know what questions they could ask when they went there—for example, 'If I say to the incontinence nurse, "I've wet myself," will she think I'm talking like a baby? Will she understand what I'm talking about?' They solved that problem not by changing the men's heads but by giving them a sheet of questions. They said, 'Your nurse will understand any of these questions.' The men could say, 'I could ask that. Okay.' So I would make the point that information is important, not just attitudes.

CHAIR—Sure. Thank you.

Senator WILLIAMS—It is amazing what we have learnt from you today during your presentation, Doctor. The whole thing through your presentation is the services accessing the men. In your opinion, are men so inward-looking that they do not want to go out and seek services? Do they think they are bulletproof and they do not need help over many issues? Is one of the problems that men simply do not go looking for help, even seeing their GP?

Dr Fletcher—Yes, but there is a role division that we have in the community. You could say it has some unfortunate consequences, but I do not know that you would say it is terrible. For example, when I interview men in their home about health and ask them their ideas about health, I say, 'What are your ideas about insurance?' and nearly all of them—these are men in their 30s and upwards—say, 'Alice, are we insured?' She looks after that side of things. She looks after the health system and, if he wants something or wants to know something, he asks her. There is that role division. Men do not know much about the health system because she usually takes care of it. That would start around birth, of course. My take on it would be that, rather than them being reluctant to seek health, they do not see the relevance.

Senator WILLIAMS—We have had a lot of discussion on mental health over the submission hearings in Canberra as well as here today. Just going back to physical health, you mentioned earlier Apex and its campaign for testicular cancer. I was part of Apex in those days when they ran that scheme.

Dr Fletcher—Congratulations.

Senator WILLIAMS—I still am. I am a life member. It is a great organisation. That seems to have fallen by the wayside. We see the Rotary clubs, the big bus and the mammograms carried out and, as you said, the pap smears et cetera; things for women's health. But men's health seems to have strayed off the radar. How do we bring it back onto the radar? How do we bring it to public notice and make men aware that they have to go and have these tests, and test themselves for any strange lumps et cetera, for testicular cancer, and have their blood tests and prostate tests and so on? Surely we are failing in the whole promotion of this around the nation, aren't we, as far as men's health is concerned? We seem to be doing a pretty good job with women.

Dr Fletcher—Yes, we are missing the mark with men, but within pockets you can see very good things happen, like the Pit Stops and so on.

Senator WILLIAMS—Why is that? Pit Stop is one great example, yes.

Dr Fletcher—I think it is because we are still stuck on this notion that it has to be the men's organisations that do it, like Rotary or Apex. Right beside them, there are thousands of health workers who have not made a change in their thinking, who have not adjusted to the idea that men—and in my case, particularly fathers—should be looked at just like mothers in that way. We have not adjusted to the new research and men's roles with children. All of those things have not happened in the service sector.

Senator WILLIAMS—Surely one way to improve this —I come from a country town—is to have it driven at a local community level. Should our local health organisation get the Pit Stop

organisation into town, or form a Pit Stop organisation, or promote it, or have an awareness day or whatever? Do you think it should be driven by government or by local communities, or both in conjunction?

Dr Fletcher—It certainly helps to have government backing, even if it is driven by a local community. I am thinking of my sister who is married to a farmer and lives out in western New South Wales. He would certainly respond a lot better to a local initiative than he would to something from Sydney. It makes perfect sense to have local organisations making the links for men. I think that is happening. It does not have any coordination in the health area and it does not have that bridging across to the established Cancer Council, Heart Foundation and so on. I think they have now changed their general opinion and that men's health is an issue, whereas in the nineties, when that other material was written, they were not sympathetic to the idea, so that is a positive thing. But there is still a long way to go to get them to support local organisations to do things for men.

Senator WILLIAMS—Perhaps you could have something like a Pit Stop at every country show. Just about every rural community of any size has their annual show.

Dr Fletcher—Yes, we have Tocal in the Hunter Valley, and it is an important area. My worry would be that people would say, 'Yes, we've done that. We had a Pit Stop at the local show. That happened in February. We've done it.'

Senator HEFFERNAN—'And it still has not rained.'

Dr Fletcher—Yes, 'It still has not rained.'

Senator WILLIAMS—And they probably got five per cent of the men and the other 95 per cent are left out.

Dr Fletcher—Yes, while the blokes who are on their way to hospital for check-ups or whatever are still going into a system which basically does not recognise men's health as an issue. That would be my worry: that when people do those good programs, they tick the box and say, 'Okay, we've done men's health. We've done it now.'

CHAIR—Why is it that they do not recognise men's health as an issue when they are going into the hospitals? They are going into a hospital because they are seeking diagnosis, or treatment for a particular issue.

Dr Fletcher—Yes, they are. If they are a woman going into the hospital, there is a whole network of knowledge that goes around her. Because she is a woman coming into the hospital, they think about her relationships, about children that she might be responsible for and so on. If a bloke walks into the hospital they think, 'Here's a body walking in. It needs fixing,' and the treatment you get might be fantastic in that sense, but it does not have any of this connecting stuff. Drug and alcohol is a classic area for this, for example. If you present with a drug and alcohol problem, nobody asks you about your family. What they ask you about is your substance abuse and how you might fix that. There is a lack of a framework around men's health for all health workers to adopt. We already have one, due to the hard work of all those people who put

together the women's health policies and frameworks, and good on them. That is a good idea. But we do not have anything like that for men.

Senator HEFFERNAN—Whose fault is that?

Dr Fletcher—I would say ours collectively.

Senator HEFFERNAN—You tend to stew in your own juice in this life.

Dr Fletcher—Do you? Yes, we have been arguing about this since the early nineties. I think you can see that a lot of things have changed, and it gives me a lot of confidence that things will get better.

Senator HEFFERNAN—I wonder why there have to be men's and women's health as separate issues, rather than just 'health'.

Dr Fletcher—The reality of service provision is that, if you just call them all 'people', they do not notice important differences. There are important differences between the way depression, for example, works in men and women. If you just call them all 'people', you lose sight of that. There is an important difference between mothers and fathers. We have had this problem in the whole service sector—they call them 'parents'.

Senator HEFFERNAN—Could I just say as devil's advocate, Mr Chairman, I think that is hooey. I think that is much the same principle as detailing someone's rights in a bill. You limit rights by cataloguing rights and saying , 'Health should be health, whether you're a man, woman or child.' To try and catalogue people's health, you actually restrict access. You restrict people's rights, as long as you don't live in a dictatorship or in the UN, which is the largest, most corrupt body on the planet, most of the members of which are autocratic dictatorships with no measurable outcomes. They want a bill of rights. You say, 'We want a men's health program and a women's health program.' I say, 'We need a health program that doesn't bias itself one way or the other.'

Dr Fletcher—You would think that in the health area it would make a difference—whether your biology was male or female.

Senator HEFFERNAN—Yes, but you would think in a modern world of communication, transport and science—der!—that you would not have to work out, 'Yes, he's got a penis, he's a man. She's got breasts, she's a woman,' when you come into hospital. Why wouldn't you say, 'This person is sick. He comes from 23 Bolton Street, Wagga Wagga, where there's a wife and three kids,' or whatever, and not have to define it other than that? You almost build in the bias. You almost promote the bias by promoting the difference. I am sorry to do this, Mr Chairman. You could argue, as you could argue with politicians—'Pay them nothing or pay them double and still get the same outcome.' With health care you could argue that, sure, there needs to be a women's health program and a men's health program, but surely you could argue that there ought to be—and I am not saying I am right—just a comprehensive health program.

CHAIR—Perhaps we will let Dr Fletcher respond.

Dr Fletcher—When you characterise it in terms of rights, it sounds like you are making a political argument, whereas with service delivery it is the same as saying, 'Is the person in front of you over 50 or are they under 20?' You would expect a clinician to be thinking a whole lot of things if they are under 20, quite different to if they are over 50. What we have not had is the thinking that says, 'We've got a female; we've got a whole lot of things that have happened. We've got a male; we've got a whole lot of things that have happened.'

Senator HEFFERNAN—I will give you an example. Are you familiar with BRCA1 and 2?

Dr Fletcher—Sorry, no.

Senator HEFFERNAN—BRCA1 and 2 genes?

Dr Fletcher—No.

Senator HEFFERNAN—What sort of doctor are you? Are you a doctor of words?

Dr Fletcher—I am a research doctor, not a medical doctor.

Senator HEFFERNAN—You are what I call a doctor of dust, with a PhD somewhere on a shelf that is gathering dust.

Dr Fletcher—Yes.

Senator HEFFERNAN—BRCA1 and 2 are genes which have been patented, and predispose women to breast cancer and cervical cancer.

Dr Fletcher—Right.

Senator HEFFERNAN—The BRCA2 gene also predisposes men to prostate cancer. We do not hear about it. We hear about breast cancer. You have not heard about any of it.

Dr Fletcher—Right, yes.

Senator HEFFERNAN—But there are 15,000 patents taken out on bits in your body which are not inventions, they are discoveries. So under that principle, if we were doing that, the person who discovered the moon should have patented it because it was a discovery not an invention. What I am saying to you is that, if you really want to get on the pace with men's health and women's health, you have to understand what the issues are and, since we have plotted the genome in humans in the early nineties, most people have ignored what all that means for future health cover. There is a bias even in the gene patenting thing, which I am afraid, Mr Chairman—

CHAIR—Is the subject of another Senate inquiry, I understand, Senator Heffernan. But perhaps we could move on.

Senator HEFFERNAN—Yes. I have to say that I am trying to make it a little bit of an awareness program on just what that means to future medical wellbeing, not only of men but of women, where companies are tying up the patents so you cannot have public laboratories doing

research because you are breaching someone's patent somewhere. If you absolutely want to separate men's health from women's health—

Dr Fletcher—Yes.

Senator HEFFERNAN—go for your life, but there are a few traps in that as well, because a lot of the stuff crosses over from women's health to men's health, in the genome side of health, in the gene side of it.

Dr Fletcher—Yes, it does.

Senator HEFFERNAN—Anyhow, I will not burden you.

CHAIR—It is the subject, as I say, of another Senate inquiry, Dr Fletcher. I do not expect you to respond, unless you have something you would like to add.

Dr Fletcher—No. I think that, yes, there is overlap between the two.

CHAIR—If I could return to your submission, if you do not mind: are there any programs offered by your centre for dealing with men that suffer from depression?

Dr Fletcher—Not by my centre. There are state health services which offer services for men who are dealing with depression, fathers or not, in the normal mental health services. So, yes, there are.

CHAIR—You are purely a researcher in that regard?

Dr Fletcher—Yes, in that regard.

CHAIR—Have you done any research in relation to family breakdown and depression in men?

Dr Fletcher—We are just completing a study where we interviewed fathers before they got to the family relationship centre and asked them what they did before they got there. We are not interested in the centre and how it operates but what happened before they got there. That is an interview study of 30 men. We are interested in this idea that they do not seek help, that they bottle everything up inside them, and we found that they actually get a lot of help from a variety of people, but the services do not seem intelligible to them. So they were not sitting there stewing. Out of the 30, I think three of them reported that they had considered suicide, or made attempts, and another one described how he was on his way over to 'do-in the boyfriend' and his mate stopped him—so to take revenge. They described those sorts of crisis points.

They described getting help particularly from other people who had been through the system, from other friends who had been through a separation. They did say that, when they called services, it was not that the services were antagonistic but that they were not familiar with the services, so when they rang one they all sounded the same to them. So they called Centrelink or Centacare: they sound the same. They would call Unifam or a counselling service and they did not seem to be appropriate, but they could not figure out who was. There are plenty of groups

out there but they do not know who they are and, when you go to the telephone book, that does not explain much to you. So they were frustrated and did not get a great deal of help, even from the legal profession who were there to help on the legal side of it but were not there to sort out all the other stuff—what was going to happen with the kids. So we have just done that bit of research, and depression came into it in their descriptions of stress, alcohol use and thinking about suicide.

CHAIR—Did you identify greater issues faced by men who had children?

Dr Fletcher—These were all men who had children.

CHAIR—They all had children? Okay.

Dr Fletcher—They were all in dispute over children.

Senator HEFFERNAN—Do you think that goes back to traditionally—perhaps you could say there is no such thing as tradition; some people would argue that—and historically men have been the keeper of the house, so they have been worried—not any more, but historically—if there was no money for the tucker. It was the man's fault because he was the person who was in charge of the budget and the mother was in charge of the kids and it worked while there was money there for the tucker.

Dr Fletcher—Yes.

Senator HEFFERNAN—Do you think that in some ways that has now carried the loneliness of the financial burden away from, 'Go on, you go to work and get the money because we want steak tonight for dinner, and I'll look after the kids,' type of thing? I do not mean that in a demeaning way, but that is historically perhaps what used to happen; not so these days, because we have got plenty of families where both parents are working. But the thinking in terms of, 'What is the man's role?' is perhaps the old-fashioned way?

Dr Fletcher—Yes, I think that's exactly what happens. I think there is evidence that that is exactly what the process is now for young couples when they have their first baby. They do not actually discuss it, as far as I can see from the evidence. They do not talk about, 'Well, what will you do and what will I do?' so much; they just fall into it. What they fall into is the thing you describe, even if they are both working. The normal time after the birth for men in Australia is two weeks.

Senator HEFFERNAN—So does the man feel that he has failed to a large extent, rather than the woman, if the marriage falls apart because the man has lost his job or something? Is there more pressure physically, emotionally and in a mental sense on the man because it is considered that he is the one that could not earn enough money to keep the family in the style in which they wanted to be accustomed?

Dr Fletcher—I do not know how you would balance it out, because the woman would have pressure on her that says, 'Well, it's her job to keep the family together, because she's the one that looks after the home.' I do not know how you would add them up.

Senator HEFFERNAN—Mr Chairman, I have a view that if society continues to separate women's and men's rights in a family, when I think they are equal, and that that is done in a healthcare system, it is doomed to failure. I do not think it will work.

Dr Fletcher—But you have to accept that there are fundamental differences.

Senator HEFFERNAN—Yes, I accept there is a fundamental difference, but there should not be a difference in the way that that is considered by a healthcare worker, whether you are a man or a woman. There should not be any subliminal thinking of, 'Oh, he's only a man.' While you continue to have a separate health system, you will have people saying, 'Oh, yeah, he's a man; he's under this formula. She's a woman; she's under this formula.'

Dr Fletcher—I would say that that is one of the drawbacks with the whole project of men's health. We are doing some research for Attorney-General's on how to train people to be inclusive of fathers in a setting where they are talking about families. We see lots of health workers who cannot quite put their mind to the idea that this is a man in front of them and that that might have certain implications.

Senator HEFFERNAN—The cycle I can see is that it becomes a subliminal position in the mind of the person who is giving the advice. If I was in charge, I would get rid of—I usually say 'shoot' but I had better not—two out of three lawyers, because there are far too many lawyers who live in another world and have got no idea what this is all about. As I said earlier, the courts are about the law and not the truth. The courts cannot consider the truth in these issues; they are driven by the law. That is why, if you are guilty of murdering someone and you go to court, get yourself a smart lawyer who can avoid the truth for you and you get off.

Dr Fletcher—Coming back, though, to the point about the health workers, if they were talking to me sitting opposite them, or somebody who was Somali or Aboriginal, for example, you would want them to notice that. At the moment, health workers have no framework to notice that that is a bloke sitting across from them, not a woman. That is the same logic, we would say, that is missing at the moment. There is no training anywhere in Australia.

Senator HEFFERNAN—Why would you want them to notice that you are an Indian or an Australian?

Dr Fletcher—When you are talking to them about what they are going to do about their health, they would be coming from a different framework.

Senator HEFFERNAN—Only if they came from a biased background.

Dr Fletcher—They do; we all do.

Senator HEFFERNAN—No, not necessarily. This is not meant to derail the process.

CHAIR—I know that it is not.

Senator HEFFERNAN—It is just something to think about.

CHAIR—We are delighted to have this sort of input, Senator Heffernan.

Senator HEFFERNAN—I am only here for the morning!

CHAIR—We have only got a couple of minutes left. Dr Fletcher, you tabled a document earlier which graphically showed the major causes of death for 15- to 24-year-olds—

Dr Fletcher—Yes.

CHAIR—and the contrast between males and females. Do you have a view—and would you share it with us if you do—about why so many young men are attempting suicide or committing suicide?

Dr Fletcher—Do you mean the two-minute answer?

CHAIR—The three-minute answer, if you like.

Dr Fletcher—A mix of biological factors and social factors I would say are the reasons. The biological factors relate to brain development and hormone levels and the idea of risk, which is not just a social notion, and the social factors are the obvious ones: more access and more relevance for things like motor vehicle accidents and guns and so on, and choice of methods makes a difference—whether you try and shoot yourself or you take some pills. Those sorts of social factors obviously mean that men have more chance of successful suicide, if that is the right way to put it.

There are the broader social factors, that relate to Senator Heffernan's line of thinking, around the lack of value for young men. If you think about the value to the community of young men, unless they are in a particular job category or there is a war at the moment, there is not much value. I think that is an underlying issue for young men that relates to the broader factors. We did a lot of work in schools through the nineties, for example, around boys' education. We asked the parents, 'What is it you value about men in this community?' and always that was the first time that it had ever been discussed. That was a bit of a reach for them, and that affects the boys around them.

Senator HEFFERNAN—What is the answer on the female side? If they are put through the same set of questions, have they got a much more useful purpose?

Dr Fletcher—Yes, they have. In the biological sense, it goes back to the notion of maternal bonding, and that maternal love and so on is essential.

Senator HEFFERNAN—If you go back to nature, you join about 1½ to 2½ per cent of rams to ewes, so you do not have a one-on-one bonding. You can put a bull in with 50 cows. Is that sort of extrapolated out into the use of a male in the community?

