LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON SOCIAL POLICY

(Reference: Inquiry into men's suicide rates)

Members:

MR T EMERSON (Chair)
MS C BARRY (Deputy Chair)
MISS L NUTTALL
MS C TOUGH

PROOF TRANSCRIPT OF EVIDENCE

CANBERRA

TUESDAY, 25 NOVEMBER 2025

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WITNESSES

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Amended 20 May 2013

The committee met at 1.01 pm.

EMERSON, MS SALLY, Facilitator, Canberra After Suicide Support
MARSHALL, MRS VERLENE, Facilitator, Canberra After Suicide Support
O'HANLON, MR MURRAY, Peer Member, Canberra After Suicide Support

THE CHAIR: Good afternoon and welcome to this public hearing of the Standing Committee on Social Policy for its inquiry into men's suicide rates. The committee will today hear from a range of witnesses from the health, research and community sectors.

The committee wishes to acknowledge the traditional custodians of the land we are meeting on, the Ngunnawal People. We acknowledge their continuing culture and stewardship over the beautiful place we call home, over many generations, and would also like to acknowledge and welcome any other Aboriginal and Torres Strait Islander People who may be taking part in today's hearing.

This hearing is a legal proceeding of the Assembly and has the same standing as proceedings of the Assembly itself. Therefore, today's evidence attracts parliamentary privilege. The giving of false or misleading evidence is a serious matter and may be regarded as contempt of the Assembly. The hearing is being recorded and transcribed by Hansard and will be published. The proceedings are also being broadcast and web-streamed live. When taking a question on notice, it would be useful if witnesses use the words: "I will take that question on notice." This will help the committee and witnesses to confirm any questions taken on notice from the transcript after the hearing.

As this hearing will touch on sensitive matters, some witnesses or people watching these proceedings might be impacted or even triggered by what is said or heard. Please take care of yourselves throughout this process—take it slowly, breathe deeply and take breaks when needed. Witnesses do not need to share any traumatic details. We have a duty counsellor available on site, if needed. For those in the room today, please indicate to the committee secretary for an introduction or just pop into the small committee room in the corridor. The counsellor is there to support you if needed, even if you just want to have a break and a cup of tea. A support handout is available at the entrance to the committee room as well. We encourage witnesses to take a copy home as unpredictable emotional reactions may occur in an extended window after leaving the hearing. The handout has tips and strategies for self-support and referral points in case of a crisis, or more in-depth counselling supports. For those attending remotely, an electronic copy is also available from the secretariat.

We welcome representatives from Canberra After Suicide Support. Before we go to questions, would you like to make a brief opening statement to cover matters not covered in your submission?

Ms Emerson: Yes; we have some points. Thank you for inviting Canberra After Suicide Support to this inquiry. CASS is a volunteer-led group that is open to anyone bereaved by suicide. I started CASS in 2005 after the loss of my husband to suicide. Everyone involved in CASS has a lived experience of suicide bereavement. Over 20 years, we have spoken to hundreds of community members sitting in the pain and grief of suicide loss. These are the people, along with the loved one they have lost, for whom suicide prevention policy has failed.

I want to take a moment to honour the lives lost and highlight the far-reaching impact of suicide in Canberra, with 952 people having died by suicide in Canberra from 2000 to 2023, and, tragically and preventively, this number has increased in 2024 and 2025. I acknowledge the strength and resilience of everyone who has been bereaved and impacted by suicide, particularly family, friends, colleagues, first responders and crisis workers.

In appearing today, I point out that CASS is a volunteer group. Our role is not to design policy or programs or conduct research. Instead, we hope to sound the alarm and urge greater ambition and creative solutions to make our community safer. We have shared some ideas along those lines in our submission, and we hope these can be taken forward, but today we have additional feedback from our CASS community. I will pass to Verlene for that.

Mrs Marshall: Thank you, Sally. We spoke with many members of our CASS community about coming here today and asked if there is anything that they would particularly like presented on their behalf. One of the things that comes across frequently is how long it takes to receive information from the ACT Coroners Court. A lot of them find that the Coroner's findings come very slowly, sometimes taking years, and meanwhile the family's experience—while they are experiencing the ongoing distress and pain, the worst time in their entire lives—is made almost unbearable. The delay often means that legal processes, like wills and finances, cannot be resolved, and that leads to further distress and adds to their already complicated grief. We would like to see timely resolution of coronial findings and timely communication with families. This drawn-out process is one of the reasons we believe specialised suicide bereavement counselling and peer-led support is needed.

The grief after the suicide death of a loved one is very complicated. Not all counselling services provide the particular help needed, and sometimes, unfortunately, they actually worsen the situation. Our experience is that counselling for suicide bereavement is insufficient in Canberra. It is especially important for suicide prevention, because researchers have found that people bereaved through suicide are 65 per cent more likely to attempt suicide themselves. That is a reflection of the immense distress, pain and isolation that accompanies a suicide loss. Such a service is available across the border in New South Wales, and in Queensland, Victoria and the Northern Territory. Those governments fund suicide bereavement counselling and lived experience support workers through the StandBy Support After Suicide program, but the ACT government does not. A family bereaved in Jerrabomberra or Yass can access these services, but a family in Tuggeranong or Belconnen cannot.

Our members also recommend that those experiencing suicide bereavement and its accompanying trauma are flagged in health systems for trigger awareness and to enable timely and targeted support. One example is when children might be targeted in schools as not coping, but the reason for them not coping is not flagged, and therefore it may not be handled in an appropriate way. If suicide data were generated in this way, it could be used to improve the targeting of community support. Murray has some other ideas.

Mr O'Hanlon: Thanks, Verlene. I will speak briefly on some additional feedback around suicide prevention that we received from our CASS peer members. CASS

members have shared the challenge that parents face in engaging with mental health services for adult children they care for who have severe mental health conditions. For example, it has been raised with us that the Child and Adolescent Mental Health Services, or CAMHS, collaborates with parents until the young person turns 18, after which time they are treated as an adult. Parents who care for adult children have deep insights, knowledge and concerns about their child's suicidality; however, they tell us that their concerns are not given priority and their attempts to get further help for their adult son or daughter are ignored.

A young man or young woman of this age experiencing severe distress may not have insight, independence or support outside of their immediate family to get them safely through this period. We also hear that some young adults will refuse contact from mental health services, and in that case parents feel that they need to be heard when advocating for their young person. If parents cannot be included, they or a nominated adult should be allowed to advocate for that person.

Members of our community have noted that prevention initiatives are especially needed for men employed in trades. The ABS, the Australian Bureau of Statistics, reports that, for men who died by suicide in 2024, technicians and trade workers were the most common occupation group. I note in this regard the fantastic efforts of I Got You, which is a local community-led group that specifically seeks to engage in advocating for suicide prevention in the trades community.

CASS observes that gambling can provide temporary relief for emotional distress but exacerbates feelings of guilt, shame and purposelessness, and this results in a loss of face and severe financial and family distress, and in some cases suicide. We urge governments to seriously limit access to gambling and to ban all online and television advertising of gambling.

Thank you for inviting CASS. We are happy to take questions.

THE CHAIR: Thank you very much for each of your statements. I want to ask about upstream prevention and what we could do. This is something you touched on in your submission. What do you think is specific to the ACT, and what could we recommend the ACT government do when it comes to working more upstream in terms of suicide prevention for men?

Ms Emerson: We are not policymakers, but things that encourage resilience; flagging; and transition points in people's lives. If people are changing jobs, for example, that can be a trigger point for people.

Mrs Marshall: The narrow focus on it being a health issue or a mental health issue does not reach out to all the men who have suicidal ideation. I do not know the answer, but I think a lot of the men who die by suicide never thought that they had a mental health problem or that they should seek help for their mental health issues. For a lot of them, possibly other things were needed to help them over a hump in their lives, but they probably would not have gone to a doctor or a mental health service.

Mr O'Hanlon: We have provided some ideas in our submission, so I will not try to re-prosecute the argument for those. I echo what Sally and Verlene have said. In

particular, it would be about reaching men in language and symbols that resonate with them. That does not mean that every service needs to have blokes in high vis vests wandering around and talking about suicide prevention, but it does mean that we try to think about using language that deliberately targets men. I understand that Movember have developed a set of guidelines for community services and mental health services, and health services more broadly. I believe it is called Men in Mind. So there are organisations out there that are trying to do this. I got You, which I mentioned before, is specifically trying to do things in ways that resonate with men. I think that is a very important part of prevention.

In CASS, we would argue that postvention is also prevention. We know that the grief around suicide loss is profound and distressing. It comes with feelings of extreme guilt—"Why didn't I do more? Why couldn't I? Why didn't I reach out to them?"—and that can turn into blame and self-blame. People search for a simple explanation as to why the person took their own life and it can lead them to blame others. They might blame the spouse who has been left behind or the parents, adding to their trauma and feelings of guilt and self-blame. The stigma around suicide is still a thing. People can feel a lack of confidence in how to reach out to the people who have been bereaved.

All of this is to say that the situation can be extremely isolating. It can lead to profound feelings of sadness and anger. The experience of losing someone through violent means can desensitise someone to the fear of death as well. These are what we know are the conditions that factor into people having suicidal thoughts and attempts themselves; hence, the argument we have made that support after suicide—by whichever organisation provides it and in whatever format, particularly emphasising peer-led and lived experience—would be a huge contribution that can be made here in the ACT immediately.

THE CHAIR: Thank you.

MS BARRY: I want to understand the supports that are currently available and your view on where the breakdown in communication is, if any, and what you are hearing from your members.

Ms Emerson: The supports for?

MS BARRY: Suicide support.

Ms Emerson: Post-suicide support?

MS BARRY: Yes.

Ms Emerson: There is the StandBy After Suicide support service that has been established for around 18 or so years, just after CASS started. StandBy had a presence here. Initially, they were funded through the commonwealth Department of Health and also had ACT government funding for on-the-spot presence at suicide incidents. That part of it is no longer funded. That is a referral service to support people for whatever they need following a suicide, and that could be the week it happened or 20 years later. Apart from that, what other services are there?

Mrs Marshall: Lifeline gets involved with some special sessions and things for people who have been bereaved, and there are some grief counsellors in the ACT, but our experience has been that people find it very hard to find a counselling service that is affordable and appropriate, and there is a lot of volunteer input, as we are all volunteers as well.

Ms Emerson: People bereaved by suicide are initially in limbo land. There is suddenly a new world in front of them. The other world has blown up. It takes a while for the dust to settle and figure out what their life means. I have searched for supports. There is not much. The main one is the StandBy service, which not everyone finds because you have to go looking. They find us, CASS, and that is peer support, giving people the opportunity to meet other people who have been through something similar. We just stand alongside them and let them tell their story, or not, and we can tell ours, and they realise: "This person is further down the track and they're still here. I can get through this."

MS BARRY: Thank you for sharing.

Mr O'Hanlon: I might add one or two more things for your awareness. Thirrili is a First Nation's organisation that focuses on suicide postvention as well. Switchboard Victoria is a LGBTI focused service that supports people from the queer community nationwide. That is through online support groups. There is counselling through the ACT Coroners Court, I understand. That is about the extent of it. Beyond those—Thirrili, Switchboard and StandBy, which has been mentioned—I am not aware of other services specifically supporting people bereaved through suicide.