Dr Fletcher—In your area it might be.

Senator HEFFERNAN—You are devaluing the individual value of the man.

Dr Fletcher—The evolutionists would say something along those lines: there is competition amongst males, so you do not need so many. In the more recent research, particularly around epigenetics—around not just genetic inheritance, whether DNA stays the same, but the myelinisation and so on changes around it—that has an influence on how you pass on things to the next generation.

Senator HEFFERNAN—In suicides that are successful—

Dr Fletcher—Yes.

Senator HEFFERNAN—and in suicides that are unsuccessful, would a conversation with someone else in the moments before the suicide have saved a lot of suicides?

Dr Fletcher—I do not know that.

Senator HEFFERNAN—I mean, life is pretty simple out where I come from: if you do not put the bulls in with the cows, you go broke.

Dr Fletcher—Gee, with the farmers I talk to, it does not seem simple at all.

Senator HEFFERNAN—It is very simple.

Dr Fletcher—They seem like they are faced with the most complex problems.

Senator HEFFERNAN—I know. But in terms of breeding, you actually put the bull in with the cows.

Dr Fletcher—In terms of breeding, yes.

Senator HEFFERNAN—You do not leave the bulls together.

Dr Fletcher—Thank you for that.

CHAIR—Dr Fletcher, you mentioned in response to my previous question—before we got onto cows and bulls—that there were societal and also some developmental issues in regard to young males committing suicide.

Dr Fletcher—Yes.

CHAIR—What can you do to mitigate the risk attached to being a young man, from a developmental issue? Is it part of an education program? Is it part of male mentoring?

Dr Fletcher—Yes. I do not know about an education program, but you can take account of it. Males have a higher rate of colour blindness—red, green—than females, so if you are going to design traffic lights, you would think about that and you would think, 'Well, they're going to have more trouble telling what these lights mean, so we'll do it differently because blokes have this problem.' So if you are going to say that males have a propensity to take risks, for example,

then you would adjust whatever you are doing in a society to take account of that. You would not say, 'Oh, well, that's their problem. We'll just lose them.' It is not that you are going to go back and fix their biology through genetic engineering. You can take account of the biology, like we do in other obvious areas of health, and say, 'There is a biological difference.' We should adjust our system so that we do not lose the things that are important to us, like young men.

CHAIR—Dr Fletcher, thank you very much for your contribution today and for your submission.

[12.15 pm]

GROGAN, Mr Paul Bernard, Advocacy, Cancer Council Australia

OLVER, Professor Ian Norman, Chief Executive Officer, Cancer Council Australia

CHAIR—I welcome representatives of Cancer Council Australia. Thank you for coming to talk with us today. Do you wish to make any amendments, additions or alterations to the submission that we have received?

Prof. Olver—We do not wish to amend our submission, but we are quite happy to take any questions outside our submission.

CHAIR—Thank you. Do you wish to make a brief opening statement before we take questions?

Prof. Olver—Yes, thank you. Just briefly, although the issues we have raised are global issues in health, they have particular relevance for men. That is why we wanted to have them considered in this inquiry. We have focused on three big-ticket items. The first is the National Bowel Cancer Screening Program, which is the first population screening program that has been available for men. Women have had screening programs for cancer of the breast and cancer of the cervix. However, this bowel cancer screening program is only being patchily introduced and we want to make sure it is fully introduced by 2012, because it has the ability of saving a significant number of men's lives. Men's participation rate in bowel cancer screening is less than women's, at under 40 per cent of eligible men in the current program compared to over 46 per cent of eligible women. So there are issues that are addressed by this first national screening program for men, and we think it is important that it is fully developed.

The second major issue for us is tobacco, because lung cancer is one of the major cancers for both sexes but particularly men and particularly men dying of lung cancer. The most effective means of driving down the smoking rate in the community is to increase the price of cigarettes by increasing the tax. There is no more effective measure that could be taken. The World Bank has made very accurate figures available and we have provided them in our submission. For example, if you increase the price of cigarettes by 10 per cent—and that is not to say increase the tax by 10 per cent, because the tobacco industry tries to absorb tax increases so they will have less impact—you will drive the smoking rate down by four per cent, which is quite significant in Australia because it is down to roughly 17 per cent already. Also, government revenue will go up by seven per cent with that small manoeuvre.

We think the tobacco excise should actually put the price up by 21 per cent, because the worldwide aim is to have tobacco tax at about 85 per cent of the price of cigarettes. In Australia we have not increased tobacco tax beyond cost of living adjustments since 1999. We used to be in the top four or five countries in the world in taxing cigarettes, but now there are at least 29 countries ahead of us.

The third thing—and it is a high-volume disease in Australia and the burden economically is huge—is skin cancer, which is a huge problem, especially in males. A quarter of a million males get non-melanoma skin cancer. Of the 10,000 people who get melanoma, over 6,000 of them are male. We have had skin cancer awareness programs that have been very effective and we want to make sure that they continue because this disease is an enormous burden. In terms of cancer in men's health, they are the three major issues that could be addressed, and need to be addressed, by government to improve the outcome of cancer for men.

CHAIR—Thank you, Professor Olver.

Senator HEFFERNAN—I have to declare an interest—

CHAIR—Please do.

Senator HEFFERNAN—which is going to cause someone else to declare one. I do not smoke.

Senator WILLIAMS—That is very good to hear.

Senator HEFFERNAN—You do.

Senator WILLIAMS—Sometimes.

CHAIR—Mr Grogan.

Mr Grogan—To build on Professor Olver's comments, we have been following the inquiry and there is a lot of discussion around awareness and the status of men's health and all these sorts of things, all of which have a place in the discussion and many of which have merit. We really want to emphasise that the proposals we are putting up are things that could be done right now and, in all three cases, would be building on current government commitments that we see and the evidence says are inefficient. They are also things that would improve women's health. In line with Senator Heffernan's position, we do not necessarily have to separate them out. It just so happens that these are cancers where the burden falls disproportionately on males, but they often get lost in the discussion around men's health, because the biology is not strictly male.

I really want to emphasise the point that these are things that could be done right now. The evidence is incontrovertible in terms of benefit, particularly in men but across the whole population. It just gets lost in the discussion around the gender bias.

Senator HEFFERNAN—I notice you have left out prostate cancer.

Senator WILLIAMS—We are talking about both genders here, Bill.

Prof. Olver—We do not think that prostate cancer is going to have the same immediate impact on what can be done about it as the three things we have mentioned. The screening program that males are currently involved in, for which there is evidence that it will save males' lives, is bowel screening and yet that is a half-introduced program. So we need to get that up to

scratch. The evidence for population screening for prostate cancer, as opposed to making men aware and making individual decisions, is simply still not there.

Senator HEFFERNAN—From the Cancer Council's point of view, has enough research been done to determine if there is a genetic predisposition to bowel cancer?

Prof. Olver—Yes, there is a genetic predisposition but, in common with other cancers, the majority of bowel cancers are still sporadic. That is partly because we have not yet done enough work on the genetics of cancers to be able to identify other genetic changes that lead to bowel cancer. Most people who get bowel cancer will not have a family history, but there is a group of people who will have a strong family history.

Senator HEFFERNAN—Which leads me, Mr Chairman, to the obvious question—and I am hoping that you will be making a submission to the gene patenting inquiry.

Prof. Olver—We have already made a submission to the gene patenting inquiry, because we think the issue of whether a discovery like that can be patentable and therefore rob the community of the research and the things that would follow is a particularly important issue.

Mr Grogan—Could I add that the submission is a very good read.

CHAIR—I am sure it is going to be a very good inquiry. Professor Olver, you say in your submission:

… men experience higher incidence and mortality from all cancers commonly diagnosed in both men and women …;

Why is that?

Prof. Olver—I do not think anyone quite knows enough about the factors that relate to cancer. I think that cancer is a mixture of genetic and environmental factors. For example, with lung cancer the increased incidence and mortality in men over women initially was that more men smoked than women. There are a lot of cancers where more men will be at risk because of their occupation and exposure to occupational carcinogens.

There is no global answer for all cancers why men should be particularly more at risk. If you consider it as a mixture of genetic and environmental factors, I think you will be able to dissect some of the environmental reasons. In fact, the reason that we know that that is true is that unfortunately, since women started smoking after the Second World War, what we are now seeing is that the cancer that causes the highest rate of deaths in women is now no longer breast cancer, it is lung cancer. So you can change the balance depending on what people are exposed to.

CHAIR—I may be wrong but I interpreted from that comment in the overview that if a man and a woman both had lung cancer, for example, the man is more likely to die from it. Is that not an accurate characterisation?

Prof. Olver—No. I think that would be an oversimplification, because there are, for example, some women who get lung cancer without any smoking history. It is quite a different lung cancer

from the other. So I think you would have to go into the biology and be very much more specific to be able to make a comment like that. We were not trying to suggest that men were more likely to die.

What we do know from the figures, which are highlighted in the bowel cancer overview, is that, because there has never been a screening program for men, we are concerned that the participation rate of eligible men is less than that of women. We need to figure out a way of making that program more easily accessible to men and getting their involvement.

CHAIR—You used two figures in your opening statement. I believe it was 40 per cent for men in the bowel cancer screening program.

Prof. Olver—That is right. Just under 40 per cent are in the current program. The kits are being sent to 50-, 55- and 65-year-olds. Of those who are eligible to send them back and participate in the program, we are getting just under 40 per cent of men participating and, I think, 46.7 per cent of women, so there is a difference. Women are more used to participating in screening programs. These are well people who are asked to have a test to see if they have a cancer or a precursor of cancer and, with the BreastScreen and the pap smears that have been going for decades, women have had these sorts of programs available to them.

CHAIR—The bowel cancer screening program is an at-home test, is it? You just provide a specimen?

Prof. Olver—This is different from the other tests, because the government on your birthday—50, 55 and 65—sends out a kit. You take your own sample and post it back to a pathology lab and the result gets sent back to you and back to the GP that you have nominated on the form.

CHAIR—Is bowel cancer a middle-aged illness?

Prof. Olver—Bowel cancer becomes more frequent with age, like most cancers, so it tends to be more of a problem for the over-50s.

CHAIR—Can you tell me what the prevalence of it is in younger age groups such as 15 to 24 or something like that?

Prof. Olver—We talked about genetic cancers being the ones that people get earlier. For example, with a syndrome like familial polyposis coli, which means you are almost certain to get bowel cancer, you inherit the polyps and then you will develop bowel cancer in your 20s and 30s, but that is relatively rare at only a few per cent. Like most cancers, as you get older the incidence increases. The fifth and sixth decades have the peak incidence. Although it is possible to get bowel cancer younger, it is often a very specific type and more often the genetically inherited types, which are relatively rare.

Mr Grogan—The evidence for a population based screening is for people 50 and over.

CHAIR—Do you know how many men have been screened?

Mr Grogan—You would have to look at 40 per cent of those invited in that age group.

CHAIR—I am sure the figures would be available—

Mr Grogan—Yes.

CHAIR—but you do not happen to know.

Prof. Olver—There are two problems with bowel screening. One is that you ought to be screening the 50s and up. We do not suggest that this bowel screening program could have been instituted in one hit. It took about four years for the BreastScreen program to cover everyone, because you need the health system to be able to gear up for the excess numbers having x-rays or, in this case, if they are positive, having colonoscopies. So we expect it would take three or four years.

The problem is that it started off with the kits just being sent to the 55- and 65-year-olds. In the last budget they added the 50-year-olds but no-one has announced rescreening and the first of the kits went out in 2006. We are now starting to see them needing rescreening. All the figures about the lives saved are not about a one-off screening when you are 55. They are about having rescreening every second year. What we are saying is that this is the first chance men have had to have any cancer screen and it has not been fully implemented. We think that it would be a major advance for everyone's health, including men's, if we could have a guarantee that this would be fully implemented.

CHAIR—So every two years it would be sent out to eligible men?

Prof. Olver—Every two years from the age of 50. Two things have to happen at the moment. One is that all the gaps between 50 and 55 and 55 and 65 have to be filled in. The other is that all of those people then have to be rescreened, with the bowel screening kit, every two years.

CHAIR—The other figure you mentioned was 46 per cent of women. Is that correct?

Prof. Olver—Are participating in the program, yes.

CHAIR—So 40 per cent of men and 46 per cent of women?

Prof. Olver—Yes, and that is what the trials showed would be about what to expect. We need to get that up, obviously.

CHAIR—That is my question. Is the difference significant from an experienced test in similar types of preventative measures?

Prof. Olver—I think you put your finger on it when you asked, 'Is this test sent to your home?' With the other screening tests, you go along and a doctor does your pap smear or you go along and someone does a mammogram. This is the first test of its kind where the person has to actually take the sample and send it back. So we are in new territory here in terms of how to encourage participation when you have to do so much of it yourself.

CHAIR—So it is actually not a bad result to get 40 per cent back? In any marketing sense, to get that sort of response would be quite good.

Prof. Olver—No, it is a good start but, given that we are talking about saving lives here, we would like it a lot higher. We are worried, from the point of view of this submission, by the differential between the take-up of women and men.

Mr Grogan—I think you made a good point, Senator Bernardi, in that that is an encouraging result. The problem is that this is not a proper screening program because it is not doing rescreening. There has been no communication strategy to encourage participation, so in that context it is a reasonable result. We have no comparative data on male participation because this is new territory. On one hand, yes, as you say, this is encouraging. On the other hand, it is falling way short of its potential, and we are only talking about three age bands in an appropriate target group of everybody over 50. What you are seeing as a positive really emphasises the potential for this program, if it were fully implemented, to save lives.

Prof. Olver—And it is 30 lives a week, of which almost 60 per cent are men. A fully implemented bowel screening program in Australia would save 30 lives a week. That has enormous implications for not having to treat those 30 patients later on, because they never develop bowel cancer.

Mr Grogan—Which is highly cost effective.

CHAIR—Which is a cost measure you outlined here. It is $1,300 to treat someone as a result of this. That is not $1,300 per test, is it?

Mr Grogan—No, that is for a colonoscopy.

Prof. Olver—That is if you were positive and had a colonoscopy.

Mr Grogan—Only a very small proportion of people test positive and require investigation anyway.

CHAIR—And if you do not test positive, does that mean you do not have bowel cancer or you are not going to get it?

Prof. Olver—There is no perfect test, but it is good enough to say that you do not need a further investigation. Not all of the ones that have some bleeding and get investigated with a colonoscopy are going to be positive. It has proven to be a good enough screen that the majority will be picked up. If you screen people every two years and they develop a lesion that does not screen positive the first time, it may the next. So over the course of a program, you will make a difference to the death rate from bowel cancer.

CHAIR—So it is more reliable than, say, the PSA test for prostate cancer?

Prof. Olver—Totally. The PSA test is not a reliable test. I have heard the argument put that surely one test is better than none. The answer is that it is not if the consequences of that test are harmful, and they can be in the PSA test. If you have your prostate removed when you did not

need it removed and you become impotent and incontinent, that is a very significant damage to your quality of life. The difficulty is that the PSA test, even if it is positive, does not discriminate between those tumours that would go on and kill you and those tumours that would just grumble on for the rest of your life and never cause a problem.

As we know now from the European study—we actually have the figures—to save one life, they had to do prostatectomies on 48 people. That meant 47 men were being overtreated as a result of the inaccuracies of the PSA test. That is why we have come out with a position, which we have held for many years, that we cannot advocate population screening. We cannot go out there and say, 'Every man must be screened.' So we have to take it back to an individual basis and say, 'Men should go and have a talk about the pros and cons,' because they are going to have to make some pretty tough decisions, with very little evidence, on the basis of having a PSA that is elevated or not elevated.

Senator WILLIAMS—Can I move onto skin cancer. I have been on the land most of my life and out in the sun most of my life. When we were kids, there was no awareness of melanoma.

Mr Grogan—That is right.

Senator WILLIAMS—I lived in the sun, we lived at the swimming pool, and we never used sunscreens or anything like that. Since the awareness has come out probably in the last 25 years or whatever, has the level of melanomas started to reduce?

Prof. Olver—Yes. The awareness campaigns, particularly the Slip Slop Slap campaign which we measured regularly, have been quite successful in reducing the incidence of skin cancer or probably stopping it going up as the population increases. But it can be difficult to measure sometimes. For example, in non-melanoma skin cancer, when all the skin clinics started opening up and nipping off far more skin lesions, the rate of skin cancer went up. That was not because of any problem; that was because they were being detected and people set up skin clinics to treat them straightaway. In fact, arguably, they might have been taking off too many of them. So it can be difficult to judge it from the incidence. We also ask people about whether they got sunburnt, for example, so we know that we have modified people's sun behaviour and we know that that impacts on the rate of skin cancer. In Australia, we have the particular problem of Caucasians living in a climate that they were not genetically designed for, and that is why we have the world's highest incidence of melanoma.

Mr Grogan—There is no precise answer to your question, Senator Williams. The best data we have is based on modelling, because most of the melanoma cases you see are in older people, the majority from damage that was incurred—

Senator WILLIAMS—Thirty or 40 years ago.

Mr Grogan—That is right, before awareness. Deakin University just did an analysis based on changes to behaviour, looking at research since those campaigns, and we were one of the organisations that really started this. The Cancer Council really drove the Slip Slop Slap message initially and has really put skin cancer prevention on the agenda, so we are very pleased to see government now join in and run a number of national awareness campaigns over the past three summers. Looking at the way those campaigns have affected behaviour and then marrying that

behaviour to sun exposure and then to the long-term trends in melanoma, the Deakin University data says that if they maintained the campaign we could primarily prevent 20,000 melanoma cases over the next 20 years and 49,000 non-melanoma skin cancer cases. So it is a significant benefit.

Senator WILLIAMS—On the issue of bowel cancer, has it been proven that red meat may be one of the causes of bowel cancer, or excess red meat?

Prof. Olver—It has certainly been shown that cancer in general is increased by the consumption of red meat. In fact, in a recent paper, the death rate from cancer was increased by eating red meat. One of the target cancers contributing to that is bowel cancer. There are, however, several aspects with red meat: one is how much fat it has in it. Obesity is linked to cancer as well, so lean meats would not be expected to cause as much cancer as fatty meats. One of the other things that impacts on that is the way you prepare the meat. If you barbecue it, there are a lot more cancer causing chemicals that are eaten than if you slow cook it. It is a little bit more complex but, yes, there has been a link made between red meat and bowel cancer.

Senator HEFFERNAN—Does that show up? I often go to the sushi bar and think that I will live longer if I eat sushi!

Prof. Olver—The most recent study that looked at deaths did say that red meats and processed meats were the ones associated with cancer. White meats, chicken and fish, were not. In fact, there was a small trend towards them being actually good for you in that respect. So we can say that, if you want to reduce your risk, biasing the diet—I am not saying do not have any red meat—towards white meats would be sensible, based on those studies.

Senator HEFFERNAN—Should we not drink hot tea?

Prof. Olver—You should not drink it hot. You can drink tea, but make it tolerable. The Iranians did a study that showed that the incidence of cancer of the oesophagus went up. People thought it was due to tea, because they drink a lot of it. They discovered that it was not due to the tea, because it was not correlated at all with how much they drank; it was correlated with the temperature at which they drank it, which was about 70 degrees. They were drinking very hot tea. That means if it is uncomfortable to drink, let it cool down. This was an interesting study about hot tea.

CHAIR—You would think it was a bit of commonsense to have crept into that: 'This is uncomfortable. I won't be doing it any more.'

Prof. Olver—You might have thought so, yes.

Senator WILLIAMS—The Rotary Bowl Scan Program has also been of great assistance, has it?

Prof. Olver—I think any awareness program does have its impact, absolutely. I heard you mention earlier the Apex testicular program. Apex came to me about that program when I was in Adelaide, and I know precisely what that money was put towards—a very good study of the treatment of testicular cancer, which is going to be presented at a big meeting next year. It is

looking at the late relapse rate, which is an important thing; we have got to follow these people out for longer. That money was very well used in testicular cancer.

CHAIR—Senator Heffernan, anything else?

Senator HEFFERNAN—No. I will only cross over into another inquiry if I ask anything else.

CHAIR—Could we go back to touch on skin cancer. The diagnosis of skin cancer, it has been put to me, is probably a contribution to the high rates of mortality. It was suggested that a lot of general practitioners do not feel comfortable in making a decision about whether something is potentially a harmful skin cancer or something else, so there is a reference to specialists, often unnecessarily. Do you have a comment to make on that? I am not maligning GPs. I am just saying that this is a cautious approach that they are taking.

Prof. Olver—I think it comes back to the degree of training. Some of the studies have compared GPs that have specifically subspecialised and been part of skin clinics with dermatologists and others, and they have not been able to detect a great difference. But a GP in general who has not had training and is worried about a skin lesion should refer on, because it can be very difficult to pick benign and malignant lesions. It depends on the degree of training of the GP. If they are well trained, the figures that I have seen show that they are about equivalent to a specialist.

CHAIR—That is what has been suggested to me. There are specialist courses which are run over a day or two—a conference, I think—in association with James Cook University, which go out of their way to help general practitioners to become more competent in diagnosing lesions. I do not know how many GPs have availed themselves of it, but would you have an opinion on whether that is an effective method of broadening the ease of diagnosis?

Prof. Olver—There is a little risk of overdiagnosis and overtreatment, specifically of non-melanoma skin cancer. I would like to qualify the comments: if I was diagnosed with a melanoma, I would like to go to a specialist because there are all sorts of vagaries of treatment and things that you need to get right because it is a potentially fatal disease. With non-melanoma skin cancer, the death rate is small because most of them are successfully treated by removing them. That could be done by well-trained GPs, but it is a matter of how many you need working in that area.

CHAIR—Your message is that prevention—

Prof. Olver—Our message is that the prevention programs that the government have run have been very successful in changing people's behaviour and use of sunscreens. This is work that we have actually done—to ask about sunscreen use and whether you had been sunburnt and so on, although there is a little bit of work to be done for the teenagers. In general, it has been very effective and that will, in modelling, translate to a reduced death rate, particularly from melanoma. So we are saying that the government program should be a continuing program: it is not the sort of thing you can stop and start. That will impact greatly on men's health because a quarter of a million men get non-melanoma skin cancer and, as I said, probably just over 6,000 get melanoma.

CHAIR—Two of the issues that you have mentioned in your submission—cigarette smoking, which we have not talked about a lot, and skin cancer—have been intergenerational awareness issues.

Prof. Olver—Yes.

CHAIR—They would have started when I was a boy, when Bill was middle-aged. The message is only just sinking in again with our children.

Prof. Olver—I agree. It was the SunSmart message. We have had to modify the message over time. It was originally Slip Slop Slap. Then people said, 'Hang on, we should be telling them, "If you can, avoid the middle part of the day,"' so 'Seek shade' was added and then eye protection, 'Slide on sunglasses.' So we have ramped up the message. We have to make sure that message is just as potent for the kids of the people that heard the message 20 or 30 years ago.

With the smoking rate the same thing applies, but we have seen a progressive decline in smoking and we know which measures have caused that to happen. There is no doubt that the first measure that caused the decline was the ban on advertising. Nothing much happened until the advertising bans and, as they got more restrictive, the rate came down. So we have eked out about as much as we can.

Now the greatest driver is price. The interesting thing about price politically is that 80 per cent of the population would not complain about a tax on tobacco. That includes 60 per cent of smokers, because they want to give up and they realise that a price hike would force them to give up. So it is a total win-win situation. For the man in the street, we cannot understand why a tax increase on tobacco is not a no-brainer.

Senator HEFFERNAN—My old man died of emphysema, so you do not have to convince me. I am trying to convince that bloke down the end there to give up, and I will not challenge him to an arm wrestle—that is, the chairman. If you increased the tax, which you say will work to reduce people smoking, especially young people, won't they turn to something else?

Prof. Olver—Not necessarily, no. I will answer the question more completely than that.

Senator HEFFERNAN—Can I give you the full question before you give the answer.

Prof. Olver—All right.

Senator HEFFERNAN—When I was a kid there was a sort of peer pressure to have a smoke down behind the dunnies. It became the thing to do. Now it is, of course, the thing not to do, which is very good. But if marijuana did not have a tax on it, even though it was illegal, and became cheaper than cigarettes, wouldn't you then tend to get people into other stuff?

Prof. Olver—There is that possibility. In fact, even in the tobacco world, there is a suggestion that perhaps we should be licensing tobacco products that you do not smoke, so they are reduced harm products, but I do not know why we should licence anything to addict more people to tobacco. It does not make sense to me. So it is possible and, in fact, that may have to be dealt with. We are very disappointed that there is no tax on alcopops, because that would have—

CHAIR—There is a tax on alcopops.

Prof. Olver—There is, but we are disappointed that that is not continued, because we know that that would drive down their use.

Senator HEFFERNAN—There is no question about that, but that would drive people to another source of cheap alcohol.

Senator WILLIAMS—That is right, they would switch.

Senator HEFFERNAN—That is what we are going to argue here. In the brown cafes in the Netherlands it is legal to buy marijuana, which is the bloody judicial system turning a blind eye to itself, because I sat next to a judge in the Netherlands and asked, 'Why do you turn a blind eye to the law?' and she asked, 'What do you mean, Senator?' I said, 'I mean when a brown cafe acquires the marijuana at the kitchen door to sell legally at the front door, it is breaking the law.'

I do not want to get into too much of an in-depth argument, because you could argue that we should legalise marijuana, which is bad for you—there is no question about that—but which certainly gets all the people who are insecure to feel better about themselves. But you could argue that, if you are going to increase the tax on smokes—and I think all smokes ought to be banned, along with poker machines—you would have to do something about alternate substances. That would raise the argument whether you would legalise, as in the Netherlands, hoochie-cooch smoke and tax it.

Prof. Olver—I think I see your point, and I would like to make the point that in terms of tobacco we have evidence—and this is World Bank evidence as well as local evidence—as to what increasing the tax will do. It will drive down smoking. You can speculate that that may lead to other things, but we do not have that evidence. They may spend the money on a holiday for all I know rather than go to another source of drug or alcohol or whatever, but we cannot stop doing the things that we know will work based on speculation.

Senator HEFFERNAN—But you could actually go to a demographic in the community of 14- to 19-year-olds and say, 'All right, smokes are too dear. They're going to kill you anyhow. If we put a tax on them, what are you going to do?' and they would tell you.

Mr Grogan—To go back to your first question, Senator Heffernan, there has been other modelling work done in this area. If you speak to people in the other drug fields, the demographic is different, the experience is different and the social acceptability is different. There are a number of issues that make tobacco quite a different case that needs to be dealt with differently.

One of the keys to tobacco control is denormalisation. The evidence shows that, if you want to get kids to quit or not to take up smoking, you target the adult demographic, because what inspires children to do these things is a desire to mimic what they see in adult behaviour. That is a different thing from new drugs that come out, where there has been no modelling from their parents. This is a totally different field. There is also nothing like the level of population health damage that is incurred through smoking. So I do not think it is entirely analogous to look at—

Senator HEFFERNAN—In what consequence is there not the damage?

Mr Grogan—In terms of the disease burden. There is nothing like—

Senator HEFFERNAN—Only because there is nothing like the use.

Prof. Olver—But it is a legal product.

Senator HEFFERNAN—Yes, I know.

Prof. Olver—It is quite different.

Senator HEFFERNAN—But that is beside the point. If you go to the eastern suburbs here in Sydney, a lot of the adult population there—bankers et cetera—are into cocaine, to the point where they did not want to investigate that bloke that got arrested the other day because a lot of high-profile people in the eastern suburbs would have got done for acquiring cocaine from him. They turned a blind eye.

Mr Grogan—The reason 15,500 Australians will die this year from smoking related illness is because a lot of them are people like us who have been doing it for 20 or 30 years. That does not happen with illicit drugs.

Senator HEFFERNAN—I agree with all of that.

Mr Grogan—It is a totally different field. As I said, the evidence is that if you want to prevent the take-up of smoking in children the best way to do that is to denormalise it in the adult community.

Senator HEFFERNAN—So how do you stop them from turning to—

Mr Grogan—With the sorts of measures we are putting up. If you make cigarettes too expensive for a dad to buy, his son is less likely to smoke. It is simple.

Senator HEFFERNAN—The habit of smoking will shorten your life for sure and it is a bad thing and all the rest of it, but there is a transition to alternate things. How do you prevent that transition?

Mr Grogan—Again, as I said, the data around tobacco use, the history of tobacco use, the social acceptability of tobacco use and the demographic that smokes requires tobacco to be treated separately from illicit drugs. It is a totally different proposition.

Senator HEFFERNAN—It is a legal drug.

Mr Grogan—It does not follow that, because young people are not smoking—

Senator HEFFERNAN—But it would be irresponsible of you and everyone in the healthcare profession to use the excuse, 'Well, we'll have to wait and see what happens,' and to not have a plan to prevent the transition.

Mr Grogan—What I am saying is that, because your typical 13-year-old or your blue-collar worker 15-year-old who has gone to work in a warehouse or something takes up smoking in a very high proportion because all of their peers and their older peers that they have aspired to emulate did so—

Senator HEFFERNAN—I hear all that.

Mr Grogan—it does not follow that they are going to start smoking marijuana in the workplace as an alternative to cigarettes. It is totally different. In terms of managing the drug related disease burden, tobacco has to be treated differently.

Senator HEFFERNAN—That is generic crap, in my book! Young people today would prefer to pop a pill because it is cheaper than buying a bottle of alcohol. Go to these parties. It is more convenient.

Mr Grogan—But that is not a cancer issue, in a sense. It may be on one level, but that is not what we are here for.

Senator HEFFERNAN—But it is a side effect and it is a very serious side effect. So to ignore it and say, 'That's someone else's problem,' I think is irresponsible.

Mr Grogan—Making cigarettes unavailable to young people will not affect that, according to the data.

CHAIR—I will ask Professor Olver to make a comment.

Prof. Olver—Can I make one comment about that. We take your point that we do not want harm to come to young people. Although we do not have the evidence that they would go from tobacco to illicit drugs as opposed to one illicit drug to another, we recognise that it could be a possibility. We do not believe it is an argument for not trying to stamp out tobacco use.

Senator HEFFERNAN—No, I am not trying to make that argument.

Prof. Olver—So we are very keen to make that point, but I certainly take your point that we should take seriously the proposition that we may have other controls to manage illicit drugs as tobacco use falls.

Senator HEFFERNAN—I agree entirely.

CHAIR—Last question, Senator.

Senator HEFFERNAN—What really p'd me off was to go to the Netherlands and sit next to a judge who could say with a straight face, 'Yes, they ignore the law in brown cafes.' This is about the convenience in the community of being able to smoke marijuana legally in a brown

cafe. You know what I am talking about. Yet they break the law, which is completely ignored at the back door of the cafe when they acquire the substance to sell at the front door—

Prof. Olver—I would feel the same way.

Senator HEFFERNAN—in much the same way as this bloody mob out here do not want to arrest people because they are worried about the high-profile people, whether they are judges, lawyers or Indian chiefs, that, by social conscience, have alternate drug substances to elevate themselves socially.

CHAIR—I think you have made that point, Senator Heffernan.

Senator WILLIAMS—Professor Olver, you mentioned the alcopops tax earlier. The reason it was thrown out was because there was an easy alternative, and that was a full bottle of spirit or a cask of wine. In Inverell where I live the sale of cans had dropped dramatically but the sale of bottles of Bundy rum had soared. When they mix a drink themselves, they mix it a lot stronger than when it comes as a five per cent constant mix in a can.

If the government was to increase the tax on virginia cigarettes and not on menthol cigarettes, would you think that was crazy? In other words, they left one untaxed increase where there was an alternative.

Prof. Olver—In that example I would say that a tax on one type of cigarette was better than no tax at all, because it set a precedent on which things could be built. I would say the same thing about alcopops. I am not saying it was a perfect tax at all, but it was the first opportunity that anyone had to actually tax alcohol and look at the effect of that tax on consumption. The figures that I have seen—and we do not have them in front us here today—show that the rate of alcopop purchases did go down and was not matched by an increase in the rate of straight spirit purchases. Yes, there was some increase, but it was nothing like the rate of decrease in the sale of alcopops.

Sometimes things have to be done by degrees. To make the point on tobacco, I would rather some tax than no tax, if I believed it was going to start pushing down the use of tobacco.

Mr Grogan—The only data that we did have on the alcopops tax, which was ACNeilsen data, did show that the net consumption of pure alcohol across all products had gone down, and cancer related to alcohol is entirely dose responsive. So you could say, on a population basis, if that was continued over time, you would reduce your population cancer risk. That is one point and that is the main reason we supported the tax. Also, as Professor Olver said, it is following a public health policy position that has worked in other areas.

There is no debate around the things we brought to this inquiry. Everybody agrees that these things would really work. The only impasse we reached with these things is around funding, political will and prioritisation. There is no dissent in the scientific and political communities about these three priorities. They will all have bipartisan support over time and they can all be done without having to develop new agencies and task forces and whatever else.

Senator HEFFERNAN—Is there a connection between alternate drugs and cancer?

Prof. Olver—There is certainly a relationship between marijuana smoking and cancer. Some studies suggest that you are six times as likely to get lung cancer if you smoke marijuana, and there are links with other types of cancers as well.

Senator HEFFERNAN—So why don't we hear about that?

Prof. Olver—It is on our website. Some of that research is new, but we have certainly included the cancer risk of marijuana.

Mr Grogan—And it is an illegal product. We do not want to take up the time of government policy makers; we want the focus to be on things that government can do right now. Marijuana is already an illegal product.

CHAIR—Gentlemen, we are out of time.

Senator HEFFERNAN—The law turns a blind eye to a lot of things.

CHAIR—I would like to thank you for your contribution today. It has been of a great deal of interest, obviously, and we have strayed into other topics as well. Thank you for your submissions and for your appearance here today.

Proceedings suspended from 1.02 pm to 1.43 pm

LEMON, Dr James Arthur, Research Fellow, National Drug and Alcohol Research Centre

CHAIR—I will reopen this meeting of the Senate Select Committee on Men's Health. I welcome Dr Jim Lemon from the National Drug and Alcohol Research Centre, from the University of New South Wales. Thank you for coming along and meeting with us today. We have received your submission, No. 27. Do you wish to make any amendments or alterations to the submission that we have received?

Dr Lemon—No.

CHAIR—In inviting you to make a brief opening statement, I would ask if there is anything else you wish to say about the capacity in which you appear today?

Dr Lemon—I am representing the National Drug and Alcohol Research Centre which, as you said, is part of the University of New South Wales. I should note that this is not a consensus statement that I will be making. My colleagues may differ in some areas. As mentioned in the submission that led to the invitation to give evidence, hepatic cirrhosis is a disease to which men are relatively resistant, yet behavioural differences in drinking reverse the outcome. Similarly, men may be less likely to become depressed, yet, when they do, they are less likely to recognise their condition, less likely to seek treatment, more likely to take recreational drugs and more likely to kill themselves.

These two examples illustrate the interaction of multiple factors in men's health outcomes. Rather than reciting similar examples, I would like to present a few concepts that might find application in interventions for men's health and may even cross the sex boundary. The first of these is reality. It is surprising how many interventions ignore one of the most obvious features of drug and alcohol use: that people, men included, do it because it makes them feel better. People may not know what is good for them in the long term but they certainly know how they feel right now.