MS BARRY: Thank you. That is really useful information. I want to understand the referral pathways in the ACT. Are you aware of a referral pathway from the ACT Coroners Court, for example, to any of the services? What is the referral pathway? Is the person reaching out themselves? Is someone making an active effort to reach out if they are aware or if a person who had been bereaved chooses—

Ms Emerson: It is pretty ad-hoc, I would say. ACT police attend the scene of a suicide and they may or may not give people information about StandBy, for example. They used to have a pack that had StandBy and CASS information in it. That was when StandBy attended an event. It is pretty ad-hoc. There is nothing official; it is potluck. Regarding the Coroners Court, people can access that counselling service if the coroners process is happening. However, at the moment, the service that delivers that counselling is not taking new people. There is a waiting list. There are things, but they do not always happen.

MS BARRY: Thank you. That is really useful.

Mrs Marshall: My experience was that, because my husband died in hospital after a suicide began at home, we were treated quite differently. A lot of the things that would have happened if it had been at home did not seem to happen. A few people did not even know that the death in hospital was related to suicide, so there was a bit of a disconnect.

MISS NUTTALL: You suggested a legislated target of zero deaths by suicide by 2050.

In your submission, you also mentioned that the number of people who have died by suicide in the ACT is more than three times the number of deaths on ACT roads. Obviously, we have Vision Zero for road safety, which commits us to no serious deaths or injuries on our roads by 2050. How are you finding the ACT's current targets? Do you think that they are hitting the mark in terms of preventing deaths by suicide?

Ms Emerson: They are still happening at the same rate as they always have been. They would help some people, but there are so many who are not in the mental health system. A lot of programs for suicide prevention focus on mental health issues. I would like to have the suicide statistics in the ACT examined to find out how many who committed suicide were actually accessing the mental health system and how many were not? I suggest that the majority were not, so where are the programs for those people? How can we gather those? I do not have much of an answer, except for more support for families who are worried about members of their family and want to talk to GPs. I was continually going to appointments that my husband should have been at but did not want to, to try to push for someone to try to help him somehow because he did not want to help himself. More all-encompassing upstream things that Mr Emerson was asking about need to be put in place.

MISS NUTTALL: For those sorts of upstream supports, what are you hearing from men about the messaging that they feel is needed? You mentioned messaging, symbols and things like that. Have you had particular feedback from your members on what would resonate, in terms of encouraging people to seek help earlier?

Ms Emerson: I have three sons who were teenagers when they lost their father. I struggled to look after them following their father's death, because I was constantly worried about them. They did not talk and did not seek help, although they needed it. Somehow, we have to convince men to admit that they could do with some help. Murray may have some thoughts.

Mr O'Hanlon: I feel that, in our CASS community, we are observing that men are not coming forward. When they do, they will often say, "My wife said I should come along," which is great, but, if it is a man whose wife has died by suicide, then he is more isolated, I think. What I have read about, in terms of trying to engage men, is around avoiding the mental health language, therapy language and deficit based language—language that suggests that the blame is with men, calling men toxic and so on. It fails to connect. Movember's research has found that concentrating on concepts like being a good mate, strength and family are more effective at driving help-seeking than talking about depression and anxiety. It is about strength based messaging that resonates with male identity values. We could also observe that we need more men in the workforce and in the volunteer and peer workforce, so that the services are informed by that experience and men see themselves in those places.

I note that fewer than 20 per cent of registered psychologists in 2023 were men. Thirty per cent of registered social workers are men. We do not just need men to step up into those roles; we also need to actively encourage them to. We need to look at what the barriers are. Things like extensive unpaid placements to complete a degree mid-career are a huge disincentive to men stepping into those roles. And we need to see the value men bring in traditional, empathic, and connection and relational work. It is probably a bit different to what women bring. I realise that these are huge

generalisations. There are a couple of examples: MATES in Construction, the Movember program and I Got You. I understand there is a program called Man Enough as well, which is about recruiting more men into health and community services. There are some of those ideas out there. It is really about how we implement those in a systematic way here in the ACT, in our jurisdiction, with the resources that we have or we can get to do more.

I will make one other point, which is that there has been a lot of work around the stressful life transitions that everyone faces, but we have observed that men seem to find them overwhelmingly distressing, including in relationship breakdowns, legal troubles—running into the law—and transitioning out of defence and back into civilian life. We need to try to shift that emphasis away from mental health and suicide prevention and think more about those big life transitions. What are we doing to equip boys, teenagers and men to anticipate what those huge challenges will be in life and know that they can get support, and know that they can make it through those? It could also be a contribution in the spaces where support is being provided around that.

We talked about the metaphor of life intersections and more work needing to be done here in the ACT to understand where men are facing those big life intersections. In which industries are they facing it? In which geographic areas of Canberra are they facing it? Getting the picture of that analysis would be really useful and having that represented to decisionmakers, to say, "Over the last 12 months, we've seen this change" or "It remains the same that men in trades are much more vulnerable," and then being able to target that. We think that, with the size of this jurisdiction, some really interesting and creative ideas, such as we have spoken to in our submission, could be trialled and piloted, and then, if the research proves that they are impactful, they could be taken to other jurisdictions.

MS BARRY: There has been suggestion for a men's strategy.

Mr O'Hanlon: In the ACT?

MS BARRY: Yes.

Mr O'Hanlon: There is the National Men's Health Strategy.

MS BARRY: It is specific to health. Going to what you were talking about, I think it is much broader than that. It is a holistic approach.

Mr O'Hanlon: Yes.

MS TOUGH: I wanted to ask about the handful of men going counselling, but I think that has been covered, so thank you. Sally, you said that ACT Policing used to have a pack that they would provide to families when they attended a suicide, and you said that stopped. Do you know when that stopped? What was in the pack, and when did it stop?

Ms Emerson: I never saw the pack. It was information mostly about StandBy and CASS—one page about what next, such as coronial processes and all the stuff that you need immediately in this new world. That stopped when the funding for StandBy to

attend suicide events ceased. It might have continued for a bit, but personnel change—

MS TOUGH: Do you know why that funding ceased or when it ceased?

Mrs Marshall: Ask the ACT government. It might have changed when they funded the coronial counselling service. It was a while ago—10 years or more.

MS TOUGH: Thank you.

THE CHAIR: Thank you very much. I am sure we could learn a lot more if we had more time. On behalf of the committee, thank you for your attendance today. Thanks so much for participating in the inquiry, and also thanks for the important work that you are doing. It means a lot.

Short suspension.

COOPER, MR GORDON, President, Belconnen Community Men's Shed

THE CHAIR: We welcome Gordon Cooper, from the Australia Men's Shed Association. For the Hansard record, can you please state the capacity in which you appear?

Mr Cooper: I am President of the Belconnen Community Men's Shed. I am speaking on behalf of the Belconnen Community Men's Shed, but I was asked by AMSA, the Australian Men's Shed Association, to come and talk to you.

THE CHAIR: Thank you very much. Please note that as a witness, you are protected by parliamentary privilege and also bound by its obligations. As such, you must tell the truth. Giving false or misleading evidence will be treated as a serious matter and may be considered contempt of the Assembly.

Just briefly also, the committee recognises that some of the issues discussed in this inquiry, of course, are sensitive. If anyone is finding this hearing difficult, we can take a break, and a duty counsellor is available on site to provide support if needed. The secretariat also has a support handout available.

Mr Cooper, would you like to make a brief opening statement before we go to questions, covering anything that is not in the submission?

Mr Cooper: Yes, I would like to make an opening statement.

THE CHAIR: Sure.

Mr Cooper: Suicide has come close to my family in the past. I have been involved with the Belconnen Community Men's Shed since day one. I was the project manager that built the shed, which was built under the umbrella of the Baptist Church and its use was gifted to the community.

Men's sheds save lives. I have personally saved the life of one man in the shed. We have had one of our members commit suicide while he was a member of the shed. I have had many men come to me and talk because they had no one else to talk to. Through the men's shed, and a smaller group that meet at my place, lives are being significantly changed because of the men's shed.

You might not be aware, but men's sheds are Australia's largest men's mental health network. Most of the funding for men's sheds, which we are very grateful for, comes from the federal government, given to the Australian Men's Shed Association based in Newcastle, and the shed's apply for the funding. Most of the funding is put towards building sheds, establishing sheds, purchasing equipment. We recently got a grant through that process for mental health first aid training. I have been actively trying now for about four years, five years, to get support for the men's shed from the ACT government.

We have started a group in the men's shed called Focused Blokes. We meet about every six weeks. We were set up by a clinical psychologist who has given us the ways of working. This group is doing amazing things with men who are given an opportunity

and a quieter place to share their stories. It is saving lives. It has got the attention of the Australian Men's Shed Association and I am actually presenting at the men's shed conference in Brisbane next year on our Focused Blokes program.

We have had Andrew Barr in the shed. We have had Rachel Stephen-Smith in the shed. We have had Andrew Leigh in the shed a couple of times. Senator David Pocock. We have had Katy Gallagher in the shed. All supporting what we are doing. My push started off to get the ACT government to fund a man to get to know all of the 17 sheds in the ACT and provide someone who was our first point of contact, who would help us with mental health first aid training, who would help us with first aid training and defibrillator training.

Men's sheds are all volunteers. I have no background, other than lived experience, in mental health first aid and suicide. I have helped people with suicidal thoughts. We had one man come to the shed with his carer. I knew he was coming. I met him outside the shed, and I said, "Would you like to tell me your story," and he did. I said, "Would you tell your story at morning tea," because we always stop at 10 for morning tea, and he said, "My name is—I live on a farm by myself. I have attempted suicide twice this year. I need help." There was about 20 men in the shed. I reckon about 15 of those men touched him, embraced him and spoke to him. He is now a member of the shed. He had another attempt on his life, but he is now in a great place and he is now back working, because of the men's shed, because of the friendship he got there.

I am incredibly surprised, always surprised when men turn up at the shed who do not have friends, who do not have male colleagues they can talk to. When you get a leader of an ACT government department come to the shed and say he needs help because he has no friends, and then he sends me a message the next day saying, "I met more men and spoke to more men in more meaningful ways in two hours yesterday than I have in the last 12 months in my workplace." So men's sheds save lives.

THE CHAIR: One of the key things men's sheds offer us is kind of health by stealth.

Mr Cooper: Yes.

THE CHAIR: Where men have a space to discuss issues of wellbeing and health with peers in almost a kind of formal setting but then can be referred on to other health services, if necessary. I was wondering if you could—

Mr Cooper: Can I say something, Thomas? I understand that, but that is very difficult when you are in a crisis, okay. Health service wait lines do not work, okay. We have had first-hand experience where we had a member who was—the police were called to his residence. One of the pastors went to see him and we put him up in accommodation for the night.

Help lines do not work in those situations. We need help—we need that point of contact straight away. We have since found out about the PACER program, and the man that established the PACER program is actually a member of the shed. Do you know the PACER program? Yes. So that is a brilliant program. We have not had to access it again, but we cannot refer as such because we are all volunteers.

We need, when we have a crisis, which we do have—and I know when I was in the Assembly here with other sheds, the Tuggeranong Men's Shed was crying out the same way we do—that we need a point of contact, to ring them up and say, "This is the situation," and then get the contact that we need because we are talking—we are talking fairly immediate situations, you know, people that are bipolar.

We embrace carer-client relationships which means people on NDIS and other programs come and the carer and the client become members of the shed. We teach them woodworking skills. We teach them relationships. We show them friendships, but occasionally those relationships—those carer-clients, the client does not take his medication and then suddenly he is manic in the shed and he drives people away. So we have to make pretty hard decisions, tough decisions straight away.

Mr Cooper: Chiaka, we have met before.

MS BARRY: We have, yes indeed.

Mr Cooper: I just remembered.

MS BARRY: We have, yes, good to see you again.

Mr Cooper: You have been to the shed?

MS BARRY: I have, a few times. Plenty of times actually.

Mr Cooper: Thank you.