Whenever such departures from reality are perceived, they may not only be discounted as fantasy but they may also lead to any accompanying material being discounted. The uberfantasy that the world and life are benign, or at least can be made benign, is almost certain to have the latter effect. The reality that life and the world tend to be difficult and unforgiving may be less pleasant to entertain and explain. However, it may provide a more sound basis for building the individual's ability to deal with these problems. The worth of a man is often judged by how well he is able to face, endure and minimise these difficulties. It should not be too surprising that drug use is employed to signal autonomy, courage, endurance and skill. I will return to this later.

The second concept I will call responses. Almost everyone has an anecdote concerning the notable failure of signs to control behaviour. Stimuli fade, responses persist. A sign, unless it is a good predictor of what is about to happen, fades into the background as the individual seeks better predictors. So it is with exhortations about the costs of drug-taking. While our naive tendency to estimate the probability of events by recalling their past occurrence may serve us well with common events, it misleads us spectacularly with unlikely or temporally distant events, yet even the most catastrophic outcomes of drug-taking are rarely isolated events. Rather,

they are the result of many past decisions that finally lead to disaster. Too often the disaster is explained as bad luck in the negative lottery of life. Habit, so often lamented in the persistence of destructive behaviours, also represents the opportunity to build constructive behaviours.

Finally, we come to risks. For almost every undertaking in life there is the chance of failure. We are well equipped to learn about reality and to translate this into effective responses and decision-making processes. Risk-taking is a vital source of learning, allowing our interactions with the world by probing that world with our behaviour. As any parent knows, children are irrepressible risk-takers. The value of risk-taking is that it allows us to build up a store of knowledge that can better inform our decisions. Suppressing risk-taking or attempting to buffer the outcomes is likely to distort the map that can guide decisions about risks that involve large or permanent costs. Engaging risks affords the chance to expand one's knowledge and skill.

Men negotiating the challenges of life are called upon to display those qualities of autonomy, endurance, courage and skill. In the absence of more constructive activities, drug-taking would be a substitute. A crucial point in this regard is how men can achieve the goals that they desire, and indeed are expected to desire, with the least amount of harm to themselves and others.

I will close by proposing one answer to the question: can Australian culture be altered to foster a more moderate and sensible use of drugs and alcohol and thus improve men's health? Australians are generally comfortable with reality. This provides a foundation upon which to build effective behaviour. If the experience of reality and risk-taking is complemented by an honest account of the experience of others, the two are more likely to be synthesised than to be opposed.

The example that is passed along the generations is a vital part of the culture of drug use. If that example is perceived to be a hypocritical attempt at control, there is every reason to ignore it. By encouraging men to employ reality and risk-taking to build better decision making, we can take advantage of the strength and resilience of individual decisions to reduce the health liabilities of drug use. Will the application of these concepts result in perfect health or the absence of drug use? No. The enormous variability of humanity, which is one of our greatest strengths, ensures that some part of the distribution of outcomes related to drug and alcohol use will be negative. Our aim should not be to indulge the fantasy that perfect health or safety is currently attainable but to make that distribution of outcomes as good as we can.

CHAIR—Thank you very much, Dr Lemon.

Senator LUNDY—How do you express that, particularly to young men as they are growing up? How would you take the concept of a reality check on what life really involves and turn it into some positive messages which are being directed particularly at young men and perhaps fathers, to try to make the changes that you describe in people's attitude towards their life and how they live it?

Dr Lemon—Young people are often faced with conflicting messages. On one hand, they are told that it is bad to take drugs and that they will physically damage them. On the other hand, they often see the example of people taking drugs reaping the rewards of drug-taking, because we all know that there are rewards. They may see this and have to decide one way or the other. They may say, 'I believe what people do, not what people say.' There have been some attempts

to present health promotions in the media which emphasise this: that role modelling by parents, by any adult, especially adults who have a profound influence on young people's behaviour, should be consistent with what they believe themselves. I can recall—and I suppose this tells you how old I am—Elvis Presley trying to tell the youth of America how bad drug-taking was, when we all knew he took drugs. That is a bad message.

Senator LUNDY—I picked up on the point you made about managing people's expectations about the challenges of life: that there is no ideal or perfect life that is absent of challenges, problems, pitfalls and all those kinds of things. I am interested in how you present that concept again to the different constituencies we are interested in, whether it is young men or parents, to try to put risk-taking and coping into a more realistic perspective.

Dr Lemon—Perhaps I can illustrate that with a coincidence: our librarian, wonderful person, presented me with an inspirational account of two young fellows growing up in the United States, which I did myself, and how they were encouraged, in an informal way, by some of the most prominent scientists in the country to pursue their activities, which happened to be learning about rockets, because rockets are one of the things that fascinate. They certainly fascinated me. At the end of this inspirational tale of how this transformed these two young men's lives, there were a few paragraphs saying, 'Of course, we wouldn't allow people to do that any more.' In other words, the challenges, and the risks attendant upon those challenges, were no longer available. So it may not be surprising that other challenges are sought, in the absence of challenges that may lead to a person's better understanding of the world or science or whatever they happen to choose.

Senator LUNDY—So when you talk about those challenges, it is the full spectrum of that definition. It could be an intellectual challenge, a physical challenge; something that really takes people out of their comfort zone. You are saying that the absence of those challenges in men's lives leads to seeking that risk-taking experience in a different way. Am I interpreting your comment correctly?

Dr Lemon—Yes. I can, of course, provide you with irrefutable evidence on this, but there certainly seems to be a reduction in the availability of what I would call worthwhile challenges, and challenges that not only involve learning, but involve learning about responsibility, taking risks—taking little risks, seeing what happens when little risks turn out badly, and perhaps incorporating that knowledge when you have to face bigger risks—because that is the way everyone learns.

CHAIR—Can I ask you a related question. Dr Lemon, are you suggesting that maybe even in childhood, where children are no longer encouraged, for instance, to climb trees—I mean, there is a risk-learning activity that most children go through—

Dr Lemon—I certainly found it so, yes.

CHAIR—Pardon?

Dr Lemon—Yes, I found it so. And the inevitable thump now and then.

CHAIR—Exactly. Are you suggesting that even the lack of those experiences in modern childhood could lead to a high prevalence of drug and alcohol abuse?

Dr Lemon—As I said, I cannot provide evidence for that. I think that children seek challenges—especially children—because they have to learn rapidly how to deal with life. We tend to forget how much we learn when we are young. If the simple challenges of climbing trees are not available to us, we may choose more dangerous challenges and may suffer greater injury in the process.

CHAIR—And even if that is not apparent immediately, if you have a particularly sanitised childhood and suddenly at 18 you have this great freedom and you are allowed to then make decisions for yourself, you might be more likely to make inappropriate decisions?

Dr Lemon—This is possibly the best argument against setting some arbitrary limit of age on something that you can do; that even if we managed to suppress the behaviour—say drinking—even if we managed to keep everyone from drinking until they were 18, there would likely be a greater surge of drinking to find out what it was like, to demonstrate that they could handle it. Everyone has a different view on this. The motivations for engaging in behaviour are as varied as the people that engage in those behaviours, and I think, yes, that is possibly a good explanation and one on which I would like to be able to provide evidence, but, as I say, I cannot.

Senator LUNDY—Forgive me if I am taking what you are saying in a direction that you did not want it to go, but it seems to me that the comments you are making point to the value of childhood and perhaps adolescent experiences that do involve perhaps physical, intellectual risks, and that moving in that direction and strategies built on those kinds of things are worthy within the concept that you have presented today. Can you comment on that and the value of those, or whether it is much more of a way of life issue, as opposed to creating those experiences periodically within a child's life or adolescent's life or even in an adult's life?

Dr Lemon—Creating them is probably not what I meant. Children seek them. Within the bounds of being responsible parents, I think people have, for a long time, recognised that their children are going to do things that they would not advise them to do. They would not for instance say, 'Well, get up that tree and see how high you can go.' A child will do it anyway and, in doing so, may learn something that informs their decision on whether to go through a red light many years later. We learn much better by doing than simply by listening. Certainly I can call that as witness to that way of thinking.

Senator LUNDY—I do not know if you can answer this question. When people involve themselves in a risk-taking activity—let's stick with the climbing of the tree—and the associated physiological response to that risk-taking, whether it is the adrenalin hit or whatever, is there any research or studies that show that that has some relativity to prevalence to alcoholism or drug-taking, those kinds of experiences.

Dr Lemon—Yes, I can answer that with great confidence. Things as non-intuitive as getting sunburnt are associated with drinking too much, taking drugs. Risk-taking behaviour, that elusive characteristic that we call impulsivity, runs across a lot of different behaviours, and it is something that people who are high on impulsivity have to learn to deal with, if they are going to be successful, and avoid the big risks and the big falls. But it can be learned.

Senator LUNDY—Is there a greater prevalence for people who have a high level of impulsivity to drug and alcohol overuse or abuse?

Dr Lemon—Yes, a qualified yes. I cannot say that definitely, but certainly the literature points that way. We try to measure impulsivity. A lot of my work has been in devising tests and trying to see if they work, and it is not an easy job. Impulsivity is a terrifically difficult thing to measure—like risk-taking, which is my main area of research—and what we know of this is, yes, impulsivity does correlate with drug-taking; with excessive drug use, not necessarily with experimentation.

Senator LUNDY—Thanks.

Senator WILLIAMS—Dr Lemon, on a per capita basis, looking at alcohol first before we go to drugs, is the percentage of Australians now with an alcohol problem greater than it was say 20, 30 years ago? Have you got any statistics on that, on the history?

Dr Lemon—I could direct you to the National Drug Strategy household survey. Both the 2005 publication and the 2008 publication—which is the most recent—say that the majority of Australians drink what they call responsibly or moderately and that there should be very little health risk involved in that drinking. There are a small proportion of people who drink in a way which is likely to damage their health and which, of course, causes problems for other people, in terms of trauma, disruption, things like that. Whether that proportion is higher or lower is somewhat difficult to ascertain, because the questions that are asked and the way records are kept change over time. It has not changed much. If there were twice as many people who were having troubles with drinking, we would see it.

To go down the age scale, the school surveys, the last production of White and Hayman, in 2004 I think, showed that over the years that the school surveys have been conducted there has been no great change in problem drinking among young people.

Senator WILLIAMS—The reason I asked is that—perhaps I am wrong—it just seems over the last 10, 20 years that financial pressures are a lot higher on people that I mix with and see, especially in country areas. Some people turn to alcohol in times of stress and when under pressure. Would that be true?

Dr Lemon—It certainly is.

Senator WILLIAMS—Yes. That is why I was thinking that, in this modern day we live in, there just seems to be a lot more financial pressures on a lot more people than there seemed to be 20 or 30 years ago, and that is why I asked the question: has there been an increase in the per capita consumption?

Dr Lemon—The consumption is going down, quite clearly. If you look at the ABS figures for the overall alcohol consumption, it has dropped.

Senator WILLIAMS—With those figures dropping, are they turning to other things like drugs? Is the consumption of drugs going up, when we separate drugs and alcohol?

Dr Lemon—Over the time of the household surveys, yes, marijuana has gone up because it has become more available. The newer synthetic drugs have gone up. Again, it is availability. They simply are there, they are inexpensive and people will use them. Overall, drug-taking is probably more prevalent but problem drug-taking has not increased to that extent. If you ask, 'In your life, have you ever taken X?' the proportion will be higher, but, taking alcohol as an example, we do not see that more people are having great problems with it than they did 20, 30 or 40 years ago.

Senator WILLIAMS—That is pleasing to hear. As I said, my concern when it comes to mental health in this committee is that we are hearing submissions about pressure. A lot of people, especially in country areas that have been through drought since early 2002, are under extreme pressure financially with the cost of running their farms and their businesses et cetera. That was the reason for my question. I thought perhaps it has led to a lot more of those men turning to alcohol.

Dr Lemon—I cannot readily answer that as a breakdown of rural versus city consumption or problems. It is probably available, but I cannot answer your question at the moment.

CHAIR—In your submission you said:

> Men may be more likely to drink in response to interpersonal and social stresses or pain and less likely to respond to interventions for problem drinking.

I am interested in the interventions for problem drinking and your opinion about what government could or should be doing to have a greater benefit. I say that because there has been some suggestion that the advertisements that we see on television are not very effective because they are not designed to appeal to the psyche of men.

Dr Lemon—I do not know which advertisements you are referring to, but there are quite a variety. Yes, some are much more effective than others. The campaign against drugs, which was perhaps the most expensive campaign ever mounted in the United States in the 1990s, was, in terms of outcomes, an abject failure. It simply tried to present negative outcomes, often inflated, of drug use. At the end of the program there was a very good assessment of it. More young people were smoking marijuana than had been smoking it at the start of the program. It was considered to be a great waste of money.

Yes, the government does fund a lot of these efforts. It pays my salary in fact. It funds the research that devises these interventions, it funds the interventions themselves and it funds people like me. A lot of my job is looking at evaluating these interventions. Very often I end up being a sort of coroner who has to determine the reason the intervention died and explain this to the bereaved therapist whose intervention has not worked as well as they thought it would.

Often it is only necessary to look at the things that men approve of or are attracted by and say, 'How can we fit a message, how can we get the content that we want, in a format that people will accept—both listen to and accept intellectually—and say, yes, that is consistent with my experience?' That is the point I was trying to make about reality. A number of people have devised interventions to simply argue that alcohol is no good for you, it is not doing you any good and it is not worthwhile drinking it. Anyone who drinks and enjoys it knows that that is not

true. So they simply say, 'This is a load of codswallop and I'm not going to listen to any of it,' even if the entire remainder of the content is quite sound and would be helpful.

CHAIR—That is my point. The advertisements I was specifically referring to are those to do with alcohol that have taken place on Australian television over a period of time. One of them that sticks in my mind had this catchphrase: 'Four men and women two,' which was about excessive drinking. Four was the limit for men and two for women.

Dr Lemon—Yes, that was a previous campaign.

CHAIR—There is also one targeted at young people which is basically that getting drunk is not cool and seeing the consequences of doing that. It has been suggested that they are not particularly effective at targeting men because men are looking for something different or they had a different psychological assessment of these sorts of messages.

Dr Lemon—The second example you gave is a particularly good one. As long as young men see an advertisement on television telling them that getting drunk is not cool and their experience of getting drunk is that it is cool—that, 'My friends and I engage in exciting behaviour which is much more pleasant than going to school or working at a boring job'—they are going to think, 'This is worthless; why should I listen to it?' If you say, 'You may be able to get away with drinking for a while, but it will eventually cause some damage. It may be fun. Is the fun you're getting now worth what you're going to have to deal with later?' people will be much more likely to listen, because it would be consistent with their experience. They say, 'Well, yes, I notice that dad is not in too good a shape after all those years of drinking. Maybe they're right. It might have been fun when he was 18, too.'

CHAIR—You mentioned that alcohol consumption patterns—and I do not want to verbal you here—are reasonably consistent with where they were 30 years ago.

Dr Lemon—Patterns probably have changed, but the overall amount of damage that comes out has remained reasonably constant. It goes up and down, but it is not as though twice as many people or half the number of people are having alcohol problems now.

CHAIR—It is about the same percentage of regular consumers as a part of the population?

Dr Lemon—Yes.

CHAIR—You have also refereed to men having higher levels of alcohol problems.

Dr Lemon—Men tend to drink more.

CHAIR—Men tend to drink more?

Dr Lemon—Yes. That is an easy one.

CHAIR—Yet that goes against the recent debate which was about young women who were binge drinking to harmful levels, and the government took steps to try to mitigate that.

Dr Lemon—Yes. Relatively more young women are drinking heavily, but this still represents a small change. Again I could direct you to the last two National Drug Strategy Household Surveys: the most recent one and the one before that. Men drink a lot more than women. overall. You may be able to find some particular subgroups where women drink nearly as much as men, but overall, no, men drink considerably more than women.

CHAIR—Do you know why men drink more?

Dr Lemon—If I did, I would be much more famous than I am now!

CHAIR—We have two men and a woman here. We can probably work it out.

Dr Lemon—It is considered a masculine behaviour. I do not think I have to provide a number of citations for you to realise this. Holding your drink is considered to be a masculine accomplishment. Women may aspire to that. Whether or not that is a worthwhile thing to aspire to, I do not know, but it certainly is embedded in Australian culture and has been for many years. It is not that men find alcohol particularly more rewarding than women. As far as I know, men and women tend to find about an equal amount of enjoyment in consuming alcohol, but men definitely have a cultural background, an impulse, to drink more, to show that they can drink: to show themselves, not only their friends.

CHAIR—You said in your submission that there are about 1,000 alcohol related deaths of men?

Dr Lemon—Attributable. This is one of the most striking differences between men and women. I think that is from Collins and Lapsley. If we look at the alcohol attributable deaths for a single year, it is estimated that there were about 1,000 for men and that for women the number was negative. Alcohol, as you are probably aware, when taken in moderation regularly provides a slight health benefit. For women, who tend to be more moderate regular drinkers, the alcohol attributable deaths were negative—that is, more deaths were prevented than were caused—which gives you some idea of the relative amount that men and women drink on average.

CHAIR—Yes. That is what piqued my interest: there is a net benefit to drinking, if you do it moderately—

Dr Lemon—And regularly.

CHAIR—and regularly, both of which have some appeal, I am sure, to some people. What is moderate consumption of alcohol then?

Dr Lemon—What we call the nadir of alcohol harm is about two drinks a day, 20 grams of alcohol a day. It does not matter what you drink—beer, wine, spirits; it seems to be indifferent to the type of drink—but alcohol itself, for a number of reasons—I will not bore you with the technical details but this is one area that I study—does seem to have a modest health benefit when taken regularly.

CHAIR—So two drinks a day. How many days per week defines ‘regular’?

Dr Lemon—Every day.