MS BARRY: Thank you very much for that. I just have a few questions particularly around what you just mentioned around people living with disability and the inability to access the shed. In that scenario, what do you think could be done perhaps to encourage—you want to make it safe for the men in the shed, but you also do not want to be restricting people being able to access it. What do you think we can do or could be done to provide that access to people living with disability, if anything?

Mr Cooper: Lots can be done. I will answer your question. We need—the best thing I think we could have in a men's shed is a single point of contact, so when we have those crises we can ring someone.

As a result of the Focused Blokes program—set up by people, a psychologist, who is a member of the church and works for the ACT government, she did it up free of charge for us —she has been in contact with the ANU, and the head of the ANU research school and a medical student are now doing a survey into men's sheds to get the data to back up the statements that we make.

Now, we say men's sheds save lives, but there is no data. So ANU is doing longitudinal research into men's sheds and will be potentially presenting next year at the national men's shed conference. They presented last week at a health muster that the men's shed ran for about 80 shed men from Canberra and 100 kilometres around Canberra. We had the special envoy for men's sheds, Dan Repacholi come and close that conference. ANU opened the conference with the research they are doing. They are just embracing

it because they know that we do not have the data to back up what we actually say is true. Once we have the data, you understand, when you have the data, you can go in and ask for it.

MS BARRY: And target, yes.

Mr Cooper: But we have one man who we made a life member of the shed because he is a compulsive obsessive cleaner, and you do not want to lose him, but he has had an 18 month journey into dementia. For the last three months we had him in the men's shed for respite care, and then he went to hospital. He has been in hospital—he was in hospital for nearly four weeks.

I am not going to give you figures because you know figures, how much it costs, but if it is $2,000 a day and he is in there for 20 days, there is $40,000. The salary is $180,000, or just about. That is what I think a salary would be for someone to come and look after the men's sheds. If we can keep people out of hospital we are saving the government money. We can show that. So that is what we are doing this research for, is to find the data, to give you the data to back it up.

MS BARRY: Thank you very much for sharing. So in previous submissions it was referenced that the way the community deals with men's suicide needs to go beyond it being a mental health issue and I just wanted to get your comments on that. So it needs to be a broader holistic approach to the things that affect the lives of men, for example, transition between jobs, breakdown of relationships and things like that, because most men who go on to commit suicide or attempt to commit suicide do not think they have a mental health issue. So a mental health response is perhaps not the—whilst it is the focus, it is probably not right for them because they are not going to engage. I just wanted to get your thoughts on that based on the members that you—

Mr Cooper: I made a comment that mental health was not—some people who suicide did not have mental health issues. I was called to task over it quite awhile ago, but I think it is a mental health issue if you consider it is about their wellbeing, it is about their sense of identity, their sense of purpose. I strongly counsel, and I have been working with men most of my life—I strongly counsel men never to retire until you have got a retirement plan. You need something else to do so that you can move your identity from your work to a new situation. The men's shed does that for a lot of men. You know, we are the largest men's shed in the ACT by membership. We are open more days a week than any other shed in the ACT. We have more carer-client relationships and we are the leading shed in working with mental health. We have not shied away from it. These shirts are part of it. About 40 of our members wear these shirts because mental health is now the conversation, cards face up on the table.

MS BARRY: You have talked a lot about this one point of contact, can you please expand on that and what that would look like. Would he be coordinating all of the men's sheds in the ACT? What would that look like?

Mr Cooper: The one point of contact I think would only be needed three days a week. There are 17 sheds, but if that one point of contact could do the mental health first aid training, could do the first aid training, could do the defibrillator training and training for questions like, "Are you okay," that would save all of us putting in for grants to try

and get training for mental health.

You know, we just got a $5,000 grant for mental health first aid training which will run early in the new year. We just had 14 of our members first aid qualified because we put in for a grant and got the first aid training. If the ACT government was to put in one man with those qualifications to teach all the sheds, he is potentially teaching 100, 150 men a year on mental health first aid, first aid, defibrillator, things like that.

That is—yes, and even questions—the simple question—now, we have this R U OK, but what do you do when they say, "No," when the bloke says, "No." Some people just turn away. So it is preparing them to have that response. So just having that ability to have someone train the largest men's mental health network in Australia, to train some of the members, to bring them up to speed.

I am confident talking now with people who have mental health issues. I know how I can get away. I know how I can escape from it or how I can move out of that when I need to, but I am happy to be in there for the hard yards. I have always been a very black and white man. I ran a men's ministry for a long time and have always dealt with men who are being honest with me, but I have learnt in the men's shed with men who have acquired brain injuries, they are not being dishonest, they are just telling stories as a result of acquired brain injury. We have one man who was a builder now in the shed with an acquired brain injury. He just stands there until he is told to move. He is a fantastic member of the shed.

So we impact and help an incredible amount of people, but we are all volunteers. We have been taken to ACAT—I think it is the ACAT here and process here. We had to buy out way out of a situation just to get peace in the shed. I have had to stand down twice because of accusations made against me while I have been investigated because of people with mental health issues. So we do not shy away from them. We embrace them because we know we save lives. We know that we make a significant difference in people's lives.

MS TOUGH: You mentioned there is 17 sheds in the ACT.

Mr Cooper: Yes.

MS TOUGH: I know you are at the Tuggeranong one and the Veteran Shed as well, but I am wondering how many of the sheds are involved in the Focused Blokes program. How does that work?

Mr Cooper: Only one at the moment.

MS TOUGH: Only Belconnen.

Mr Cooper: It is only the Belconnen Community Men Shed. It was our own initiative. I have spoken to the AMSA, Australian Men's Shed Association, reps and they have embraced it. They want me to present at the conference next year and the ANU research is part of that because the AMSA head office does not have the data to back up the statements that everyone makes.

MS TOUGH: Ahead of that, is there conversations with the other men's sheds to expand it across Canberra?

Mr Cooper: I have. I have spoken to Tuggeranong. I have spoken to the Hall Men's Shed. I have spoken to the Melba Men's Shed. I am a member of the veterans' shed. I am a Vietnam vet, but I have not spoken to them but they have their own programs. We are trying to get it out so that we can get it across all the sheds.

It is a very simple format. We put a meal on. We sit down and it is a quieter time, no tools, and the men are able to share their stories. Some men take 12 to 18 months before they will open up, other men, you have to quieten them down, but it makes a significant difference. I can bring in many, many testimonies about what difference it makes.

MS TOUGH: Do you know if other men's sheds are running similar programs but have not got a clinical psych or someone to help set them up, like something similar without those foundational—

Mr Cooper: No, I am not aware of any other sheds. Look, I know sheds talk about it, but no-one has actually got a program set up like the way ours is set up.

MS TOUGH: Thank you, it sounds like a pretty good program.

Mr Cooper: It is. It is a brilliant program, yes.

MISS NUTTALL: I am interested—again, I appreciate that you are in Belconnen—in the demographic breakdown of your membership. I think you mentioned that it tends to trend older. Are you seeing many people from culturally and linguistically diverse backgrounds? As Ms Barry asked before, are you seeing many people with a disability accessing your service?

Mr Cooper: Yes, we have quite a few people with disabilities. We have a few people from different ethnic backgrounds. We have people who travel from Woden, to come to the shed, because we have a good website, and we are quite an active shed. We give back to the community. The word "community" in our name is because we embrace the community and give back.

We made footstools for the Canberra neonatal clinic, for nursing mums. We do work for preschools. We rebuild mud kitchens and things like that for playgroups and kids' groups. We are always working back in the community. That is one of the ways that we upskill our men and give them things to do.

MISS NUTTALL: Do you find often, when you have those community partnerships, that you will start to draw members from the groups that you work with—for example, fathers who have appreciated that you built footstools for the neonatal clinic?

Mr Cooper: Yes. We have had men come along, because of our community work. We cook a few barbecues for people. We are doing one for the health department in Belconnen in December. We did one for Harvey Norman, and we can advertise the shed there. We get members that way. Our age range is from early 20s up to 96, I think it is.

MISS NUTTALL: That is quite impressive. Do you get many people at the younger end?

Mr Cooper: The majority would be 60 to 65, but there would be 10 or 15 who I would consider to be young, below 30—probably below 35. We have a minimum age of 18, because there are so many other responsibilities. With respect to our shed and our committee, one thing we have instigated in the shed is that all our committee members have Working with Vulnerable People cards, and all the committee members sign a code of conduct. We have quite a serious vetting process for all our committee members, We come under the umbrella of a church, so we have to meet safe church policies, which we do.

THE CHAIR: I have a question about how the different men's sheds engage with each other, and how we can ensure coverage across different regions in the ACT. What role does the association play in that, or is it more a matter of different men's sheds popping up and seeking support from you?

Mr Cooper: Most of the sheds come under the umbrella of AMSA. The ACT sheds and the regional sheds are in zone 13, and we normally have a rep. We do not have a rep at the moment. The zone rep is the contact for all the sheds within that zone. So there is contact amongst sheds within a zone.

Every shed, though, develops its own character, because of the nature of the men. The Melba shed is basically what I would call an academic shed. They have lectures; they do bike riding and things like that. The Hawker men's shed runs repair cafes. Obviously, the veteran sheds look after veterans. Tuggeranong men's shed has a very large day where they feed their men; they have a social gathering and have someone speak to them. Every shed develops its own character.

THE CHAIR: Do you think there is a need for more sheds in the ACT?

Mr Cooper: There is always room for more sheds. We are in conversation about potentially building another shed under the umbrella of the church, because they just bring the men in who otherwise might not be with us.

THE CHAIR: Is there a role that you see for the ACT government in supporting the establishment of new men's sheds?

Mr Cooper: There is, and you do. The ACT government has. Mary Porter was a champion for our men's shed. We got grants. We have received a lot of grants over the years. Mary Porter was a champion for us, and she did a phenomenal job. She opened the shed for us, with Alan Tongue.

With the government's role, I would ask the government to look seriously at the benefits of men's sheds. I know you are doing this. There are old scout halls and old garden places that they allocate to men's sheds. That is brilliant because, as volunteers, we cannot afford to pay the rent. Some sheds have trouble paying the electricity, so there are big overheads with running a shed.

It costs us about $30—or at least $29 or something—for every member, just for

insurance, through the Men's Shed Association. There are all your liabilities and all those other things. You are using power tools; we have our own training programs. I can see a very good role for the government in building more men's sheds.

MS BARRY: The men's shed is a good example of peer-to-peer support. Do you work with other peer-to-peer support networks or are you connected to other networks?

Mr Cooper: No. We thought about becoming an NDIS provider, but the overheads were way too much for us. When you have volunteers and when you have men like me who have caravans, we are not there all the time, so it is very hard to do that.

MISS NUTTALL: Is Health by Stealth something that you would be keen to speak to? I know that your submission mentions it, but I am interested in how you think those sorts of conversations change the willingness of men in men's sheds to seek help over time, and whether, after having a few conversations with mates, they are more likely to start to be receptive, if someone mentions more clinical settings.

Mr Cooper: They are. We were asked by AMSA to appoint welfare officers. I asked one of the members, and he said, "All the Focused Blokes are welfare officers, because they know more about each other and they care for each other." We are a lot more open now, as a shed, to talking about the tougher issues, and we get guest speakers in all the time, to come and talk to us about a lot of health matters and things like that.

MISS NUTTALL: Is that something that you are seeing across other sheds as well? Have you heard this from other sheds when you get together?

Mr Cooper: No, I have not. It is hard enough running one shed. I go and speak to other sheds, but no, I have not.

MISS NUTTALL: That is so powerful; thank you.

THE CHAIR: We might leave it there. Mr Cooper, thank you very much, on behalf of the committee, for your attendance today and for everything you are doing.