CHAIR—Every day?

Dr Lemon—Yes.

CHAIR—So there is no negative health impact to daily drinking if it is less than two drinks per day?

Dr Lemon—There are a number of studies that have shown that ischemic heart disease, which is the major thing that people worry about with drinking, declines monotonically with regularity of drinking—that is, the more often you drink the less likely you are to have ischemic heart disease in the population. Clearly, if you have some condition—and this is a sort of complement to this—it has been argued in the past, and I think it is a good argument, that if people realise they have a health liability which will be made worse by alcohol, they may decide not to drink, and this may account for part of the apparent health benefit for abstainers who have decided to abstain because they say, 'Well, I know I've got a problem.' For instance, are you familiar with what is colloquially known as 'the Asian flush' with drinking? Many Asians lack an enzyme called aldehyde dehydrogenase 2. When they drink, their face becomes flushed, they have marked erythema; they may become dizzy. They have tachycardia and other things. This is caused by a failure to metabolise the principal metabolite of alcohol, which is acid aldehyde. Acetaldehyde is a quite toxic chemical, it is carcinogenic. Normally our liver metabolises the alcohol to acetaldehyde and then mitogenic aldehyde dehydrogenase metabolises that to free-acetate, which means that we get rid of the acetaldehyde. If you know you have this problem with aldehyde metabolism, it is a very good idea for you not to drink, and some people realise this. They say, 'Well, drink affects me badly. I just won't drink.' That is a good decision.

Senator LUNDY—I wanted to ask about the incidence of diabetes and if there was a link with the rising use of alcohol and diabetes.

Dr Lemon—Again, it is like ischemic heart disease. Arthur Klatsky, I think, did the biggest analysis of this, and his finding and the findings of other people who have studied it are that moderate frequent drinking tends to be protective against diabetes; irregular excessive drinking tends to make it worse. This is also the case with obesity and a surprising number of other conditions. In other words, excessive drinking, especially when it is done like the weekend binge or something, is tremendously harmful. Twenty grams of alcohol a day seems to be somewhat beneficial. It is definitely a biphasic effect.

CHAIR—Dr Lemon, is there anything else you would like to add before you conclude?

Dr Lemon—No.

CHAIR—Thank you for your evidence today and for making a submission. It was very interesting.

Dr Lemon—I thank you all for your attention.

[2.22 pm]

ANDRESEN, Mr Gregory John, Director, Men's Health Information and Resource Centre

WELSH, Mr Rick, Aboriginal Men's Health Project Officer, Men's Health Information and Resource Centre

WOODS, Mr Micheal, Co-Director, Men's Health Information and Resource Centre

CHAIR—I welcome representatives of the Men's Health Information and Resource Centre at the University of Western Sydney. Thank you for coming along today. Mr Woods, I apologise because I understand that Micheal is spelt 'e-a-l' and your nameplate says differently.

Mr Woods—I have lived with that for 58 years.

CHAIR—I am familiar with the misspelling of names certainly. Mr Welsh and Mr Andresen, thank you for coming along and we appreciate you starting a bit earlier, as our program allows us to. The committee has received your submission as No. 57. Do you have any amendments or alterations to make to the submission?

Mr Woods—No.

CHAIR—I invite you, Mr Woods, to make an opening statement.

Mr Woods—Thank you, Senator Bernardi. I would like to make a few brief points and allow my two colleagues to also make some brief points, if that is suitable for you. Most of what we need to say in terms of information is contained in our submission—I hope it is contained in our submission—but there are a few things that I would like to emphasise at the beginning. I was at the roundtable in Parliament House a couple of weeks ago and there was a general consensus, I believe, from the people there that any men's health interests in Australia must go beyond purely medical or the traditional medical; we must ensure that we focus a lot on the social determinants of health, those social contexts that are impacting on men's health and wellbeing. These are the things that have to be addressed. There was also some discussion at the roundtable—and I think it is important to emphasise here—about the risk factors.

This is a bit of a danger in some ways I believe—to focus on behavioural risk factors as being an emphasis for men's health. Altogether the 14 primary risk factors account for no more than 30 per cent of the burden of disease for men, so there is 70 per cent left unaccounted for. If we drift back into, 'Let's stop the hunting, fishing, shooting, smoking, drinking, whatever it is about men's health that's problematic,' we are still not going to have the desired level of impact and improvement that we would like to see with men's health. That is another argument: to start to consider the social context more strongly.

The second point I would like to make is that, with the lack of attention to men's health over many years, some wonderful grassroots organisations have been developed. That fact is worthy of consideration. In regard to the question that economics are going to have some part to play in

determining what is able to be done for men's health, at this point in the economic development of this country there is not going to be a lot of spare money to be throwing around at some new initiative. No government likes to do that at the best of times and certainly this is not the best of times.

These grassroots organisations that have developed provide a possibility of a way forward that reduces some of the burden of expenditure that would be incurred by government, utilising these organisations which already have demonstrated track records in having an impact with men. They are local organisations, not subject to the monolithic problems you sometimes find in large government departments. They are able to deliver on the ground in a cost-effective way.

I would love to see a lot of those organisations being developed, supported and refined in what it is that they are able to offer over the years: some of the dads organisations are particularly worthy in that regard, as are Men's Sheds, Pit Stop programs and the health screening stuff that has been done by people in various parts of Australia. All of those are wonderful initiatives and it would be great to see them being supported and developed rather than the responsibility for those being turned over to large departments which will absorb a lot of the funding just in operating costs.

The final point I would like to make is in regard to one of the aspects which I know has already come up in your inquiry—that is, this idea of masculinity. That is a very dangerous concept in some ways because it means too much. It is too broad an area. Certainly we need to analyse gender when we are looking at things, whether it is the workplace, school systems or the ways that men access health services. It is important that we consider gender in regard to that. But this idea of masculinity somehow locates the difficulties within men themselves, so it then becomes an enterprise of trying to change our whole culture rather than trying to change the system to allow men to better access the services that are there.

As an analogy, if you have a party and no-one comes to your party, it is not really appropriate to blame the guests. You have to turn around and think, 'What is it with my party that no-one wants to come?' When we are looking at health services and things, we have to get rid of this idea of somehow blaming men, saying they do not use health services. Men do use health services, we have seen that. The Pit Stop programs at the agricultural field days out west I know are inundated with men.

We hear that men do not like to talk about feelings. Mensline Australia cannot answer all their calls. A lot of them are from rural men who we would see as being stoic and unemotional, but they are quite prepared to access services when they see those services being relevant for them and as being appropriate and male-friendly. They are some of the considerations I would really like to throw onto the table for you to add into your mix of the many considerations you will have.

CHAIR—Thank you, Mr Woods. Mr Welsh, do you have something to say? Mr Andresen?

Mr Andresen—Thank you, Senators, for this opportunity to address you today. One point I wanted to briefly raise was the issue of the almost complete lack of men's health education programs running at tertiary education level in Australia. There is a critical need for men's health education programs to be made available at tertiary level in those disciplines that have broad

social impacts upon the health and wellbeing of men and boys. Examples of these areas of study include medicine, public health, nursing, social work, youth work, education, counselling, psychology and gerontology.

As Dr Fletcher argued earlier in today's hearing, many health and social services are not particularly men-friendly or father-inclusive. Obviously the best way to raise the awareness of workers in these fields about men's health issues is to add men's health programs to their training and education. At the moment there is virtually nothing happening across any of those fields at a tertiary level in terms of specific men's health training for workers. That is an area that could be addressed to make services much more male-friendly.

CHAIR—Thank you.

Senator LUNDY—You mentioned 'social determinants of health for men'. Can you describe what you mean by that and if it is possible to give some sort of priority order to what those social determinants need to be, and their impact, from greatest magnitude to lesser magnitude?

Mr Woods—That is probably a whole textbook with lots of chapters, But to give some indication of what I mean by that, some of those deeper layers of our social lives impact on our health. One in particular I would refer to is a boy's education. I see that as being one of the social determinants of male health. Education, we know, is strongly correlated with health outcomes in later life. The more years of education you have under the belt, the more years of life you are going to live. That particular correlation has been demonstrated time and time again.

In Australia at the moment we have 14 per cent fewer boys going to year 12 than girls. Last year there were 80,000 more young women graduating from our universities than young men. I am not saying, 'Let's achieve parity here. We must have absolute equality.' I have two daughters, so I am pleased to see that a lot has happened for girls in the past 20 years. But I do worry that that drop-off in education for boys is having an impact on their health and wellbeing later in life. We have a whole generation of young boys today whose health outcomes later in life are going to be compromised because of their dropping behind the eight ball educationally. I see that as one particular aspect.

Another that I would see as being more topical is the lack of attention to dads in the workplace, around work-family balance. There have been some major changes going on in the ways we live our lives today—a lot more women spending a lot more time in the workplace, guys trying to chip in back at home—but we are still finding workplaces that have not caught up with that fact. That puts a lot of pressure on the dads because they are trying to fulfil their roles at home and they still have no flexibility from employers to do that. I see that as having a very powerful impact.

They are examples of the kinds of areas I mean. I would also consider the workplace, and this is an area I know that you perhaps have some expertise in. There are a lot of, 'She'll be right' approaches from some of the workplaces in Australia where there are significant dangers to employees in those industries. I know the Western Australian government recently has been very tough with BHP after a number of deaths in their mines over there. But the kind of toughness that is needed across a range of industries has not been applied. That is one of the social

determinants: the ways in which our workplaces have not been as up to the mark as we would like them to be in a range of industries.

Senator LUNDY—What about the social environment where people live and the physical environment in the suburbs, effectively? What are the socioeconomic disparities with respect to the social determinants of health?

Mr Woods—I was born and grew up in Western Sydney. I now work in Western Sydney. I know the area very well and there are a lot of problems purely due to the location; problems like transport. That is a fairly simple one to point to. You see these streams of commuter belt guys going to work in the morning.

Senator LUNDY—It means you are away from home longer each day and that has a whole commensurate series of impacts, hasn't it?

Mr Woods—It is dreadful. From where I live it is a two-hour trip into the city and then two hours back. I am fortunate that I work near my home but a lot of guys I know do not. That is a 12-hour day. I have a friend who works at Botany. If there is a traffic jam or an accident on the M4, he is sometimes working a 13- or 14-hour day, depending how big a traffic jam it is, and he has two young kids. But that is where the work is, that is where the money is that he needs to run his family, and he is one of tens of thousands in Western Sydney. So I see transport as being a huge issue in Western Sydney.

Location of services also plays a part. Mount Druitt is one of the dormitory housing suburbs of Western Sydney. There is a lot of public housing. We are working with guys there that have just come out of prison. That is one of our new projects. You want to access those services you need around that time, such as Centrelink, parole and maybe a GP or the Aboriginal medical service.

You can spend a day just travelling between them, and then you have got to go and sit and wait. But the lack of transport is dreadful in Western Sydney; also the access and the distribution of services across that area. There is not a lot of work there. People are travelling long distances to find work. Location is certainly one of the really huge factors that is impacting on male health in that area.

Senator LUNDY—Thank you for that. With respect to that issue and colocation or easier access to services and even the workplace, the policy heads-up for that is how we design, effectively, new communities and how we plan to at least try, where possible, to make the proximity of the employment base as integrated with the residential precincts as possible. Can you extrapolate on that a little so that we can hear about what some of the latest theories are about the social determinants of health, understanding of course that these go to other areas of public policy as well. Your perspective, I think, on this would be important for the committee to hear.

Mr Woods—It certainly is one of the difficulties with trying to address health and seeing health as something that is self-contained, because obviously once we accept that there are social factors that are impacting on health, it cuts across so many portfolios and there is such a strong need to try and ensure that there is some cross-governmental approaches around this. Environmental impact statements, for example, we can do across a range of portfolios. Perhaps

when we do health impact statements, when we are looking at things like developing new areas for housing, looking at new transport systems, we could give some consideration to the consequences for people's health—things like physical activity. I am sure all of us would like to see more opportunities, because you must make health choices easy choices. You cannot put barriers in people's way and then say, 'We want you to go and exercise more.'

Building cycleways that take people from meaningful points to meaningful points, not just go around in circles, ensuring that there is good lighting so people are not going to be afraid to walk around places of a night, are very small considerations in urban development that are going to be essential for future generations and their health and wellbeing. It is a shame that our past decision makers did not incorporate some of these considerations at the time.

Senator LUNDY—Do you know anywhere that conducts a health impact statement of the nature that you describe?

Mr Woods—No, I do not.

CHAIR—Senator Lundy, I think Mr Welsh had something to add in here.

Mr Welsh—As a bit of an introduction I work with Michael and I am an Aboriginal male health projects manager. First and foremost, I want to acknowledge the Gadigal people whose land we are meeting on today. To give you a bit of an idea of what I do, I work with a lot of volunteer Aboriginal men's groups across New South Wales and based across Australia. There are about 36 of them established in New South Wales. They are in all corners of the state, from metropolitan areas out to more remote places like Wilcannia; from north-west, south-west, right across the state.

Some of the groups provide support around specific issues to do with social and emotional support, others deal with physical wellbeing, but one of the commonalities that they all have is that they deal with a lot of male crisis management—males are being removed from the home. There were a couple of things, from talking to the men's groups, that they identified themselves. One was a lack of accommodation for males. In the case of AVOs or if the police remove the males from the home, there is nowhere for them to go. There are places, but it is a bit complicated to find somewhere that does not involve a police escort or a cell.

There is a lack of male-friendly support services. Like Michael was saying, there are a lot of area health services and stuff, but a lot of them tend not to be male-friendly. The Aboriginal males are turning up for services, but who should be providing the support services to them? Is it the Aboriginal medical service? There is a lack of funding, a lack of male specific projects in communities. All the men's groups are actually working on volunteers: basically working on the principle that there is a group of blokes and one bloke is a bit of a bush lawyer and a bush mechanic and a bush doctor and all this type of stuff.

One of the things they would like to do is to look at training and, with all these men's groups, it is a huge network. One thing that I suppose came through with Aboriginal Affairs was that there was a lot of silo building around specific services, health services and that type of thing. This is one thing that they do not want to see happen again. They want to do a lot of capacity building, capacity building with groups within the Aboriginal men's groups themselves, because

it is going to be local. The aim is to look at local Aboriginal men to deal with local Aboriginal issues, and the issues can vary from community to community. Some of the things are advocacy training around legal issues or health issues.

One of the other problems that has been identified is that there is a lot of engagement with Aboriginal communities, and they talk about government planning—whether it be federal, state or local government—but there seems to be a lack of consultation with Aboriginal men's groups. When governments come in and they talk about looking at community planning and shared responsibility agreements and all this type of stuff, there is a lack of consultation with Aboriginal men's groups. They feel left out, or they do not seem to be in the area of priority. The consultation tends to be with a lot of the services that are funded in some way or other, so the local Aboriginal medical service, the local Aboriginal land councils; those types of services are generally the ones that are engaged in the consultation. The volunteer Aboriginal men's groups, because they are not incorporated or grant funded and stuff, seem to be overlooked. But they do a lot of work in communities. They run everything from doing counselling sessions with blokes to mentoring youth, young males. That is about all I can think of off the top of my head, but I do know that there are a few problems.

I recently visited a community in north-western New South Wales, at Wilcannia, and that is a pretty grim place, because the average life expectancy for Aboriginal males out there is 35, so they are basically lucky to see their kids hit high school. Another place that I also have a fair bit of contact with is a place in western New South Wales, Condobolin. The Aboriginal men's group out there contacted me to talk about trying to get a bit of funding support for them. They were looking at trying to get about $100 a month to put a meal on, because there are big issues in the community about domestic violence, The blokes tried to get organised and wanted to bring the blokes in and sit down and talk with them about the domestic violence issues that were going on, and the blokes wanted to tackle it themselves—the alcoholism and the other problems that were happening. I chased around everywhere trying to get $100 a month for these blokes. All they wanted the money for was to put the food on to get the other blokes to come in and sit down and have a meal and do a bit of talking, and it was absolutely impossible. You think of all the money that gets pumped into Aboriginal affairs and—

Senator LUNDY—And you could not get $100.

Mr Welsh—I could not get $100 a month for them, and that group is sort of basically struggling and falling apart at this point. Maybe something as small as $100 a month could make a huge change, not just to those blokes themselves but to their families and the community as a whole. That was about it. That was all I really had to say.

CHAIR—Senator Williams has some questions.

Senator LUNDY—Can I just do a quick follow-up, with respect. We have had some discussion on this committee before about, I suppose, the need for groups like the one you described to access some funding—not usually a whole lot, because you are quite right, these groups usually do not need much money. But it is a good idea that works for them in their community, controlled by them, and just a little bit of financial resourcing goes an extremely long way. So I guess my comment—more than a question—is that that is a really useful

observation for you to share with the committee, because for me it certainly reinforces the point of how hard it is to find just a little bit of money that can make a big difference.

Mr Welsh—Yes, that is right.

Senator WILLIAMS—Thanks, Mr Welsh. It was a very interesting presentation of yours. I have spent quite a lot of time at Condobolin, Wilcannia et cetera, in my life. I must say that Wilcannia—and I first went through Wilcannia in about 1973—really has become a sad place today, and I find it alarming that the average life span of a man you say is 35 out there.

Mr Welsh—Yes.

Senator WILLIAMS—Is there anything being done about that at the moment?

Mr Welsh—That depends who you talk to. I basically go out and talk to the men's groups themselves. They say, 'We don't get anyone here. We don't get any attention.' You guys would be aware that it is 200 kilometres from Broken Hill.

Senator WILLIAMS—This side of Broken Hill, yes.

Mr Welsh—They have a lot of problems. They basically cannot get anyone to come in and sit down and talk to them. There are a lot of services out there but, when you sit down and talk to the blokes, they will tell you that there is nothing actually happening.

The other day I went to Wilcannia. It is a community with not much happening. There is around 90 per cent unemployment and not much for people to do. There are 12 police officers in town and problems with probation and parole. Blokes are getting locked up. They go to jail; they get out on probation; they go back in on community service orders. Then there is an expectation for the men to travel from Wilcannia to Broken Hill each Friday to report in to probation and parole, and I have taken that up with the Attorney-General's Department and said, 'Is there some way we can get probation and parole to come to Wilcannia?' There is no employment. Hardly anyone in town has got a car.

There is chronic disease. There is the Merrima area health service out there, which is basically an Aboriginal community controlled area health service. They have, I suppose, when you look at it, a great chronic disease strategy, but a chronic disease strategy and being able to afford to buy food in places like that are two different things. I stayed there the night and the next morning I got up to go and have a cup of coffee and a bacon and egg roll for breakfast. It cost $11. The price is high, and the distance that needs to be travelled is long, to get the basics, the basket of food that they need for their families.

CHAIR—Mr Welsh, could I ask a question related to what Senator Williams just asked. Mr Woods said that, if you removed the behavioural risk factors, that would only account for 30 per cent of the cause of men's deaths. Is that a correct assessment of what you said?

Mr Woods—Yes.

CHAIR—So in the community that you were just talking about, if we removed the smoking and the drinking and all of those sorts of things, would the statistics be consistent there?

Mr Welsh—It would improve the situation a lot, but there is also a lack of services going into places like Wilcannia. I asked a question about the Indigenous coordination centres. I said, 'Do you know who your regional manager is, or your solution broker?' They have this concept of solution brokers in federal government. They did not know who they were.

But the men's group out there is motivated. They want to see change. I have been doing a bit of work with them over about the last two years to try and get a men's group going, just because of the statistics alone. The week before I went out there, they said, 'We'll try and get together to have a bit of a committee so that we can sit down and start really looking at the issues that are going on,' and 43 blokes, 43 Aboriginal men, turned up. This is a big number for such a small community. It is a community of 600 people.

The bloke who sort of heads up the men's group out there is also the football coach. He wears a number of hats in the community. He said, 'I can't get this many blokes to turn up to football training.' I thought, 'Jeez, there must be a strong interest in what's happening out there.' They want to engage and try to do things to make the community a better and a stronger place for them. They see it as not a male versus female thing. It is something that they are looking at doing to try and make themselves better men to play a stronger role and have a stronger part in the community.

CHAIR—I regret we do not have much time, so I will go back to Senator Williams.

Senator WILLIAMS—Those statistics for Wilcannia are frightening. Is one of the biggest problems out there that people are simply bored? I remember buying diesel out there about four years ago and it was about $1.90 a litre. As you said, there is the expense of the place. In the small communities, the jobs are not there. Is one of the huge problems that they have not got a job; that they simply go to the pub, have a drink, go down the river, whatever? Are they just lacking things to do with their lives?

Mr Welsh—Yes, I think a lot of it is boredom. As well as boredom, in some ways it is overpoliced. There are just the environmental stress factors involved in having 12 police to service 600 people. I think it causes more problems than it should, when you look at some of the statistics around Wilcannia. Maybe that is one of the factors, one of the underlying issues, that is impacting on the community as well, because you look at imprisonment rates and everything else that happens within Wilcannia. In my opinion, it is something that is detrimental to the community out there.

Senator WILLIAMS—Are there other communities like this? Are there other similar towns that you know of, besides Condobolin? Condobolin has obviously got some problems. What about Walgett, Bourke, Brewarrina? Have you been to those areas as well, looking at the Aboriginal health issue here, and the men's health there?

Mr Welsh—I think there are a lot of similar problems in those areas. A lot of it is to do with the unemployment and the boredom and that, as well. In a lot of those places they also look to try and do things, but there is just a lack of funding for men's groups in general. They try to

improve people's engagement in sports and that type of stuff, but when you look at a small place like Wilcannia, there is one shop and one service station. Trying to get a sponsorship to do anything is basically impossible. The blokes do not have the money to jump in a car and drive 200 or 300 kilometres for a game of football. It can make things very hard for them.

Senator LUNDY—To certainly Mr Welsh, but also the other two witnesses: what role can organised sport play? And, Mr Welsh, you just mentioned that the market fails, effectively, in terms of sponsorship and supporting teams in any viable way in an isolated community like that. If there were some support for organised sport—and that means a bus and transport costs on a weekly basis to have games—would that help?

Mr Welsh—Yes.

Senator LUNDY—Is there any research out there showing that involvement in a team sport and a regular physical activity improves health outcomes, reduces crime et cetera? Can I tip that out there and get a response, and also ask you to please take the initiative and follow up if there are any research papers that could help inform the committee in this regard once you leave here. Please respond.

Mr Welsh—The Royal Commission into Aboriginal Deaths in Custody occurred in the nineties and one of the recommendations was to have Aboriginal people engage in sports. The answer to your question is: yes, I think it would make a difference, because the blokes have a hard enough time trying to keep a team together for themselves, and they do not have a lot of capacity to engage the younger blokes and younger females into sports. It is about the logistics of travelling 200 kilometres to play a sport; no sponsorship; no dollars; nothing on the ground for them; no support service for it. So I think it would make a difference. Also, we talked about boredom, and it could take a lot of that boredom away if that happened.

CHAIR—We are out of time. I regret that we are. I thank you for your submission. I thought it was very well laid out. There are lots of recommendations in there which are absolutely pertinent to this inquiry and I thank you for those. I would love to have another hour in which we could ask you to answer questions about that, but unfortunately we do not; we have a very busy program. Thank you very much for your contribution. If there is anything further you would like to add, please do so. Indeed, we may have some other questions which we submit to you on notice. If that be the case, we would appreciate a response. Thank you very much.

[2.54 pm]

CLAYTON, Ms Stevie, Chief Executive Officer, ACON

PARKHILL, Mr Nicholas, Director Community Health, ACON

CHAIR—I welcome the representatives from ACON, which was formerly the AIDS Council of New South Wales. Thank you for coming along and talking to us today. Please accept my apologies: we have rearranged the program a little bit, so we are a little bit late in getting to you. We appreciate your submission, which is No. 75. Do you have any amendments or alterations to the submission that we have received?

Ms Clayton—No, but we probably have some additional information to give you.

CHAIR—Thank you. We are happy for you to table that. Perhaps you could do so when I invite you to make a brief opening statement, as I now do.

Ms Clayton—Thank you. We thought in opening it might be useful to add a few words of clarification to explain to the committee a little more about the context of gay men and other men who have sex with men in Australia and what some of the key health issues are for them, elaborating a bit more on the submission that we made, it only having skimmed the surface.

The first is to explain the terminology that we are using. Gay men seems self-evident to people in Australia because it is a commonly used concept and it is about sexual identity. It is a term that someone claims for themselves in describing the way that they exist in the world. MSM, or men who have sex with men, is a term that is used by people who work in sexual health and it is based on sexual practice rather than any concept of self-identity. It is to include a much broader range of people, including gay men but, as I said, much broader.

It includes men who might identify as bisexual but it also includes men who identify as heterosexual but do have sex with men. It would include men who reject any notions of identity but have sex with other men, but it also includes men who are transgender but have not had gender reassignment surgery and have sex with other men. So, whatever gender or sexual identity someone has, if they are anatomically male and have sex with other men, they fit that concept of MSM. It is a very broad concept that we use in planning sexual health services and programs, just so we are clear about the use of that throughout our paper.

The second is to clarify a couple of overarching issues for us. The first of those is to understand that all of the issues that you have been hearing from just about everyone who has made submissions to you about issues that impact on men's health in Australia all impact on gay men's health and MSM's health in Australia because gay men and other MSM work in every occupation and live in every part of Australia. Gay men are from different CALD backgrounds, are Aboriginal men and are increasingly having children. Many of them previously were in married relationships and have children from those relationships, and certainly, as we see our community spreading in New South Wales more and more beyond the ghettos of Darlinghurst

and Newtown, they are increasingly in rural areas and experiencing all the problems that men experience in rural areas.

So all of those health issues are shared but gay men have particular health issues that impact on them disproportionately, have particular impacts on them or have impacts that are exacerbated by social, cultural and political contexts. Just to mention some of those health issues quickly: HIV-AIDS of course remains the No. 1 health issue of importance to gay men in Australia, but one of the problems that we have is that many health providers and politicians think that HIV-AIDS is the only health issue that impacts on gay men, and that makes it difficult to have their other health issues dealt with.

The impact of antiretroviral treatments being widely available since 1996 and the very broad take-up of them in Australia has meant that, for people with HIV, very few people progress to AIDS, and HIV has moved from being a life-threatening illness to being a chronic condition. We are now seeing the impacts of ageing on our HIV-positive population, something we thought once we would never see. It is great that they are living longer, but now we are having to deal with a range of health conditions that we have not had to deal with before.

Many studies overseas are now showing that both HIV itself, the virus, and the treatments for HIV accelerate the ageing process, so we are seeing slightly younger men who are dealing with the impacts of ageing sooner, and we are seeing people with HIV, whose lives are being extended by the treatment, dealing with the impacts of heart disease, renal problems, liver problems; the things that you see in much older people. They are experiencing them sooner and they are seeing them on top of the impacts of toxic treatments, side effects and other opportunistic problems of HIV. So we are seeing a much broader range of health issues that now need to be dealt with within the context of HIV.

When we look at the area of sexually transmitted infections, gay men account for a large proportion of the syphilis and gonorrhoea cases that we see within New South Wales, which is a particular problem that we are trying to deal with at ACON. We have a large role in dealing with that. Gay men report much higher rates of anxiety and depression than we see in the general population and, in an Australia-wide report looking at health issues for the community, 16 per cent reported having suicidal ideation in the preceding 12 months.

Violence remains an incredibly important issue for our community, and 88 per cent of gay men in New South Wales reported that at some time in their lives they had experienced homophobic abuse, threats or violence. Drug use in our community is very high. Illicit drugs are used at something like five times the rate of the general population and alcohol and tobacco are used at much higher rates also, with obviously both short- and long-term impacts on health. Men who have sex with men, gay men and other men who have sex with men, are likely to get anal cancer at something like 35 times the rate of heterosexual men, and men with HIV are likely to get anal cancer at even higher rates, and yet we have no screening programs. People in the gay and lesbian community experience same-sex domestic violence at the rate of about 35 per cent, which is something like the general population.

Why do we experience all of these health issues? There are two issues in particular that jump out for us. The first is that we have an incredible lack of research to tell us exactly why we are experiencing these health issues and how best to tackle them and get on with solving some of

those problems. The overwhelming reason that we do have that lack is that most of the major health studies in Australia refuse to ask a question about sexuality, including government funded research. We have lobbied for that for many years and they simply refuse to ask a question about sexuality. They constantly come back to us and say, with no research evidence on their side, that if they do it will scare people away and they simply will not fill in the rest of the research. So any assistance that we could get for researchers to simply ask that question would be great.

The second problem we have is that the many years of discrimination that people in the gay and lesbian community—but obviously, in this context, particularly gay men—have experienced has taught them to expect discrimination from health services, so they do not access them at the rates that they should. I know it is surprising given that, in the context of HIV, we have one of the highest rates of testing in the world, which is why we have one of the most successful responses to HIV in the world. But when it comes to all other health issues, gay men access health services at a lower rate than the general population. They are underscreened for all other medical conditions and, even if they do go and screen, they do not then go back for subsequent treatment.

Generally gay men anticipate that they will be discriminated against in health systems and for the most part they are accurate in that assessment, so they do not access them at the rate they need to. That is particularly true in rural and regional areas where they are also more likely to be accurate in their assessment that they will be discriminated against. So there is a great need for us to tackle discrimination in our health systems generally against gay men, and then to tackle their perceptions that they will be discriminated against so that we can get them to better access those systems. Thank you.

CHAIR—Thank you, Ms Clayton. Mr Parkhill, do you have a brief opening statement?

Mr Parkhill—Not really. But I would like to add in support of what Stevie said that, while there are these health conditions that are, by and large, socially determined as they impact on gay men and men who have sex with men, I think it is important to acknowledge that there is a high degree of social capital within the gay community itself, and this has been evident in the response to HIV and the community's response to HIV, particularly in New South Wales. It is a very useful model, I think, for looking at how other preventable health issues can be addressed, how communities can be engaged in that process of addressing health issues, and there is a lot to learn from gay men's experience in responding to HIV, particularly in New South Wales, and some of the social capital that has been built up through that process should be acknowledged, as well as being an important model for public health.

CHAIR—Thank you. In reading your submission—and I appreciate the clarification that you have provided for the descriptive factors; I found that very helpful—and discussing your submission with a couple of my friends, they acknowledge that quite often gay men have specific health issues that they like to discuss with someone who understands what those specific health issues are, which is a gay-friendly doctor; it might be a gay doctor. But they did not agree with the assessment that there is general discrimination in the health system. They thought that if they went into the general health system there was maybe not quite an appreciation of the specifics of the issues that they may be dealing with, but people were open-minded and tolerant and they received pretty good service. That is not what you are telling us. I do not want to misinterpret what you are saying, but how do you respond to that statement?

Ms Clayton—Do they live in Darlinghurst?

CHAIR—No, they do not. They might; I do not know.

Ms Clayton—It depends where you live in Australia. There are certainly pockets all over the country where you will be treated really well, if you have the right doctor and you go to the right location or you go to the right hospital. It is probably true in the centre of every capital city and then, as you go out, it is increasingly difficult. We have certainly experienced in New South Wales and, probably surprisingly to me on last World AIDS Day, even in the middle of Sydney, really homophobic treatment of HIV-positive gay men in our main hospitals. It showed us how far we have not travelled.

Senator WILLIAMS—When you say experienced homophobic treatment of HIV-positive gay men in the health system, was that treatment from the hospital staff?

Ms Clayton—Yes.

Senator WILLIAMS—When you say 'treatment', that was from the doctors, the nurses? Can you expand on that a bit, please.

Ms Clayton—Sure. One of several complaints that came to me was an HIV-positive man who was walking into one of our main hospitals in Sydney, which has been a centre for HIV for some years, to visit his male partner who also had HIV and was an admitted patient. He was walking behind two ambulance drivers who were pushing an old man in a wheelchair. Because it was World AIDS Day, there was a table where there was a big display and ribbons being sold. As he walked along, one ambulance driver said to the other ambulance driver, 'Have a look at that. That's for those poofters who gets AIDS from sticking their dicks where they shouldn't. They deserve everything they get.' That is two ambulance drivers, in the foyer of a hospital, in 2008. You just do not expect that any more.

Senator WILLIAMS—I am, you could say, ignorant about all of this. Is HIV-AIDS continuing to spread, is it stabilised or is it shrinking, through the gay community?

Ms Clayton—In Australia, there are about 1,000 new cases of HIV every year. There have been 24,000 recorded cases ever; 7,000 people have died. There are currently about 17,000 people living with HIV. Of the new infections every year, about 82 per cent are gay men, but we make a distinction between new diagnoses and new infections. New infections are ones where we can tell that they were infected in the last 12 months. New diagnoses are newly diagnosed this year, but they may have been infected some time ago, and it will include people who have come to Australia and been infected overseas. Of the new diagnoses, about 65 per cent are gay men, because a number of the new diagnoses are women and children who are coming in as refugees from overseas. So, within Australia, about 82 per cent of new infections are gay men.

Senator WILLIAMS—Some of the refugees coming to Australia are carrying the virus. Is that what you are saying?

Ms Clayton—Some. It is not a huge number, but some. But also some of the late diagnoses may be women. Most infections in Australia are still gay men, and that is because we have been

so successful in keeping HIV out of the general population, keeping HIV out of injecting drug users and keeping HIV from sex workers, so it is about having kept HIV contained amongst the population that was first newly diagnosed. If you look across Australia, since 2000 we have seen quite large increases in infection amongst every state in Australia, except New South Wales. New South Wales has had a stable rate of transmission for the last 11 years. We are seen as indisputably having the best response to HIV in the world.

Senator WILLIAMS—You have referred to not accessing health services, and that it is more the case in rural and remote areas that gay men do not access health services. Why is that?

Mr Parkhill—It is largely because of fear of discrimination and issues associated with stigma: stigma and discrimination and the repercussions of that.

Senator WILLIAMS—Are the rural areas more unaccepting, if that could be the word, of the gay community?

Mr Parkhill—Yes, that is correct. In relation to the cultural appropriateness of mainstream health services, some of the data indicates that gay men do not discuss their sexuality even with their GP—some research has highlighted it is about a third of gay men. They might be seeing their GP about a cold and they will not come forth and discuss sexuality issues. That then has a flow-on for the type of screening or testing that the doctor might prompt them to discuss, if the doctor is in fact providing a culturally appropriate and responsive service. Some of those issues around stigma and discrimination exist because they fear that they will not get that appropriate care and treatment, but then there is the flow-on effect—what service is the doctor actually providing those gay men?—rather than having a much more open and transparent kind of interaction between healthcare provider and the client.

I also think it relates to the intensity of the service that is required—for instance, some people presenting with drug and alcohol issues to a drug and alcohol treatment service provider. Sexuality is a big issue in the rehabilitation process, and the whole social interaction and social environment of that particular client is really important to their rehab process, but often there is no room for that. If someone is in rehab for a period of six weeks to three months, it is going to have a major impact on the treatment outcome if those issues are unable to be addressed through that treatment process. It happens on occasions of smaller service with GPs in rural areas, but when the kind of treatment that needs to be provided is more intensive, longer term, that can have flow-on effects as well in relation to really culturally appropriate healthcare providers.

When you are looking at social determinants of health—things like Aboriginality, culturally and linguistically diverse backgrounds—they are really important in healthcare settings.