Mr Cooper: Thanks for listening. Please think about helping, with one man to go to all the sheds. It would make an incredible difference; you would get a lot more men trained, and a lot more men helping other men. That is significant.

THE CHAIR: Thank you very much.

AGOSTINO, MS EMMA, Senior Policy Officer, ACTCOSS
BOWLES, DR DEVIN, Chief Executive Officer, ACTCOSS

THE CHAIR: We welcome witnesses from the ACT Council of Social Services. Please note that, as witnesses, you are protected by parliamentary privilege. You are also bound by its obligations. As such, you must tell the truth. Giving false or misleading evidence will be treated as a serious matter and may be considered contempt of the Assembly.

The committee recognises that the issues raised in this inquiry are, of course, sensitive. If anyone is finding this hearing difficult, we can take a break. A duty counsellor is also available onsite to provide support, if needed. The secretariat also has a support handout.

Ms Agostino, I believe you have a brief opening statement. Please go ahead.

Ms Agostino: Thank you for the opportunity to appear today. Suicide is a complex and deeply painful issue shaped by intersecting social, cultural and personal factors. Our core recommendation is straightforward: improve supports for men at risk of completing or attempting suicide through adequately resourcing the community sector to continue to provide the supports they already successfully deliver.

Since lodging our submission, new findings from our state of the sector survey highlight the growing pressures on both services and the people they support. Eighty-three per cent of organisations report increased demand, which is up from 67 per cent in 2022. The leading drivers of this demand are cost-of-living pressures, housing stress and lack of mental health support. Seventy-six per cent of organisations report rising client complexity, with mental health, housing and homelessness, and poverty as the top three contributing factors.

These risk factors erode the traditional masculine identity of self-reliance and often lead to relationship breakdowns, which are both significant drivers of male suicidality and barriers to seeking help. As we outlined in our submission, typical masculine identities of stoicism, self-reliance and strength are more likely to lead men towards social isolation and avoidance of support.

Many men at risk of attempting or completing suicide that engage with community services have experienced long histories of service failure or stigma around seeking help. When funding is uncertain or inadequate, organisations lose staff, continuity and the relational depth needed to keep men engaged. This undermines early intervention and pushes more men into acute health and justice systems—responses that are more costly, often harmful and do not address the root causes of distress.

We also highlighted the unique factors contributing to high suicide rates among Aboriginal and Torres Strait Islander men and the essential role of community-led, culturally safe support services. In addition, we have raised concerns from ACCOs about their limited access to detainees to provide these services.

The Jumbunna institute report released earlier this year confirmed that the ACT has the highest rate of over-representation of Aboriginal and Torres Strait Islander people in

custody nationwide. Despite the ACT government's commitment to justice reinvestment, millions of dollars continue to be spent on incarceration rather than being redirected into community-based interventions, as promised.

When men take the step to reach out, the service system must be stable, trusted and equipped enough to meet them. Strengthened long-term investment in the community sector is essential to achieving that.

THE CHAIR: Thanks very much. I will kick us off with some questions. We know multiple co-occurring factors can be at play when men contemplate or attempt suicide. I am curious about the extent to which the government fosters or hinders collaboration across the community sector with respect to those co-occurring factors. You can imagine someone having a crisis in multiple different areas and needing support from multiple different organisations, and perhaps struggling to find that support. Is that something you are able to speak to?

Dr Bowles: That is a great question. One of the biggest transformations in the community sector is through commissioning. Commissioning is taking much longer than I think was initially anticipated, and it is occurring in a siloed and graduated way, so some areas have been through commissioning and some have not.

One of the problems with commissioning—and there are some potential benefits to it—is that it disrupts service provider ecosystems that have often taken a decade or more to form. Left to their own devices, service systems that are people focused—in the community sector perhaps especially, but also when that interacts with government service providers—will naturally figure out, "Okay, a lot of my clients come from this place, so maybe I should develop some relationships with this other organisation," and "For our clients to exit what we're doing safely, they need this kind of support." "Oh. It's that organisation that provides that. Let's develop some relationships there."

Commissioning throws that all into the air. For me, one of the lessons learned about commissioning so far is that government has not consistently seen itself as a steward of a service system. It is very easy for it to be like, "We've procured five different types of services; it's up to them to figure out how to go and work together."

Ultimately, though, the taxpayer wants a functioning service ecosystem, and it is really only the government that can provide that early jump start to make it a functioning ecosystem more quickly. It can do that in a couple of ways. One is making sure that there is funding for a very warm transfer of clients. That means, potentially, funding an outgoing service and an incoming service at the same time, so that they can—

MS BARRY: Consistency.

Dr Bowles: Yes. It also means, though, having a really clear view of the service ecosystem that it thinks it is purchasing, and sharing that with the sector; obviously, getting input from it, because government is not going to know everything, but having a view that it needs to be a big part of the rapid re-establishment of an ecosystem that functions with interrelationships.

THE CHAIR: How can government best do that in relation to procuring services, as

you have said? Do you see processes that are underway or have been carried out that, in fact, are not just not doing that, but are contrary to that—doing the opposite?

Dr Bowles: One thing that we have been calling for, for some time, is for the government to publish, after procurement, what it thinks it has purchased. There are a number of advantages to this. One is that it sets out at least its initial thinking about how the different players are going to work together. It is really important to note here that it is not just the services that the government has procured; it is also community services that are funded by the CHN or the federal government. It is also services delivered directly by the ACT government.

There should be a clear view of that, and a published view. Another benefit of that is that, as part of the commissioning process, a bunch of community organisations and potentially service users come together and work with government, ideally, to come up with a clear understanding of what the ideal service mix is.

Having done all that work, for the government to be able to then publish, "Here's what we think we bought," and therefore "Here's what's missing," I think is really important. It could, in my view, absolutely change for the better how government considers incoming budget bids, because it would already have its established thinking about, "Here are the priority investments that we recognise were priorities but we couldn't make."

That would also assist the community sector to make better budget proposals, because it would not be wasted effort. It would be focused on, "Here's what the government's already identified are its priorities." It is about having that role as a sector steward. That is one very particular example of what the government could do. Overall, it is a shift in mindset from, "We procured a bunch of stuff; go for it," to a continued engagement.

MISS NUTTALL: I have a quick follow-up, if that is okay. One of the references in your work was Slade et al. It was a sort of scoping review of men's mental health and suicide prevention across Australia, and it had really interesting findings. Something like only 22 per cent of services are being evaluated. Do you think there is scope for the ACT government to do a similar thing to Slade—something more applicable to our landscape? Where are we in the process of scoping the ecosystem?

Dr Bowles: There is certainly potential for that, but this also comes back to what I would see as a few broader trends. Across most Western countries, there has been growing social isolation. It has affected men; it has affected women; it has affected everybody. Overall, I think it is fair to say that there has been, in the ACT and perhaps in other jurisdictions as well, more and more focus on trying to use really clear evidence to inform funding decisions. That means: "Can you show that you stopped three people from attempting suicide?" or whatever. But, with social isolation, often the downstream effects are really hard to capture. One of the things that I think has happened in the ACT, and indeed across much of the Western world, has been that government is funding fewer of the really basic things that make community.

I have heard anecdotally that there used to be—say, 20 years ago—more than five independent spaces specific for youths to drop in. They were there permanently. I am not sure that there would be that many now. The idea is that there has been a decline.

You do not need a psychologist for that; you just need a space, maybe some hockey tables, and someone to make sure no-one gets too rowdy. Those spaces are less frequent. We have kind of outsourced that to the clubs, which especially in the context of male suicide has its own set of problems. There has been less emphasis on the fundamental work of community building, and we are seeing the effects of that in increased social isolation, which then has a number of effects, one of which is a higher rate of suicide.

MISS NUTTALL: Thank you.

MS BARRY: Some of the comments that have come through this hearing are around a holistic view of issues affecting men beyond mental health. One suggestion was for a men's strategy, for example. I think the evidence was words to the effect of: there is no one area in the ACT government that is responsible for men's issues or has a bird's eye view of men's issues. I want to get your views on that, in terms of the community sector. How do you see that playing out in the community sector? And do you think that the idea of a men's strategy is a way forward?

Dr Bowles: It is absolutely true that there are a number of disparate factors that influence men's suicide, and indeed suicide more broadly, and that the ability of government to talk between directorates or even between different parts of the same directorate in a way that addresses that intersectionality is limited. I cannot say that ACTCOSS has given specific thought to whether a men's strategy is a useful tool in that context. What I would say is that, if there were one, it would need to avoid some of the common traps that happen for strategies in the ACT. It needs to have sufficiently high-level buy-in—that it happens. It needs to be specific enough that, in three years, a similar committee can review whether it has achieved its aims. And it needs to have the community sector really visible in it. It is not sufficient for it to be about three new types of acute care that the ACT government will deliver. The community sector needs to be able to look at it and say, "Here's how I'm contributing".

In relation to that, for it to be a worthwhile exercise it probably also needs to have new funding. If it is just enumerating, "Here are the five things that we think the community sector is already doing, and here are the three things that we think we are already doing as a government," I do not know how much having that in a document helps people experiencing that psychological pain.

MS BARRY: Other evidence that has emerged in the hearing is the way that community sectors procure services to men. It can be in reaction to, say, domestic and family violence, which perpetuates this. I cannot remember the term that was used—whether it was "a blame mentality". Are you finding that is the case outside of mental health services? The evidence, as it is emerging, is that the way that services are provided to men is reactive, rather than being about some of the issues outside of mental health being addressed. One of the other areas is homelessness and how the service is funded for men. What is your view on those sorts of observations?

Dr Bowles: When I am discussing social policy across a whole bunch of realms in the ACT, if I hear the word "men", it is most likely to be associated with perpetrating family and domestic violence. I think that speaks to the fact that there are a rather limited number of supports or limited thinking about what supports for men would look like

outside of that context. Do you want to add anything?

Ms Agostino: Certainly something that came up in consultation is that services that are providing supports to men that are at most risk have usually not been in the context of mental health. It could be that they are not receiving any mental health funding. It is often in the context of perpetrators of violence requiring rehabilitation of sorts, connected with the justice system. Particularly for the most vulnerable men—we are talking about men who are incredibly socially isolated—their problematic behaviour has been such that they do not have family connections that can support them.

We have recently been looking at the cost of the prison system in the ACT. It is really significant. A lot of men at risk of attempting or completing suicide have an intersection with the criminal justice system. Particularly for First Nations men, it has been identified time and again that it is a place of risk of self-harm. We did some preliminary calculations of how much is being spent on First Nations incarceration in the ACT. It was based on recent government data. This is something that I have done with ANTaR ACT. There is a cost of $618.22 per prisoner per day, which is the highest of any jurisdiction. We estimated that the cost of imprisoning First Nations people—this includes women as well, but we know that the AMC has predominantly men incarcerated—is approximately $25½ million per year. That is what we are spending on incarceration. I think that is really key when we are talking about men at risk of harm and suicide, particularly because of the risks that the justice system presents.

MISS NUTTALL: This probably leads on from that. Your submission mentioned some of the challenges associated with Aboriginal community controlled organisations being able to access First Nations people within the AMC. Could you walk us through that in a bit more detail?

Ms Agostino: Yes. This came up more incidentally. It was outside of this inquiry. We convened the Justice Reform Group, and part of that membership are ACCOs that provide services to people in custody in the AMC. When we have had more in-depth discussions about reintegration, all the ACCOs spoke about not being able to get access to people in custody. Particularly since COVID, it seems to be something that is being felt by not just ACCOs but also all organisations that are servicing detainees in the AMC. It has been a persistent issue for years, it appears. We have heard that a number of times in our Justice Reform Group.