Sexuality is one of those social determinants of health that is really important to preventative health, but also to the tertiary end, to treatment. So that really needs to be factored in, as well, as a social determinant of health and appropriate care.

CHAIR—I agree with you, Mr Parkhill, it is a social determinant of health. In any number of surveys and questions in relation to insurance or other product purchases, you are asked if you engage in what I will call high-risk behaviour, whether you use drugs, whether you have had unprotected sexual intercourse, and if the answer to any of those is ‘yes’, it goes on to, ‘Who

with?', 'Where?', 'Have you used prostitutes?' and all of those sorts of things. So it does impact on the assessment and the direction. I am surprised that doctors do not feel the need to ask that of their patients in some circumstances, and also, I have to tell you, I am surprised by the evidence from Ms Clayton about the level of syphilis and gonorrhoea in gay men, because I thought that would have been an educational issue as much as anything else, about the dangers of unprotected sexual intercourse, which would have been captured by the HIV-AIDS message. Am I missing something there?

Ms Clayton—No. One of the issues with HIV and STI prevention right now is that you would be hard-pressed to find a gay man in New South Wales who does not know that condoms and lube will protect them from HIV and most—not all—STIs, and most gay men do, indeed, use condoms most of the time; it is that they are occasionally not using them. So quite complex risk management equations are coming into play. They are making assessments about risk management on some occasions and on other occasions it is about other factors that are impacting on their decision-making processes.

It is those other factors that we are now having to look at increasingly. They are things like drug and alcohol use, pre-existing mental health problems, the impact of depression, the impact of homelessness, and, given the current state of the global financial crisis, what happens when someone loses their job and they are feeling depressed and they fall back on drugs and alcohol and start hanging out in the bars, and how all of that then impacts on people's sexual decision making around condom use. It is much more complex than just handing them a condom and giving them a bit of information about safe sex.

CHAIR—Gay men obviously experience very much the same problems as other men do, but maybe at a higher level, such as depression, and abuse of alcohol and drugs that affect decision making. They affect everyone's decision making. The consequences of poor decisions are often not as grave in other aspects of life as they may be if you have unprotected sexual intercourse and contract HIV or something like that. There is nothing unique about those issues for gay men except their higher incidence. Is that a reasonable conclusion for me to draw?

Ms Clayton—Yes, except that at the end of the line, if we were looking at a gay man and a heterosexual man in their late 30s, in the same two scenarios, the gay man goes out and has unprotected sex in a bar in Darlinghurst and he has probably got a one in seven chance that it is with someone who has got HIV, whereas the heterosexual man goes out and picks up a woman in—I do not know; where do they go?—a bar down in George Street—

CHAIR—I have not been to either.

Ms Clayton—and he has a one in a million chance that it is going to be someone with HIV.

CHAIR—So the consequences of the behaviour are potentially much riskier.

Ms Clayton—Yes. He might get chlamydia. That is much higher in the heterosexual population.

Senator LUNDY—Regarding MSM as distinct from gay men, how differently do you have to pitch your health services or the service in the range of health areas to those different groups?

Mr Parkhill—It really is quite different. One of the successes of our response to HIV is being able to engage with gay men directly and involve them in the design of the public health programs that we build, not only in relation to message development but also distribution, execution, all of those factors that flow through a good public health program. We involve gay men in that process because they are fairly open about their sexuality, they identify as that, and they are engaged to a large extent. There are gay men that are not that community attached, but we can still reach them through other mechanisms: through web based sort of stuff.

MSM are more difficult to target and we do need different approaches for that. Increasingly, we use web based approaches to target those men with health messages, because often they will use that as the mechanism for which they will hook up. Other mechanisms have involved needing to provide public health information at places where we know that they would potentially meet, like beats, and other things like that. It is not as obvious a way to address their needs and it is really important that we can continue to work with healthcare providers and GPs so that some of these issues can be addressed through those clinical based settings as well as through community channels.

Senator LUNDY—How important is it for a men's health policy to acknowledge both MSM and gay men and the different approaches that are required?

Mr Parkhill—I think it is really important, because often, while those MSM might be having sex with gay men, they will come in and out of that, so those needs should be reflected, I would imagine, but I think some of the social determinants of health, if it is being framed in that way, are different for gay men and MSM, and perhaps that could be highlighted in a policy approach too.

Senator LUNDY—It was a bit of a leading question, but I think an important one, to get your response on the record and to draw out that distinction and the different approaches that are required. Thanks for that.

CHAIR—Senator Williams, anything further?

Senator WILLIAMS—No. I am just gobsmacked at the level of that Darlinghurst example: one in seven. That is a serious problem. You said the chances are one in seven in Darlinghurst if a man were to have unprotected sex.

Ms Clayton—I did say a man in his late 30s. It is about prevalence. One of the things that is unique about the Australian HIV epidemic that most people do not realise is that the average age at which someone becomes infected with HIV is 38 and rising. People always think of it as something that young people get, and it is not. Particularly in New South Wales, the prevalence in the younger age group is falling, and we are being really successful in making sure that younger people do not get HIV. That 38 and above age group is the older age group where HIV mainly started. That is the cohort amongst which HIV mainly started in Australia, and people mostly have sex with people in roughly the same age group as themselves—10 years up, 10 years down; that sort of age group—and so that is the age group that has the most prevalence. It is one in seven in that age group but it is less in other age groups.

Senator WILLIAMS—We saw the adverts on TV years ago. On the publicity side of things, we see little about it now. Do you see that as a fall-down on behalf of the government, the health commission, the health authority et cetera, that there is not more awareness of it, more education on it? What do you think should be done?

Ms Clayton—We, of course, have continued to churn out lots of campaigns over the last 25 years. They have just been highly targeted at those most at risk.

Clearly, as I said before, when you look at the results of New South Wales leading much of the world in HIV prevention, that approach of doing highly targeted work has succeeded. The problem for us more recently has been that, as our community becomes more geographically dispersed, it is not so easy for us to get to them by just putting up posters in bars in Oxford Street and putting ads in community media.

It is becoming increasingly the case that we need to become more reliant on the web. It would be easier to get to people with larger scale, multimedia type campaigns; so with TV advertising and those sorts of things that cost way beyond any budget that we could ever afford. But I do not think that the government is ever going to do advertising on TV that does the type of highly explicit, honest sort of information that we know is the only sort that works when you need to talk about sex and sexually transmitted infections like HIV. It may be that until we come up with something better we need to continue to do highly targeted work.

CHAIR—Ms Clayton and Mr Parkhill, thank you very much for your submission and for your evidence today. It has been interesting and I appreciate your patience in our slight delay.

Proceedings suspended from 3.26 pm to 3.37 pm

SHARMA, Dr Anita, Researcher, Royal Australasian College of Physicians

CHAIR—I reopen the Senate select committee inquiry into men's health and welcome the representative of the Royal Australasian College of Physicians. Thank you for coming along and talking with us today. We have received your submission. It was No. 64. Do you wish to make any amendments or alterations to the submission that we have received?

Dr Sharma—Not at this time.

CHAIR—Thank you. Dr Sharma, I will invite you to make a brief opening statement, and perhaps give us any other information about the capacity in which you appear today, then we will take some questions from the committee.

Dr Sharma—I am a geriatrician and I have recently, on 31 March, submitted my PhD thesis. The reason they chose me to come and present here is because I did a thesis on dementia and mild cognitive impairment in older men and looked at all the aspects: prevalence, health service use, driving and dementia and also the neuropsych symptoms. I may not have the authority on men—it is general—but I think I can answer your questions.

CHAIR—I do not think anyone has authority on men. It is general, Dr Sharma.

Dr Sharma—Yes. The reason I am here today is that male health needs to be considered as a discipline in its own right. The development of a national men's health policy is a good start towards that. Overall, there are a lot of issues about men, though we are focusing mostly traditionally on male health issues such as genito-urinary symptoms—for example, prostate cancer, testicular cancer and erectile dysfunction. However, men do not suffer only from those. They suffer from lots of issues. Other conditions are outlined in the submission, particularly chronic conditions caused by lifestyle factors, such as alcohol, tobacco or illicit drug use or from poor nutrition and physical inactivity. Men also have higher rates of depression and suicide.

I need to discuss that in context with men living in the city and living in remote areas. We have not done too much research and the reason we submitted this is to look into how we should do it. Research is the way to go, but we need funding for that. We need research to give us evidence so that we can practise evidence based medicine.

CHAIR—Thank you, Dr Sharma. You mentioned a national men's health policy. If that is introduced, which I understand is the government's intention, do you see that as leading to a specific branch or specialty in medicine dealing exclusively with men's health?

Dr Sharma—It should not be exclusive. It should be in the context of general medicine, but we need to understand the issues with men. Men are working. They do not go and see doctors. By the time they present to doctors, it is too late, and even if it is too late, they still do not want to face the issues. Then, when they get older, it is the same issues that I see reflected in older men. When we are catering for the services, the problems that we are dealing with in younger men are the same problems that we see in older men. It is very important to know about their priorities, but whether we should deal with them exclusively, I am not sure.

CHAIR—You mentioned lifestyle factors. You talked about alcohol, drugs, nutrition, those sorts of things. Earlier today we had some evidence suggesting that, even if we could remove the lifestyle factors, that would deal with 30 per cent of men's health issues. I think that is a fair characterisation of what it is. Firstly, do you agree with that? Secondly, how do you then think we should deal with the remaining 70 per cent of the issues, such as the diagnosis of things that are unrelated to lifestyle?

Dr Sharma—It may be true. We cannot say, because we do not have research for that. It would be looking at lifestyle measures. If we do that, and take that out of the picture, you mean the other issues?

CHAIR—If you take lifestyle and say, 'Okay, there are 30 per cent that we can deal with through lifestyle factors,' how are we going to reduce the other 70 per cent, which come from early diagnosis or getting men to seek medical treatment or discuss some of the issues that they are facing?

Dr Sharma—How do you resolve that issue? I would say we should attack them early. If you look at women's health, we educate them from the beginning because, for example, with women's health we have our menstruation, then it is having babies, and a lot of emphasis is placed on having pap smears. If you compare that with men, the emphasis is not there to get them early to see a doctor to have a PR—per rectal—examination or just a blood test to check for prostate problems. We need to look into educating these people.

It is a problem. If you look at all the studies, it is difficult to educate them. How do we do that? We need research to convince us of how to do that. But if we attack them and educate them early, half of the work is done. They are then more user-friendly towards medicine and seek medical attention earlier, so get their treatment done earlier.

CHAIR—The term you used there that I found intriguing was 'user-friendly', because the education programs that have been pitched towards women, dealing with women's health issues, have been targeted to women and designed to appeal to women. Based on the evidence that we have received, it seems that we have a limited number of marketing campaigns designed to get men to engage more fully with health issues, but there are some. One that has come up repeatedly is Pit Stop. Are you familiar with Pit Stop?

Dr Sharma—I just read about it, yes.

CHAIR—Senator Williams has been through Pit Stop. He can tell you about that.

Senator WILLIAMS—I am not roadworthy, either, I can tell you.

CHAIR—At the risk of reinforcing stereotypes, we have to engage men at a level where they understand and want to engage. Do you have any comment to make about that?

Dr Sharma—Not really.

CHAIR—Do you see Pit Stop as effective?

Dr Sharma—They are effective in their own ways, but they are targeted at specific groups, I think. We need to make something that is universal and user-friendly. We need to do more research into how we achieve that. We should start by looking at all the measures that are in place now, evaluate them, see the risk-benefits and then come to a conclusion. I have not looked at those studies very well, so I cannot comment on that. I have just read it here, but I did not evaluate everything. I think that is the way to go but, reading through these articles, we still do not have anything in black-and-white so that we could say, 'Yes, we can do this, and this is the outcome.' We need more study or research into those areas.

Senator LUNDY—One of the features of the evidence we have heard is that different things are going to work for different communities. Different groups of men might identify with Pit Stop. Gay men will identify with a gay men's health service or services pitched to them. Do you think that trying to come up with a universal model is going to inevitably mean that some men are just not going to use those services at all? Surely it is better to have men's health services grow out of the communities themselves so that they are a good fit for the men they are trying to support and help?

Dr Sharma—I do not think there will be anything universal. I think we need to look at Pit Stop and all other programs and put it together.

There was another program that was used that would address men over 40 and men who were of a lower socioeconomic class. So some of these programs are targeted to address, say, gay men. Some are targeted to represent men over 40. Many of those programs are there and work. We need to evaluate that. We need to also target programs that are not there to capture those men who do not fit there and try to pit it together to address the problem as a whole. I think that is how you deal with it. I do not think there is one answer.

Senator LUNDY—Sorry, I misunderstood what you said.

Dr Sharma—Yes. Everything is multifactorial, and I think you look at it, you evaluate it, put it together and come with evidence based medicine.

Senator LUNDY—And then make it available through the different deliveries.

Dr Sharma—Yes. It could be at different levels, but it is capturing everybody, so it is the over 40, the lower socioeconomic. Then how do we address the men who are living in the remote areas, the Aboriginal men? I was quite amazed. In this study, I looked at 1,705 men and did a complete assessment for dementia in 421 men. I was struck by the attitudes of men; the multicultural society and the problems. I think that same problem should be across the board, because we are a multicultural society. In fact, one in three Australians is culturally and linguistically diverse.

Senator LUNDY—Yes.

Dr Sharma—I was struck by that. With them comes a different problem and we cannot just say, 'This is this,' and, 'This is going to capture this.' We look at everything, try to address every problem and put it together. It is a hard problem, I think.

Senator LUNDY—It certainly is. Someone recently told me a story about the prevalence of what they described as cognitive compensation, particularly in men, and particularly in people who found themselves at the early stages of dementia. Did you cover that in your study? And what were some of the findings or observations you made about how men coped with this experience or compensated for this happening to them, as compared to women, but also generally?

Dr Sharma—I only did it for men, so there is no comparison, but I studied other studies and compared it. What you are referring to is now commonly known as mild cognitive impairment. Mild cognitive impairment is a transient phase. You have got normal and dementia. In between is the transient phase, which is called mild cognitive impairment. It is quite interesting. There are different types of mild cognitive impairment. The most important thing here and the reason we are interested is that mild cognitive impairment patients have a high risk of conversion to dementia compared to a person who does not have MCI. Twenty to 60 per cent convert. Within two to, say, 10 years they will convert to dementia, different types of dementia, and there are five or six population based studies to prove that. For me, it is a very important point, because if we had a treatment, which we do not have, then we could target our patients to prevent dementia.

Senator LUNDY—So identifying them when they are at that stage is really important?

Dr Sharma—Identifying them. Most of the people are undiagnosed because our GPs do not know about the condition. They should be educated. When many go to see GPs, they are told, 'This is normal ageing,' but it is not really normal ageing. I think the reason is that we do not have any treatment and it is easier to say it is normal ageing. In some communities in my study the prevalence of dementia was 5.9 per cent and the prevalence of MCI was 7.7 per cent. Comparing to other population studies, it ranged from three per cent to 15 per cent.

Senator LUNDY—So it was within the range of other population studies?

Dr Sharma—US studies and Canadian studies.

Senator LUNDY—Thank you very much. That is very interesting.

Senator WILLIAMS—Thank you for your submission. What you have said is very common in many of the other submissions: the men do not seek help; they do not go to the doctor enough; they think they are bulletproof and they do not need help, and so on. I went over the pits at the Bombala show a few weeks ago in Pit Stop. I had not had a blood test for 20 years, yet I am 54 years old. How do you encourage us to do this? Once they turn 50, how do we get men to have a regular blood test and the various other tests they should be having at that age? You are saying through education. Shouldn't we have to also have some sort of an advertising campaign or some promotion? How do we get men to go to a doctor?

Dr Sharma—When I say 'education' I mean having campaigns—through media, through paper, through family. Secondly, once again, be user-friendly. You work eight to 4.30. You cannot go and see a doctor after 4.30. Somehow the services should be more accessible to men—for example, having them available to you at work. If we have these campaigns, if we educate the GPs so that your GP is more encouraging and easier to get along with, you look forward to seeing your GP, hopefully.

Senator WILLIAMS—The GP could send you a letter saying, 'Your 12 months is up. You're due for another blood test,' et cetera.

Dr Sharma—Yes, it may help.

Senator WILLIAMS—When it comes to educating GPs, there are things like that: the reminder note. The vets certainly do it with my dog. They send one out every 12 months to say, 'Your dog is due for a check-up.' But I do not get one from my GP.

Dr Sharma—Yes. I think they do it with women for pap smears. They send a reminder when two years is up so that you know you have to go and have that. I think a similar thing should be done with the men, and, once again, bring it to you as well somehow. Make it more accessible.

Senator WILLIAMS—As I said, I get a reminder every year from my vet for my dog to have a check-up—

Dr Sharma—But not for you.

Senator WILLIAMS—but I do not get one from my GP.

Dr Sharma—Yes.

CHAIR—In regard to check-ups and testing, does the college have a position on blood tests for prostate cancer? I do not want to give you a leading question: we have heard some evidence that it could actually be counterproductive because, of 40 people receiving treatment for prostate cancer, it might be that 39 of them are unnecessary.

Dr Sharma—There is no evidence to suggest that. I do not think, reading through the papers, that we have said that. However, the study that I am involved in is called Concord Health and Ageing in Men Project. We have 1,705 men and we have tested this, looking at prevalence, and we are doing the blood test, so from that we could answer some of those questions.

CHAIR—Yes. I am just asking whether you had an opinion about the effectiveness or the wisdom of—

Dr Sharma—Having a PSA?

CHAIR—Yes, a PSA test.

Dr Sharma—I think over the age of 60, and if the man is symptomatic, then I would do it.

CHAIR—But you wouldn't have a mass screening program for it as a matter of course as we do for some women's health issues or as they are suggesting with bowel cancer?