MISS NUTTALL: Is it the case that Aboriginal community controlled organisations, or any organisations supporting someone in the AMC, are alerted when there is a situation that they can support a detainee with? Is it automatic that they are contacted?

Dr Bowles: I am not sure that we would have visibility of that. One thing that is especially worth noting is that the signs that Aboriginal and Torres Strait Islander people have ahead of suicide are often different and therefore would be more easily missed by non-Aboriginal and Torres Strait Islander staff, so having ACCOs having regular contact with Aboriginal and Torres Strait Islander people who are incarcerated is really important. I do not want to underplay the challenges of organising access for a bunch of people into prisons. I do not underestimate that as a difficult task. But, in 2023, 7.1 per cent of all deaths among Aboriginal and Torres Strait Islander men were by suicide, and we know prison is particularly high risk. I am not underestimating the

challenge; I am just saying the problem makes it worth rising to the challenge, regardless of how big it is.

MISS NUTTALL: Absolutely. Thank you.

MS TOUGH: I want to touch on something that representatives of Canberra After Suicide Support mentioned earlier this afternoon. CASS have only a handful of men coming to them for support post a suicide. They see only a handful of men getting support when they have lost a family member or a friend. They said that one of the things could be that there are not many men working in community organisations and in clinical psychology roles—in support services. Do you see a way we could get more men into those roles so that men feel more comfortable in accessing services, so that they can then see themselves in the service provider?

Dr Bowles: That is a great question. I do not think there is a silver bullet. One thing I would say is that the community sector on the whole is underpaid and that may act as a particularly strong deterrent for men joining or staying in it, particularly because of notions around the familial breadwinner et cetera. That comes back to the earlier point, that, on some level, the risk of suicide is distributed across the community. Often identifying the people with the highest risk is hardest for a service system, because they are at the highest risk because they are not engaged with the service system. That is part of the reason that having informal places—places where there is an air hockey table and you can hang out—is important. Particularly post COVID, as a society we have not fixed the broken social bonds that COVID created. Also, we have not grappled with the fact that we have a cohort of students who, for a couple of years, did not learn how to socialise. We are now in a situation where we have a city full of lonely people who could absolutely help each other if they had the tools to make the connections, but they do not. Compounding that, they do not even have the infrastructure of spaces where they can hang out, as we had 20 years ago. It is a real challenge.

Part of the way that you get more men in post-suicide support groups or other things is to have them in any kind of group, where there is someone they can talk to who can then recommend it, or they go to a community space where one of the 20 posters on the wall is about a group, so that people are able to self-identify a bit more.

MS TOUGH: That makes sense.

MISS NUTTALL: Young people have had social infrastructure. Obviously, for a lot of young people under the age of 16, some of that will now disappear through the social media ban. Does that indicate more need to get third spaces quickly and identify those sites now? I cannot imagine they are quick to build or put in place. Maybe they are. It would be great if they were.

Dr Bowles: It is certainly something that we need to look at quickly. The social media ban has positives and minuses. It is a way to cope with social isolation, which for some cohorts has been useful. A lot of people have found it counterproductive. Whatever its faults, it was a mechanism that many people used, so, if we do not replace it with some social infrastructure, it will be problematic. Let me phrase it in a slightly different way. This city is investing in huge amounts of physical infrastructure. I know that individual Canberrans have their own views about that, but we are investing billions of dollars in

physical infrastructure and people will be able to point to: "That's what happened in that term of government. That's what was built." But we are not investing in any way like that in social infrastructure, and the real risk is that we have this city full of disconnected people at higher risk of suicide and a whole bunch of other bad outcomes amidst great physical infrastructure.

MS BARRY: You make a really good point when you put it like that. It is a really good point because, when we talk about communities, what does that mean in the ACT in 2025? What is a community? It is a good point.

THE CHAIR: I want to ask about the integration between different parts of the service system and different parts of the community. There are things like community sport. That is not a service and it is not there to address a problem, so to speak, but it can prevent a lot of problems. Perhaps the community sector is a bit above that, where there is more targeted service delivery, and then you have things like formal health services, whether it is a hospital or otherwise. Where do you see the gaps in that kind of network? What role do you think government can play in addressing those gaps and facilitating greater connectivity between the different parts of that system, so that a man might not end up in a place of suicidal ideation?

Dr Bowles: One of the great benefits of community sport is that, by attending it, there is no idea that you need help. Even though you actually need other people on the soccer team and you need another soccer team to play a game of soccer, it is not seen as an admission of being incomplete that you need to join a soccer team. For men in particular, the more using a service is seen as an acknowledgement of failure or weakness, in some ways the bigger the barrier to it. So having things like sport—things that are widely available for people to participate in and you do not have to have a lot of money—is really important, and I think it is something that we are lacking.

I come back to shared social spaces, where you just have to turn up; you do not have to pay anything. You might be going there because you are lonely and you do not have a lot of friends, but going there does not mean that you are lonely and you do not have a lot of friends. That kind of low-intensity, community-building activity, where there is a really low risk of stigma, is something that we have progressively lost in the ACT and across the West. Churches once played that role to an extent, as well as other religious institutions, but they do not do that for everyone now. There are other shared spaces and activities like that that have also become de-emphasised and are less funded. That has meant that, to engage, you either need to be wealthy enough to do an activity in Civic or wherever, where someone is making a profit from you, or you need to identify as having a problem that the government will directly or indirectly fund to help you fix.

MS BARRY: We could have you here all day.

Ms Agostino: Can I offer something on the gap as well?

THE CHAIR: Please.

Ms Agostino: I have worked in the community sector for a long time, and before working in policy I worked on the front line. Often people working on the front line are doing the job of three to four people, and a lot of it comes down to resourcing.

Connecting with local sports groups and connecting with acute health care requires time, and you need money to resource that. A huge part of the problem is that you just have not resourced people enough to have the time to connect. This inquiry prompted me to connect with members that I might not otherwise have had an opportunity to connect with recently. One of the key ones did not even know the inquiry was on. It was a simple: "I prioritise the time." I also have more time than someone on the front line does, but they are the ones who hold the expertise. A lot of it is about resourcing sectors adequately.

Dr Bowles: I can also answer in a slightly different way. The ACT government is in some financial difficulty. That is fairly open. A third of the budget is on the health system, which includes formal mental health, and that proportion is increasing. It is a challenge for the ACT government and it is a challenge for state and territory governments across Australia, and we are not going to use psychologists to get out of this problem. We need to shift from acute services upstream to a lower level of specialty, a lower cost and more organic community-building. It is really hard to say, "John made friends. He didn't have to go to the emergency department, because he just called his friend instead." It is really hard for any one program to show that.

The budget has, time and again, tended to fund acute services, which are really expensive, and we just need to set John up with some circumstances where he can make friends. If you look at the amount of mental health cost versus acute government delivered services versus the less acute but still clearly mental health services, there is lots of room for a shift towards the community sector. I would argue there is also room for a lot of investment in: "Help John to make some friends."

THE CHAIR: Part of my curiosity as well is the level of connection. We have touched on it a bit—collaboration and connection between services. When John—who ended up in the emergency room because he did not know where else to go—leaves the formal mental health sphere, he could be told: "This is where you can go tomorrow. Now that we have hopefully got you out of the crisis, this is where you can go to seek some more ongoing support." And then the psychologist, or whoever it is at the end of the process, can say, "By the way, we have this great local sporting team that you might want to check out," and that kind of stuff. There seems to be gaps. It is a bit more like a widget of: "You're out of my patch and I don't know where you go from here, but I hope you find the help you need."

Dr Bowles: I do not think we are best placed to answer that question, but anecdotally it certainly seems like there have been gaps.

MS BARRY: To me, it sounds like, as a society, there needs to be a shift. It goes back to what you said about building physical infrastructure and not social infrastructure, and that there has been a shift from religious organisations providing that. There needs to be a replacement for that, be it peer-to-peer support or Men's Shed—those sorts of things. There needs to be a replacement for that kind of support that organisations like that provided and an investment in an organic process—a rethink of basic things and priorities.

THE CHAIR: What matters.

MS BARRY: Yes.

Dr Bowles: Yes.

MS BARRY: I do not have a question; I am just thinking.

MS TOUGH: I have nothing further. That has been really helpful. Thank you.

MS BARRY: Thank you so much.

THE CHAIR: Thank you very much for your evidence. We really appreciate you coming along and writing the submission—all your engagement in preparation for this—and thank you for all the work that you are doing all the time for the people who need it. Thanks for your attendance today. We will catch you at the next one.

Dr Bowles: Thanks very much. I appreciate your time.

Ms Agostino: Thank you.

Hearing suspended from 2.46 to 3.05 pm.

AUST, DR KERRIE LESLEY, President, Australian Medical Association (ACT)
RYAN, MISS EMILY, Junior Doctor Adviser, Australian Medical Association (ACT)

THE CHAIR: Welcome back to the public hearings for the inquiry into men's suicide rates. We welcome Dr Kerrie Aust, from the Australian Medical Association, and Miss Emily Ryan. Do you have anything to add about the capacity in which you are appearing?

Dr Aust: If it is possible, I would like to wear three hats today. The first is President of AMA, the second is that I am a GP who provides a lot of mental health services in Canberra, and the third is that I am on the clinical team for Drs4Drs ACT. If we have time, I would like to speak to some of our experiences addressing suicide risk within our own cohort, because I think there are some interesting lessons to learn out of that.

THE CHAIR: No problem at all.

Dr Aust: Emily has just passed her exams.

THE CHAIR: Congratulations.

MS BARRY: It is a big deal.

Miss Ryan: Thank you very much.

THE CHAIR: Please, note that, as witnesses, you are protected by parliamentary privilege, and bound by its obligations. You must tell the truth. Giving false or misleading evidence will be treated as a serious matter and may be considered contempt of the Assembly.

The committee also recognises that some of the issues discussed in this inquiry are sensitive. If anyone is finding this hearing difficult, we can take a break. A duty counsellor is also available onsite in the other committee room to provide support, if needed. The secretary also has a support handout available.

Would either of you, or both of you, like to make a brief opening statement before we move on to questions?

Dr Aust: I will. I have a tendency to be verbose, so start grabbing your ears if I speak for too long! I also, unashamedly, get teary when I talk about suicide, especially around colleagues. I am fine, but if I cry, it is okay. I am just going to do it.

When someone dies by suicide, the evidence shows that our initial reactions are almost universal, and we have really good data to support this. We respond initially with, "I can't believe it," followed by self-blame: "What did I miss? What could I have done? How could I have prevented this and why does this happen?"

I mention this because we live in a blame culture, and I believe that this is contributing to the problems. When I read the responses to the survey of AMA members who are working in this space, that Emily put together, I was not struck as much by the direct issues phrased, but by the frequency of underlying shame in the responses, and then by

the question about how we give space and support for men not to be okay.

Doctors who are seeing men see the shame, the anger and, most importantly, the loss of hope. We are thinking about how we can provide them with care and resources to help. How do we prevent mental health issues from turning into self-harm? And how do we get the message out there that the help actually helps?

Very few people have the capacity to walk into a room with someone they have never met before and say, "I am not okay. I am suicidal." The ability to open up is earned through a trust bucket that has been filled with time, listening and care that they have seen and felt with their own eyes. It is usually actually managing their head colds and their gastro infections which leads them to come in later. It is only then that they lean in, usually at the end of the consult, and say, "My friends are worried about my drinking," or, "I am gambling too much, and I am going to lose my house," or, "I just feel so sad all the time, and I'm worried that I'm going to kill myself."