Dr Sharma—I would love to do it, but I would want a bit more evidence before I made any recommendation. I do not think I have enough evidence. When you screen for something, during the screening you should have a higher sensitivity. If you do the test and the test gives a false

positive, say, it causes unnecessary anxiety, angst. I would like that to happen, yes, but before I do that, I need more evidence.

CHAIR—Which is, I think, a reasonable position to take—as, might I say, was the college's position about targeting funding to what works from an advertising point of view rather than continuing with programs that have not been deemed to be effective. Certainly that is consistent with some of the evidence we have heard today that some of the smaller programs are much more effective than some of the mass based programs, which is reflected in your report, and I think in the clarification which Senator Lundy gained from you in your evidence.

Dr Sharma—Yes. I think we can learn from the small projects and investigate why they are working well and then build on that. In Australia, if you do research, you are struck by it. For example, dementia: we are not doing much research. We need a cure for this disease. In 20 years we all will have dementia. It increases with age, but nothing is being done here; the activity is overseas. If you find a cure, it saves you massively—economically, socially, personally—because it is a devastating illness. Here we are not doing as much research. I think if we do evidence based medicine, it is much better. The outcomes are much better. In order to do that, although research is tedious and a bit drawn out, at the end of the day it gives you good results; not all the time but most of the time.

CHAIR—I know. But we have seen the rewards of some Australian based research in any number of areas.

Dr Sharma—And the ones that have been done are excellent, especially with HIV. I am from Nepean. We are doing lots of research. I am setting up my research in dementia, and also we are doing osteoporosis, and we should be leading that research.

CHAIR—Dr Sharma, is there anything you would like to add?

Dr Sharma—No. What I would say is that you should consider funding us for research. That is all I would say. Thank you.

CHAIR—Dr Sharma, thank you very much, for your submission and your evidence today on behalf of the Royal Australasian College of Physicians. We appreciate it.

[4.02 pm]

HELMERS, Mr David, Executive Officer, Australian Men's Shed Association

CHAIR—I welcome Mr David Helmers from the Australian Men's Shed Association. Thank you very much for coming along and talking with us today.

Mr Helmers—Thank you.

CHAIR—The committee has received your submission. It is No. 81. Do you have any amendments or alterations to make to that submission?

Mr Helmers—No, not at all.

CHAIR—I invite you to make a brief opening statement.

Mr Helmers—Thank you very much for the opportunity to be here today. I would like to open my statement with a quote from Professor Barry Golding which has now become the motto for the Australian Men's Shed Association and sums up what Men's Sheds are all about: 'Men don't talk face to face; they talk shoulder to shoulder.' This echoes the sentiment of sheds around Australia. Men's Sheds, in essence, are a comfortable place for men to gather and talk. It is a very comfortable environment for them. When explaining about sheds, I quite often say that if you want men to talk about their problems or about health related issues you do not put them in a room around a table and say, 'Let's discuss this.' You put them in the room, put an engine on the table and some tools on one side and they will talk about everything. It is about creating a comfortable environment and sheds creates that environment.

The association itself is a very new organisation. We have only been around for a bit over 12 months, even though the idea has been around for some time. It is estimated currently that we represent between 20,000 and 30,000 men working within sheds around Australia. Due to our limited infrastructure and resources, we do not have an exact idea of how many men are in sheds around Australia. We do know that there are over 300 sheds in Australia at the moment in various stages of development, and also we are working with overseas governments to establish sheds in England, New Zealand, and especially Ireland where the Irish National Men's Health Policy makes reference to the Australian Men's Shed movement, and delegates from the Irish government are currently being invited to come to our conference in Hobart.

I would like to take this opportunity to highlight the achievements of these last 12 months to give you an idea of the rapid growth that we have experienced in Men's Sheds within the environment. The Men's Shed Association set up a 1300 number to assist communities to establish sheds. In the last 12 months we have been directly involved with the establishment of over 100 sheds around Australia. Through distribution of the information that we learnt in the very early days and have perfected over time, we estimate that we have probably saved $50,000 per shed in human resources in establishing these facilities, so that is about $5 million in the last 12 months.

Although it is not documented, it is strongly arguable that in every shed you go to you will hear stories directly from the men—and I have heard some subjects mentioned in sheds that you would not expect to be discussed so casually within the environment—about how every shed has at least saved one life from potential suicide, and multiple lives heading down the road to depression. The value on human life that has been saved and people that we have kept out of the health system through providing these places is totally unknown at this stage, but it would be quite considerable.

It is very important to note, after looking at other submissions made to this committee, the number of submissions that have mentioned the Men's Shed movement and the Men's Sheds. I have a number of them listed: Lara Giddings, Deputy Prime Minister of Tasmania; Department of Health and Ageing; Foundation 49; and beyondblue. They have made quite notable comments about the shed movement within Australia.

The association is the peak body, representing sheds in Australia, and we firmly believe that Men's Sheds are a men's health preventative measure. We just do not tell the men that at all. Thank you.

Senator WILLIAMS—Thank you, Mr Helmers, for being here today. I must say, last August was the opening of the Men's Shed in Inverell, which I played a part in, and it was great to see it up and running. Are you familiar with Pit Stop?

Mr Helmers—Yes.

Senator WILLIAMS—I think Pit Stop is excellent. It puts things in men's language, about the chassis and the shock absorbers et cetera. Do you think there would be some way of perhaps running them in conjunction with the Men's Sheds, or perhaps the Men's Shed running its own Pit Stop style thing?

Mr Helmers—Certainly. This is where we believe Men's Sheds can be a platform for the launching of other men's health initiatives.

Senator WILLIAMS—Yes.

Mr Helmers—We are currently working with Foundation 49 and the Royal Australian College of General Practitioners in New South Wales to use the sheds, within New South Wales to start with, as a platform for their M5 Project, which is quite similar, I believe, to the Pit Stop program, where the GPs will actually attend the sheds on open days. The men within the community, who are not even members of the shed, will feel a lot more comfortable coming to a Men's Shed for a general check-up, than what they will to any clinic.

So I totally agree that sheds could be used in this manner. A lot of sheds are already doing this independently. As I say, with 300 around Australia at the moment, it is very hard to communicate with each one individually, so that is where the association comes into play here.

Senator WILLIAMS—Men do feel at ease in a shed, don't they? It is where they have got their workplace. They have got the welder and the spanners and the sockets and—

Mr Helmers—Very much so.

Senator WILLIAMS—they go and carry out the service of the lawnmower or whatever. They can do that in their own time and think to themselves.

Mr Helmers—Yes.

Senator WILLIAMS—I think it is a wonderful thing that you have got going. It is going to do a lot of good for men's health, and especially their mental health, over years to come, and congratulations on it.

Mr Helmers—Thank you.

Senator WILLIAMS—You have set it off in the world now.

Mr Helmers—We have. We state that—and believe that—only about 10 per cent of the activity within a Men's Shed is the product, is the woodworking and the metalworking. Ninety per cent of it is the companionship, providing that place, very importantly, of belonging as a preventative measure against social isolation, which especially in rural communities and in the cities is a very important factor.

Senator WILLIAMS—You talk about social isolation. If a bloke is retired, he is at home most of the day and does not have the company around him. It is obviously a place to go to basically exercise their brain, keep their brain in shape and have a chat to their mates.

Mr Helmers—It is very much a lot of moral support within a shed environment. I have personally witnessed situations where a member has had some health issues and has not gone to a doctor, and the other members have been concerned and have arranged for that member to go to a doctor. They have arranged the transport, if it was unavailable. They have made the reservation, the booking with a GP, got the person in—in some areas that is an achievement on its own, as we know—and taken care of that particular individual and provided ongoing support.

Senator WILLIAMS—Do you get any government support, state or federal, or local?

Mr Helmers—I would like to point out that all these achievements in the last 12 months have been achieved on a FaHCSIA grant that was rolled over for the Lake Macquarie Shed project. We were given a wider scope to set up the association. We have done this on $50,000. That funding expires in June of this year.

Senator WILLIAMS—So all those sheds that have been established, some 300 in Australia, have all been established on their local money, their local finance?

Mr Helmers—Yes, essentially by utilising a lot of the information. Logistically, sheds are not hard to set up any more. The cheapest shed I have been involved with is one of the greatest sheds I have seen. It was $800. The dearest I have been involved with was about $300,000, a bit over. It depends on the demographics of the area. We target disused government buildings a lot, especially in rural areas. They are quite easy to obtain and it saves a lot of expense. On the logistical side, sheds are quite easy to establish now. Conveying this around the country is

probably the biggest task that we have at the moment. It has become very clear that a lot of other agencies—in the last three weeks alone—that we have contacted, want to utilise our network to deliver; mentioning beyondblue and Mensline.

Senator LUNDY—Yes. I saw that in the submission about the work you are doing with beyondblue directly.

Mr Helmers—Yes, and beyondblue just distributed 160 of their training packages to sheds. Without our network, this would not be possible. They would have to try and find them.

CHAIR—Well done!

Mr Helmers—Thank you.

Senator LUNDY—I am really interested in the success of Men's Sheds. As far as I can observe, it is because they grow out of the local community; that is their inherent strength and value. What would, in your view, an appropriate funding model look like, that would not take away any of those attributes that make the shed such a success, but provide a financial resource to take it where it needs to go and respond to the varying demands of the various sheds in the various communities?

Mr Helmers—One of the issues that shed projects face is to secure funding. Very few sheds have risen to existence without some type of funding or support, whether that has come from the local Rotary Club or through government departments. It is a very broad range. What sheds really require is one avenue of funding, with certain guidelines and goals within those funding requirements for them to achieve. That is what the association has worked on: defining more of what a shed is about. The main thing is that sheds, on an individual basis, need a single approach to funding. On a collective basis, yes, we need funding to continue the work that we are doing.

Senator LUNDY—Do you think that funding ought to be associated with some kind of preventative health outcome, or are there more effective ways to measure social inclusion, for example? I am very familiar with the traditional health promotion model of assessing outcomes, and it is quite a cumbersome, bureaucratic process, and more evidence shows that running projects is not really the way to do it. You really need an ongoing presence for those things to be truly successful and change attitudes. So how do you see access to funding being measured by government in a fair way that allows you to do what you do?

Mr Helmers—Funding, in summary, has to be put towards the training of key personnel within sheds, who have to deal with a lot of situations, whether that be paid facilitators or volunteers—the majority are volunteers. They do it well, but they still need training, and a lot of outcomes can be measured at that level, on reportability.

Senator LUNDY—So you could measure how many people you are training and the hours that they are putting in to the shed—

Mr Helmers—Yes.

Senator LUNDY—for example, not necessarily on the actual outcomes? It just worries me that if it is outcome orientated, that changes the nature of things. It kind of institutionalises it.

Mr Helmers—It does.

Senator LUNDY—It loses a lot of what I think are the characteristics that make them such an easygoing place and comfortable place for people to go. If people are thinking, 'How I perform here is going to be contingent on whether they get their grant next year,' that is going to change everything, I would think. Hopefully not, but you know what I mean. It is a tough one.

Mr Helmers—Yes, I know exactly. When I assist communities to set up a shed, one of the main questions I always get asked at a community forum is, 'What will we do in our shed?' and I say, 'Whatever you want to do'. That is where it really gets that grassroots development. And the men manage the sheds. We steer them in that direction, to self-manage themselves. As I said before, we primarily view sheds as a men's health preventative measure, but we do not like to tell the men that themselves, and we let them develop that.

Senator LUNDY—They work it out for themselves.

Mr Helmers—It would be very hard to measure. I totally agree on that. We do not want to change this nature of sheds. If it is regulated, it would be more of a hindrance than a help. It is very difficult, I know. We do not have the data available on the results of sheds to date. A lot of the work, as I put into my submission, is a result of working out there with the men around the country and their direct feedback.

Senator LUNDY—The testimonials, I think, express it really well in terms of what you are achieving. But for the government, the challenge to justify the expenditure of taxpayer money is that there is some highly rigorous test of whether that spend is effective, and I think classic health promotion or preventative health strategies is an area where that rigour is counterintuitive to actually achieving the goal in some cases, and this might be one of them.

Mr Helmers—The association would like to work closely with whichever government department is looking at funding sheds so we can provide assistance and clarify that a shed is to actually be a Men's Shed. We have seen some funding being given to organisations saying they want to build a Men's Shed and it ends up being a three-car garage at the back of a community hall used once a week as a men's gathering place. There needs to be a more streamlined approach to funding sheds and more definitions made.

Senator LUNDY—That was very interesting. Well done! Thank you.

Mr Helmers—Thank you.

CHAIR—Thank you, Mr Helmers. Has the Men's Shed movement been under any pressure to admit women?

Mr Helmers—That has been raised a few times. A lot of the time I steer sheds away from calling themselves Men's Sheds and toward another name—'the shed at' somewhere. Three

years ago when I started working with Men's Sheds I had to explain what they were. Now, wherever I go, everyone knows what a Men's Shed is. So we do not really need that name.

Women play an important part within sheds. Well over 50 per cent, if not more, of the calls I receive are from women, inquiring on behalf of either their husbands or their communities. Particularly in rural environments, it is often a woman starting it, and quite often the CWA.

Senator WILLIAMS—They are often secretary-treasurer on the committee of the shed.

Mr Helmers—Yes, so women do get very active within sheds. There are no set rules or guidelines, but a lot of women members appreciate that it is a male domain as well and will work with the men a few days of the week and then leave them to their own devices. Each shed has its own rules, I suppose.

CHAIR—So there is not a ban on women going into a shed or anything?

Mr Helmers—By no means. In the early days there was a bit of pressure, with some sheds in particular calling themselves Men's Sheds, but that seems to have fallen by the wayside now.

CHAIR—If there were an exclusive arrangement whereby only men were allowed in, it would be subject to some anti-discrimination act, wouldn't it—

Mr Helmers—I think it would.

CHAIR—unlike women-only health centres, which of course are exempt from these things. You would have to make that argument for Men's Sheds, wouldn't you?

Mr Helmers—We would. It would be a bit difficult. When the name of the association was put forward—the Australian Men's Shed Association—we thought that it would come under scrutiny by way of the Anti-Discrimination Act. The Country Women's Association was established before the Anti-Discrimination Act, but they are very strong supporters of the Men's Shed movement.

CHAIR—That is really encouraging from a commonsense perspective.

Mr Helmers—It is.

CHAIR—You have included a number of profiles in your submission about the older shedder, the younger shedder and so on. Can you put your members into a demographic? Are the majority of these people over 65 and retired?

Mr Helmers—The target market for a shed participant, or a shedder—the classic shedder, as we call it—is male, between 45 and 55 and unemployed. That is also the highest risk area for social isolation. With the current economic environment, we have lowered that to 35. We are seeing a very dramatic increase in participation of unemployed males.

I made reference in my submission to the Centrelink scenario, where they are put into this one-size-fits-all basket. Some of the stories that we hear through the sheds indicate that a

significant amount of anxiety—from, firstly, being out of work and, secondly, being put through this process—is being suffered by these men and, when discover their local shed and become involved, it is literally a lifesaver for them.

At the moment we have males working within sheds as young as seven to nine, going through to 100. It is a very broad range. A lot of sheds do use mentoring programs, which is very beneficial to the mentoree and the mentor. At the moment our target area is from 35 through to 55, 60.

CHAIR—Could you hazard a guess at how many are in the very young age group? You mentioned that they were as young as seven, but I am thinking more about high-risk youth, early adulthood, 15 to 24.

Mr Helmers—It would be impossible for me to guess. I would say at least 50 per cent of sheds around Australia are doing mentoring programs. Most sheds work between four and eight youths per school term, who may be there two days a week. If you did the mathematics, that would give you as good a guess as I could hazard.

CHAIR—And this is all being done on a $50,000 budget?

Mr Helmers—It is being done on an absolute shoestring.

CHAIR—I think it is amazing, as Senator Lundy said. It is a credit to everyone that was involved and had an idea about this, because it is an extraordinarily valuable resource for the men of Australia and, quite frankly, the families of Australia, which has been recognised by submission after submission that we have received in this inquiry. On behalf of the committee, thank you. Is there anything that you would like to add, Mr Helmers?

Mr Helmers—Thank you for the opportunity to be here and to convey what community sheds are all about. You are now more aware of the benefits of Men's Sheds, and it has been a long, hard road to do this on a shoestring. We have had commercial pressures from organisations trying to cash in on sheds. There have been a lot of issues over the last two years, but we are still managing to go forward very strongly. That pretty much sums it all up.

CHAIR—Thanks.

Senator LUNDY—Sorry, just before you wind it up, I know I mentioned at an earlier hearing that I recalled seeing an article either on *The 7.30 Report* or one of the news shows about Men's Sheds. I do not know if the committee was ever able to source that, but I thought Mr Helmers might be able to. My memory tells me it was Boorowa Men's Shed, but I am not sure. Could you help us source that news article about the shed?

Mr Helmers—Yes, certainly.

Senator LUNDY—It might have even been on *Stateline* or something like that.

Mr Helmers—I think I may have a copy of that. Sheds around Australia forward all media extracts through to the association.

Senator LUNDY—Just give us the reference, because we can certainly source it once we have that. That would be helpful, thank you.

CHAIR—Perhaps we will ask the secretariat to contact you, Mr Helmers, in relation to obtaining a copy of that.

Mr Helmers—I will be happy to do that.

Senator LUNDY—It was quite a few years ago, but I think it would be worthwhile for the committee to have a look at that. Thank you.

CHAIR—Thank you very much, Mr Helmers.

Mr Helmers—Thank you very much.

CHAIR—That concludes today's proceedings. I thank all the witnesses for their informative presentations. Thanks to Hansard and to the secretariat. There is no requirement for a motion to accept any tabled documents because we have accepted them as they have come through. I declare today's hearing closed.

Committee adjourned at 4.26 pm