A person who is in a high state of distress who might be reactive or impulsive may only knock on the door once. If they cannot access assistance, they may see this as further evidence that no-one cares and that there is no point. We have so little capacity in our health system to meet daily needs, let alone the needs of the people who find it really hard to come in. One of the most uncomfortable pieces of data that we have is that our suicide risk assessments do not capture real risk. It is the people who are assessed as low risk—when we look at our mental health report card, those people who are triaged at the low level, non-urgent—who are actually more likely to complete suicide.

I am a really average GP. I am not doing anything different to my colleagues every day, but I have a little box of cards like this one, which I got this week, that says, "Thank you so much for your support in the last five years. I would not be here, where I am at the moment, or anywhere, without you." I held that young man for 4½ years through constant suicidal ideation.

Many of the men who have benefited from care, from referral to the right service, have the capacity to pay. The needs will vary. Contrary to some of the media that we sometimes see, we always start with diet, sleep and exercise. We start with connection. We look at therapy, and we do not have enough access to male-appropriate therapy.

One of the most beneficial things that I have seen over the years is a group exercise class three times a week for veterans. I do not usually call out the other health professionals, but exercise physiologists are the unsung heroes of the mental health space. But the doctors working in mental health need support. Too many times, I have been told, when I have reached out, "I'm sorry, this patient is too high risk, and I can't help you." Even when I say that I am a single GP sitting in a clinic by myself, they say, "I'm sorry. I hear you, but I cannot take them on as a patient because they are too complex."

When we reach the top of our scope, we need to be able to refer on. It is not just about medication advice lines; it is about diagnostic support and continuity of care. We need people who can help meet us where we are, and meet our patients where they are, in a timely way. This is actually worth the investment. We need the knock on the door to be answered, whether it is a patient knocking or whether it is other health professionals.

We cannot continue as we are.

THE CHAIR: Thank you. I have a question on the continuity of care. Could you walk us quickly through the different care interventions? If there is someone who has experienced, may experience or is experiencing suicidal ideation, specific to the ACT, where exactly are those gaps? Where are we failing?

Dr Aust: Probably the easiest to identify, if we start at the top, is general practice services. While they are urgent on the day, general practice has a reasonable amount of capacity to fit in the kid with a cold or gastro, or someone who has just had a discharge from hospital. We really struggle with the longer mental health consults. My next long appointment is in January. We run cancellation lists, and we play a juggle, but we are quite stretched in that regard. That makes it hard.

With the tertiary referral services, I have to say, from personal experience, that I have had a better response from the acute mental health team recently. However, it is still a one-off diagnostic service rather than a capacity to hold. I am still holding patients with a new-onset psychosis, and I do not know whether it is schizophrenia, depression with psychotic feature or bipolar disorder. They are giving me a lovely differential, but not actually having the capacity to see those patients long term.

Private psychiatry is better, if you want things like an ADHD assessment; but, for long-term psychotherapy, we could do with another hundred psychiatrists in Canberra, and I do not think we would meet need. With psychology, again, we had a little bit of freeing up for appointments, so it became a little bit easier to get new patients in. We went from a waitlist of three months down to around four weeks for really urgent things.

Access can be really challenging in terms of finances. There is no capacity for long-term care other than eating disorders. Once you have hit that 10 sessions, there is no Medicare rebate. Organisations like Marymead and Barnardos sometimes have some extra options for us, but my understanding is that they are absolutely stretched to their limits as well.

THE CHAIR: We have heard a bit through the hearings about the gap between someone needing ongoing support; they are in the subacute kind of space, they have not made an attempt, so they might not qualify for when someone is considered to be in a really acute place. Is that a gap that you are aware of?

Dr Aust: If we look at risk assessment data, 60 per cent of people who complete suicide were assessed as low risk. That is data out of the NHS. Rachel Gibbons' work on suicide is worth a look. I have one of her papers, if you would like me to leave it with you. With patients, we use all sorts of scales. We might say, "Are you suicidal?" and they say yes or no. I might say, "On a scale of one to 10, how worried do I have to be about you?" A man burst into tears with me last week and said, "Actually, I'm at a 9½."

Whether or not those patients should be admitted to hospital, the answer sometimes is no. I want them to be, because I want to share the risk, but the evidence is not always that a hospital admission is beneficial to somebody who is acutely suicidal. Sometimes just having someone listen, and to start to feel like they have hope, is enough to down-regulate them. But it is a temporary thing; then they need more intensive therapy going

forward.

Especially for trauma, eye movement desensitisation and reprocessing therapy can be incredibly beneficial. Others need talking therapy. Some need what we would call a side-by-side walk-and-talk. There are very few therapists who have the capacity to do that these days. Some people need housing, a job, or a way out of a gambling addiction.

Usually, when I have my asks, I come in with a list of, "I want these 10 things," and I cannot give you that today. That is actually the part that worries me the most, because everyone needs different things, and we need to be able to tailor those solutions to the individual sitting in front of us, When the first thing fails, we need to have a plan B, C, et cetera.

MS BARRY: I know that this space is really complex; thank you for the work that you do. When you say you cannot really tell us what 10 things you want, why is that?

Dr Aust: There are some really simple measures. We need more capacity within the health system. I think there have been some positive gains, in the sense that the mental health unit in the emergency department is much more suitable, compared to what we were working with previously. We do need more acute mental health beds, where people can be for a week or two, to help them to down-regulate, and sometimes to provide a safe space to change medication and see how people respond.

More than anything, I want access to talking therapy that provides more than just 10 sessions in a calendar year. Probably, my ideal wish list would be the capacity to do a session every week for four to six weeks, then to be able to step out to maintenance. When people have been in a very vulnerable, shame-based space, they need to know that, as they step out of therapy, there is a safe space to go back to, if things re-present.

The phrase I like to use, which I got from training my labrador, is "trigger stacking". It is not the single thing that breaks an individual. When you see the road rage event, there might have been 15 things that sat under that, before they got there. They yell at the person in the supermarket; it is because they have lost their job, they are not sure how they are going to pay their mortgage, their marriage is going through issues, they are feeling afraid, and they are drinking too much. The bit that we often see at that acute stage is one stuck on top of a whole bunch of others.

Some of the things that we need are not in the remit of the ACT government. They are rebates for long consults and support for general practice within Canberra. There are things that can be done to help, but I also recognise that our budget in Canberra is small, and we need to make sure that we are directing services to where they are most needed.

One of the spaces where we have had feedback is about mental health drop-in spaces, and proximity to public transport. If the drop-in mental health space is in Belconnen and the patient is in Gordon, they are not going to access it. Again, you need redundancy in systems for walk-in options. Some days, people may not need it. They will definitely need it after a grand final, when they have gambled all their money away, or if there have been issues of violence in their home. They will probably need it around Christmas time, when staff are low. Injecting redundancy into a health system is expensive, but it is absolutely needed in this space.

Another space that we talk about a lot is peer-to-peer help. I know that, in the drug and alcohol space, this can be incredibly effective. One of the things that I would like to caution against is putting someone who has had significant mental health issues into a peer-to-peer space with a risk of increased vicarious trauma. I look after a number of patients who have successfully graduated from the Karralika drug and alcohol program. They are now back, as active members of the community. Some of them will continue to either volunteer or work in drug and alcohol work. They are very vulnerable to relapse and just need that extra level of support.

MS BARRY: The other thing you mentioned is that your next long consult is next year, in January.

Dr Aust: In January, yes.

MS BARRY: Please correct me if I am wrong: is it the fact that you do not have the rebate to be able to do those long consults or is it the fact that there are so many people accessing your service, and you can only do so much?

Dr Aust: No, it is a capacity issue. Like many GPs, I work multiple jobs to ensure that the bills get paid. I work four days a week in primary care; then I have a couple of other jobs outside that. It is also the depth of work. I am dual-trained in general practice and talking therapy. I used to utilise some MBS items which were around mental health and which now no longer exist, unfortunately, from 1 November. A brief intervention over half an hour is often better than none, and a lot of my colleagues will do that kind of work.

In general practice, we do not have enough GPs. We are all trying to increase capacity, but there are also the just-in-case bookings. A lot of my mental health patients will book an appointment just in case, and they will cancel it the day before, and the reception team free up capacity as they can. If someone calls up and says, "My mental health is not okay," we will do everything we can to get them in.

MS BARRY: Looking at the clients that you see, in terms of age demographic, are they younger, older or is it a spread?

Dr Aust: I am cradle to grave. I would say there are peak times for young men needing mental health support—age 14 through to 19. We are seeing increasing body dysmorphia, which definitely has a social media aspect to it, and alarming rates of steroid use, which have a consequence of mental health distress. If you increase your testosterone, you get an increase in oestrogen, which can increase aggression.

The next group that I tend to see, which I tend to specialise in, is the men who are around the age of 40 to 50. They get angry at me, because they all cry in the room. With many of them, I saw them when they had a gastro bug; they have booked back in to see me because they saw compassion there.

Probably the most effective thing that could be done by this government is to stop undermining general practice and stop fragmenting care, because when you fragment care and you say, "Go to a walk-in clinic," or "Go to an urgent care clinic," you actually

reduce our capacity to provide care to our patients. I do not say that because I am a control freak, although I am. It is how it works.

MS BARRY: I think we needed you here for an hour.

Dr Aust: You can have me forever. I will just talk until—

MISS NUTTALL: I am interested in an observation made in the submission, that it can sometimes be difficult to trust the statistics around male suicide because misadventure can be conflated with suicide, and it is difficult to differentiate the two. Could you take me through what the policy impact of these statistics not being easy to tease out might be?

Dr Aust: When we consider the data that we rely on, I have a very high index of suspicion for any single-vehicle accident involving a young person. It is not universal. Sometimes it is where cognition, skill and conditions of the road do not match up. But people will often say, "I thought about running into the tree, not even because I necessarily wanted to die, but because I desperately wanted a rest."

When we ask people afterwards—after they have had a suicide event where they have survived—what they were thinking about beforehand, it was often about, "I was just so overwhelmed; I wanted a rest, and now I'm a bit embarrassed." We are grateful when we catch those people on the other side. But when you are looking at your data, it is very hard adequately to capture the people who never make it into the statistics. I can tell you the number of my patients who have had quiet, unsuccessful attempts and have then told me about it, but there are lots that I do not know anything about—an overdose where they just had a very long nap, or where they managed to hit the brakes at the last moment.

MISS NUTTALL: Certainly, one of the things we have been hearing across the inquiry is the reticence of some men to engage with clinical services in the first instance for their mental health. You touched on it earlier. Is your sample fully representative or do you think there are core demographics that are missing?

Dr Aust: There are. That is an excellent question about who we are missing. I will speak briefly about AFP officers in Canberra. We know that the rumour mill exists in that space, and they tell each other that they cannot see a GP because they will not be allowed to work anymore. We try, as a community, to address this gently and head-on. Unfortunately, when people are very unwell, they will look for evidence that supports the fact that it is not going to be okay. Men are definitely more likely to come in contact with a health professional if they have a wife, a friend, a girlfriend or a brother or sister who brings them in to us. It is not uncommon that, in the first consult, they say, "I'm fine. That's okay."

If I can segue for a moment to doctors' health, one of the things that we have tried to do is identify leaders in medicine who have experienced poor mental health. I go out to medical schools and junior doctors, and I say, "Hey, I take an antidepressant and I see a psychologist, and I'm President of the ACT AMA. If I can do it then you will not be reported to AHPRA, and you will just get help."

There is an absence of those people in the military and in policing. They exist, but people do not tell their good stories. They only talk about where they tried to access care, and it did not work. They hear about the suicides of their colleagues. I had an officer in my room today, and I said, "Can we pause the timer? Can I ask you: what would you like people to know?" Her answer was, "I just don't know anymore." She said, "I would love to have a solution to put on the table, but I don't know anymore."

MISS NUTTALL: It is hard; I am sorry.

Dr Aust: It is very rewarding work when you get the postcard.

THE CHAIR: Is there anything that you want to add on Drs4Drs?

Dr Aust: Yes. It is quite commonly known that we lost one of our colleagues a few years ago to suicide. There have been others, but the families have asked that we not make that information publicly available.

One of the key themes tends to be where there is investigation for error, reporting to AHPRA, or where they feel that they are working in such a stretched system that there is no way out. Doctors are one of the higher risk groups, especially male doctors. We have put significant investment into trying to provide peer-to-peer support, because that seems to be the thing that resonates with doctors quite a lot.

I suspect it would probably resonate with some of your high-risk groups. We see it in Aboriginal health; we see it in the military. With that opportunity to talk to somebody who gets it, it is more than just placation; it is actually really important. No-one understands what it is like to have a patient die by suicide and be before the Coroner, other than another doctor who has gone through it.

MS BARRY: Why are male doctors more likely—

Dr Aust: One is that they are less likely to reach out for support, so they are less likely to sit down with a friend and talk to people. There is a deep shame associated with, in particular, medical error. The other part is that we know how to do it properly.

MS BARRY: Of course.

Dr Aust: One of the screening questions, when we work with military, police and doctors, is, "What have you got at home that you can use?"

MS TOUGH: In the survey that the AMA did, the results recommended development of a mobile outreach team and specialised suicide prevention services to engage men. Can you expand on what that would look like? What are doctors thinking in that space?

Dr Aust: We do find that meeting people where they are is really important. People will put up lots of barriers as to why they cannot access mental health. Sometimes it is an industrial relations issue because they cannot get time off, sometimes it is carers' responsibilities, sometimes it is just that they cannot get their foot out of the door. Emily might like to add to this.

Mobile services which go to people can be much more effective. It does not always have to be crisis team related. There is nothing that brings me a greater level of relief than when I speak to the crisis team as they are on their way to see my patient, because at least I know that someone else is helping in that space.

If you look at some of the work that is done by Aboriginal health workers at Winnunga, they will often go out and see people in their homes, so that they do not feel like they are stigmatised, and there is less shame associated with it. We can learn a lot from Aboriginal health about the impact of shame on care-seeking, because they actually do it better than any other area of the health system.

Miss Ryan: In our submission there was a lot of highlighting of the fact that there were a lot of gaps in the system, particularly between the GP primary care areas and the super-acute settings that you have spoken about. I think that recommendation offers some solution that is an intermediate resource that people can access.

MS TOUGH: That makes sense—well before you get to that acute stage, having support for clinicians, doctors, that can come to them where they are, whether that is at home or somewhere in the community, I am assuming.

Dr Aust: Yes. Directions and Junction have an outreach bus. Much of what they do is mental health. It is sometimes a combination. With mental health, we like to pull it apart, and put it into buckets, but it is rarely separated from the physical health components. It is an "and": chronic pain and gambling addiction, and drug and alcohol, and—

THE CHAIR: We have heard very little through these hearings about the National Mental Health and Suicide Prevention Agreement and the ACT Mental Health and Suicide Prevention Plan. The second expired last year. The first expired this year. Are these any good? What are your views?

Dr Aust: When you look at the documents, they are actually good. It is rare that these plans are formed without tapping into both the expertise of clinicians and the lived experience of patients. The issue is always the funding that sits behind them. It is so important to understand that a policy is not a policy until it is fully funded. It is an aspirational goal. It is lovely sitting on a shelf.

I have empathy for our budget situation in Canberra. I want to be really clear about that. We do not have endless buckets of money. We probably will not get to zero suicide. I want to try, but we probably will not. I think we can reduce an enormous amount of harm in the middle. I keep saying it, because I hope that it gets picked up: we need to address problem gambling in our community. We need to address alcohol and drug use, and meet people in appropriate spaces for healing, trauma-informed care and support services, without judgement.

We need to address the time that it takes in the court system, not because going through those court systems is the wrong thing to do, but because that space of sitting in uncertainty drives a lack of hope. The health system sits within a broader housing and access issue.

THE CHAIR: We are out of time. On behalf of the committee, I thank you very much for your attendance today, for your submission to the inquiry and for the work that you are doing.

Dr Aust: Thank you. I think your questions today were excellent. I appreciate the sensitivity with which you are conducting this inquiry. Let us step away from blame and into action.

THE CHAIR: Thank you so much.

POOLE, MR GLEN, Chief Executive Officer, Australian Men's Health Forum Inc.

THE CHAIR: Welcome back to the public hearings for the inquiry into men's suicide rates. We welcome Glen Poole from the Australian Men's Health Forum.

Please note that as a witness you are protected by parliamentary privilege and bound by its obligations. You must tell the truth. Giving false or misleading evidence will be treated as a serious matter and may be considered contempt of the Assembly.

The committee recognises that some of the issues raised in this inquiry are sensitive. If anyone is finding this hearing difficult, we can take a break, and a duty counsellor is also available on site to provide support if needed. The secretariat has a support handout available as well.

Would you like to make a brief opening statement before we go to questions?

Mr Poole: Sure. I have got a couple of minutes, if I want, is that right?

THE CHAIR: Yes, that sounds great. Thank you.

Mr Poole: I just wanted to talk a bit about connection. From a personal perspective, a big part of my identity is that I am a dad. I became a full-time, at-home dad back in the 90s, the last century, and they were the best couple of years of my life. When I went through separation, it completely shattered my experience of fatherhood, and I personally lived with suicidality for 15 to 16 years, whilst in a high conflict co-parenting relationship. The suicidality pretty much stopped and disappeared once my daughter reached adult life. That is the personal, lived experience I bring to this topic. And for around 30 years, I have been interested in and engaged in my personal mission of finding ways to create a world where every man and boy is just one conversation away from whatever support and help he may need—that connection piece.

I work now for the Australian Men's Health Forum. Formally, we say we are a peak body for organisations and individuals working with men and boys, but we are simply a network of people who are really good at connecting with and engaging with men and boys, with decades of experience of mostly community-based organisations working to make a difference for men and boys. Many of them engage either all the time or regularly in men's suicide prevention.

When I first came to Australia in 2015, I lived by the sea. The first Christmas the whole neighbourhood was awoken by helicopters overhead. It transpired that it was a local man who had attempted to take his own life in a very public way. It made me reflect, because I was wondering at that time what I would contribute and bring to Australia in a working capacity. I thought of my mission to create a world where every man and boy is just one conversation away from help and support, and there was a neighbour for whom, potentially, had I been more connected with my neighbourhood, I could have been that point of support.

At that time, five men a day in Australia were dying by suicide, and I took on the mission of making male suicide prevention the focus of my work. My partner and I lived in a motorhome, travelled to every state and territory in Australia, and held events

on male suicide prevention, trying to bring together all the different people we could find who were working in that space in some way.

At the time, I thought my job was to convince people to care about men's suicide prevention—five men a day, why do people not care? What I found out very quickly, was that my assumption was incorrect. People did and do care profoundly. It is now seven men a day, and every one of those men is someone's brother, or son, or father, or friend, or work colleague. People care profoundly about this issue. They just do not necessarily know what to do. They feel powerless about what to do to make a difference.

Yet, within our sector, the men and boy's sector, there are people who are saving men's lives on a daily basis. I think of when I was going through my trauma of separation, there was a bloke called Tony in Coffs Harbour who was going through the same thing. He lost his home and lost access to his children. He had been to the GP and been given anti-depressants, but they were not doing it for him. He put an advert in the local paper and he said, "I am a separated dad. I am really struggling. I need people to speak to, particularly other separated dads. I am going to be on my veranda at this address at 6.00 pm on Tuesday. If you want to join me, please come along." About half a dozen other separated dads turned up, and they just talked, shared their stories and soon found out, from meeting week after week, that what they were doing was keeping each other alive and in their kids' lives. That meeting went on to become Dads in Distress, now run by Parents Beyond Breakup, which is still to this day keeping dads alive and in their kids' lives. It is one of our member organisations.

I will share one more story, which is this. You will be familiar with the Australian Men's Shed movement. In my role, I have had the privilege of speaking in many sheds all-round the country, often about mental health and suicide prevention and looking out for your mates. And I can promise you that, without fail, I have yet to go to a shed and talk about this topic without at least one of the shedders coming up to me afterwards and sidling up to me and saying something along the lines of, "They do not know it, but these old buggers are keeping me alive."

Men's suicide prevention is complex. Men's suicide is complex. But the point I would like to make today is that the stories we tell about male suicide, and the stories men tell about suicide, are disconnected. And there is a disconnect between how we culturally and systemically think about men's suicide, and how men themselves actually experience suicide. I think if we can close some of that gap, we would go a long way to starting to resolve this very challenging problem.

My final point is just to say thank you for having this inquiry. I do believe it is the first time in the 10 years I have been in Australia, focused on this topic, that any government has specifically focused on men's suicide in this way, so I really acknowledge you for starting this conversation.

THE CHAIR: Thank you for that statement. On talking about men's suicide, I asked the previous witness about the National Suicide Prevention Strategy and the ACT Mental Health and Suicide Prevention Plan. I think I may have heard a murmur over here while you were waiting for your turn.

Mr Poole: I apologise!

THE CHAIR: I suspected you might have some thoughts about it. I also notice in your submission that you note that men are only mentioned once in the ACT plan and that only three of the 117 actions in the national plan are focused on men.

Mr Poole: Yes.

THE CHAIR: Do you have more views on those documents and whether or not they have been implemented? What would you like see in replacement?

Mr Poole: Sure.

THE CHAIR: That is an open question for you.

Mr Poole: Thank you. Sorry, if I was heckling from the sidelines. I did not mean to—

THE CHAIR: No, not at all. It might have just been an in-heck, or something like that! You have got thoughts to share.

Mr Poole: I have thoughts.

THE CHAIR: Let's hear them?

Mr Poole: I have got thoughts, yes. When I joined the Australian Men's Health Forum in 2017, we had one specific policy paper already in place, which was calling for the national men's health strategy, which was then a policy, to be reinvigorated, because there was a National Men's Health Policy, but it had pretty much been left on the shelf.

There was a statement in that position paper, that has always stuck with me, and it was this: "Australian men and boys are bereft of administrative structures at state and territory and federal level." By which it meant there are just no policies, no strategies, no reference groups and no advisory groups focused on the issues that men and boys face.

We do have a National Men's Health Strategy, and it mentions men's suicide, but the reality is that no action takes place through the Men's Health Strategy on men's suicide prevention. Where it takes place is in the National Suicide Prevention Strategy. It is a brilliant document. It is the most detailed policy we have ever had. It really spells out and tries to wrestle with all the complexity of suicide and looks at the social determinants of suicide as well. It does not just look at suicide as an issue for the mental health system, and that is a significant change, because prior to that strategy, which was rushed out just before the last election, the national suicide policy was always attached to the mental health plan. So here we have this independent document which spells out the thinking, but it does not join the dots to the National Men's Health Strategy. It does not wrestle with the fact that three in four suicides are men, not at any level.

I will give one example, which is that if you look at the bigger picture, education is a protective factor and a risk factor, depending on how well you do in education. We know that boys are performing less well at school or schools are performing less well for boys, however you wish to frame that. We know that a boy with no school

qualifications is over 2½ times more likely to die by suicide than a male graduate, and I think somewhere in the region of 10 times—I would have to check—more likely to die by suicide than a female graduate. So, when we fail to educate our boys today, we increase their risk of suicide later in life. The national strategy acknowledges education as a determinant but does not mention gender at all. That is just one example. We see this as a ripple effect through every level of federal, state and territory policy.

I am here because you are talking about men's suicide, but by rights, I should not be here, because I am representing a national organisation. There should be a local ACT organisation that is doing this for us. There is not. We should ideally have an existing men's health policy in the ACT that we can connect to. It is not criticism of the ACT government, because there is not one anywhere in the country at the moment. This is extraordinary. Yet, there is a Women's Health Strategy.

This is not to create a gender war between men and women. It is not to say, "Well, women have got one, why haven't we?" I believe those of us in this room really see the value of having policies in place. Because when we put policies in place—I think the previous speaker said something about policies are aspiration. I am paraphrasing—policies are aspiration; it is the action that is important. But if we are not actually framing the challenges that men and boys face as problems, the required policy action in the first instance, then we cannot even begin to do the thinking about what the solutions might be.

We often find ourselves, as an organisation, funded by federal government, under the National Men's Health Strategy, wandering into all sorts of other policy places across departments in the federal level but down into the state and territory level, because there is no through line of policy thinking that has been done. And the good thing about the National Suicide Prevention Strategy is that it has done that broader thinking for the first time, recognising that suicide is not just a mental health issue; it is impacted by all these social determinants. But no-one yet has really mapped out what the social determinants of male suicide look like as distinct from female suicide. They are very different.

Of course there is some overlap. Of course, if you are struggling with housing, or poverty, or domestic violence, or you were abused as a child, all of these things will increase your risk of suicide, whether you are male or female, but your pathway navigating those is often very different. It is a little-known fact that about one in five suicides are linked to childhood maltreatment, and 70 per cent of those suicides are men. So there are boys who experience abuse and maltreatment, who do not necessarily get support in childhood. There has been a huge amount of focus on that—rightly so. But the real challenge is adulthood, because many of those boys, if you talk about sexual abuse, on average, do not disclose until 30 years later. They do not disclose until they are men. Often, they carry that trauma from childhood through to adulthood, without any support, culturally or systemically, and then some range of events happens that collides with that unresolved trauma and puts them at increased risk of suicide. Again, from memory, I think the risk of suicide of men who were sexually abused as children has been estimated at something like 10 times greater than the general population.

So that statement from a policy paper, written by my predecessors who were volunteers, in 2016, that Australian men and boys are bereft of administrative structures at federal,

state and territory level, I am afraid still rings true today. We are failing men and boys in the process.

THE CHAIR: I would like to get your thoughts on why that is the case. I suppose that part of the reason we have developed a range of women-specific policies is because the policies have often been written by and for, in a way, men, and they have not catered specifically to the needs of women. So, policies that have not been gendered in any way are kind of, I guess, part of the conversation that they have served men more than women, and that is why we have developed women's health and other policies.

The need that you are articulating for men-specific policies—could you tease that out a little bit more and, maybe, in doing so, talk through why you might think they do not exist? Why are the, I suppose, generic policies not sufficient? How are they not serving men and boys?

Mr Poole: Thanks. I think it is a mistake to assume the generic policies automatically serve men very well. I could find colleagues from Australia who were having conversations prior to the first men's policy—this is before the 2010 health policy, before my time here—who were saying and writing in think-pieces and papers, "There is an assumption that the health system is being built for men by men, and that is why we need a women's health strategy. The reality is that the health system is failing many different populations in different ways because it is generic." I want to challenge that assumption—not to say it was not correct and that it was not working as well as it could for women but that it was also was not working as well as it could for men.

If we take an equality approach—and I am specifically saying "equality" rather than equity; equity being the assumption that inequality exists because of unfairness—and if we just look at equality, there are so many measures for many years that have shown that men are not faring as well as women when it comes to health, life expectancy, whatever it is, certainly suicide. The suicide disparity is not new. It has been around for many years. So there has always been an equality argument to focus on men and boys.

I think the challenge is that we do not have a framework for recognising men and boys as a priority population. The assumption is that the world is working for men and boys, and then there are these other priority groups who have quite rightly advocated for better support, have highlighted the barriers that they face, have actually actively stood up and said, "Do not blame us for the poor outcomes that we get in terms of health and economic outcomes, and social outcomes. Do not blame us as individuals. Look at how, collectively, the system is failing us. Look at how, collectively, the system places barriers to us thriving." And we still do this, right from the top of government: when we look at the undeniable problems and challenges that men and boys face, if you just look at hard data on outcomes, we do not have that collective language for men and boys, so we then have a tendency to blame the individual. So we say, "It is a problem with men."

You will have heard, if you have spoken about men's mental health, or men's issues, a very common conversation is, "Blokes are their own worst enemy. You know, us blokes are not very good at looking after ourselves. Us blokes are not very good at taking care of our health. Us blokes are not very good at talking." If you take a step back, it is deficit model. It is just plainly and simply a deficit model, which we would not apply to any

other population.

There is a really simple flip we can do, and I have been playing this flip for at least 15 to 20 years: what would it look like if we simply applied the same thinking to men and boys as a population as we have done to other populations, and instead of saying, "What is wrong with men and boys," ask ourselves, "What are the problems and barriers that men and boys face?" And you start to get different answers. But that is not a natural way of thinking. It is not within our public narrative. It is not within our policy narrative. It is not within our cultural narrative. You could even go back and say, "It is not within our evolutionary narrative because of the way that masculinity has evolved that men should be strong and independent and take care of themselves, so we have no narrative for helping men."

There is even some interesting research on moral stereotypes, which looks at what the public thinks about certain issues and whether we should collectively resolve them through policy or funding. People are presented with the same issues, like homelessness, for example, but for men and for women. People are more likely to say, "Yes, we should intervene collectively for women", and less likely to say, "We should intervene collectively for men." We have this sort of collective thing where we reinforce this belief that men should be independent and help themselves, so it is really challenging to take on delivering policy for men. Also, there is a fear that in doing that, we are taking away from women, all of which is understandable. But we are a mature society; we should have it within ourselves to be able to say the phrase I have been using for years: "We need to support men and boys in addition to the support we give to women and girls, not in opposition." Those two things do not need to be in opposition. In fact, part of the argument that is now being made consistently is not only are they not in opposition—it is a neutral effect—but actually focusing on improving the wellbeing of men and boys is not just good for men and boys, it has positive benefits for women and broader society.

THE CHAIR: Yes. It is interesting. I think it was in the dynamic that we were aware of in launching the inquiry, but I think, overall, people have been really responsive and happy to be able to speak about the issue. It is funny; "funny" is maybe not the right word.

Mr Poole: Yes.

THE CHAIR: Ms Barry?

MS BARRY: I have a side comment, before I ask my question. I think what has been suggested sometimes in conversations about the approach to men's issues is that, traditionally, previously you would have a family of a boy and a girl, or you would have three boys and three girls, for example, or you would have two boys and two girls, but now because those families are growing smaller, you probably have a family that has one girl or one boy. It is really difficult then to understand—the male child and the female child are quite different in the way they learn, in the way they relate, in the way they socialise. Then it has a flow-on consequence in the way we think about issues that affect men and boys. That is just a side comment, but it is interesting—

Mr Poole: Yes; I have not a lot to add to that, but there is even research that shows

people's political leanings alter, whether they are parents of girls or parents of boys—

MS BARRY: Yes, that is another commentary—

Mr Poole: It is an interesting area.

MS BARRY: Going back to that comment around the way that we look at funding men's health, for example, I think the latest statistics, or recent statistics, from the NHMRC suggest that women's health is funded at—

Mr Poole: Six or seven times more.

MS BARRY: seven times more.

Mr Poole: Yes.

MS BARRY: I want to understand: for you, how does that play into the way that services are provided to men? From your perspective, how does that approach interact disproportionately?

Mr Poole: We can get into a self-fulfilling loop. One of the understandable resistances to providing more support services for men and boys from a policy level that we certainly see this from our members, many of whom are community based, is that they draw their funding from wherever they can get it, and when they seek to expand and take their services further and come to the level of state or federal government, the pushback is, "There is no evidence." With lack of research comes a lack of evidence, and a lack of evidence becomes lack of commissioning, or lack of policy, so it is this self-fulfilling circle.

I think, sometimes, I would like to think that we have to say, "This is an issue that we need to address. We cannot wait for the evidence. We need to build the evidence by trying things." Sometimes people say, "Well, if you had £10 million pounds, what would you do for men's health? What one thing would you spend it on?" I would say, "I would not spend it on one thing, I would spend $50,000 a hundred times to different grassroots projects to give them the opportunity to explore." Because if you look at just suicide, there are so many different pathways to suicide and there is no single magic bullet.

It is not just the research piece. If you also look at the specific federal spending that has been identified in budget statements as "women's health" or "men's health", the disparity is massive. We estimated over about four budgets—and I can get you the precise figures—there was $1.2 billion dollars of funding allocated specifically to men's health and women's health, and less than five per cent was allocated to men's health.

Then in the suicide prevention space, when we have tracked specific funding that government has announced for suicide prevention, we have found that up to four in five beneficiaries of that funding are women at risk of suicide. No-one is suggesting that should take that funding away, but I always feel frustrated, because I always look at that and say, "That was predictable." At the point when you commissioned those

services, based on their track record, it was predictable that those services would reach more women than men.

So, if you know that, you really have a responsibility to do one of two things. One, you say to those services, "Look, 75 per cent of suicides are men. We have noticed that most of the people you are reaching are women. We do not want you to reach fewer women, but if we give you this funding, we want to see you taking action to increase the number of men you are reaching." That is action 1 I would expect from a commissioner. Action 2 is to say, "We will carry on funding this stuff because it is helping people who are in distress. However, we need to set aside, ring fence and allocate an amount of funding which is specifically going to organisations that only or exclusively focus on reaching men." That thought process is not happening, and that thought process does not happen if you do not have the policy in place that says, "One of our goals is to increase the number of men we reach," and you do not have the research in place that informs that policy.

It is also about missing advocacy as well. Because there are not people in all the rooms where these conversations are happening, we do not have an advocacy framework for men and boys. I know we are an advocacy organisation, but when we are trying to advocate across all of men's health and across all of government, with two staff, we cannot do it. We just pick and choose what we can do. There needs to be advocates for men and boys, and for men and boys education, in every room, otherwise policies and systems revert to their homeostasis.

Change is difficult. Change requires people pushing over time. One of the reasons, as I always say to activists and advocates in the men's health space who do get upset about women who have got more funding, is that enough women and enough women's organisations have advocated for change over time. Rather than being jealous of that, there is a lesson to learn. I really want to get this point across: we can focus on more funding and more policy action for men without it being in opposition to women. Actually, if we are smart about it, we can do it in a way that is positive and complementary, with a positive knock-on effect for women as well.

MS BARRY: One last question, because I am looking at the time. Do you find that it is difficult to have those conversations? Because we do comparative data, do you find that it is difficult to have those conversations? Is that why there are barriers?

Mr Poole: Yes.

MS BARRY: Because you will feel not terrified but—

Mr Poole: I do not find it difficult to say, but I am consistently told not to say it by all manner of different people who say, "Don't say that, because it is uncomfortable, because people do not like that, because people think you are being anti-women, because people think you will want to take money away from women's health, so focus on an argument elsewhere." But if we do not actually highlight these issues, how can we address them? The whole answer is not funding, but the disparity in funding is a symptom of broader lack of focus. If we do not actually highlight those systemic and cultural issues, where are we left to look? We are left actually pointing the finger at suicidal men.

If I really focus on that and connect to the distress that those individual men face, many of them—and it is in our submission—have actually reached out for help and support. Here the public story about suicide is, "You don't open up. You don't get help," rather than, "We need to get better at helping you." It is cruel—that narrative—and it is not complete. Is there some truth in it? Of course. As with all stereotypes, there is some truth in it. And do you know what? If it makes a difference and helps, great, carry on. But we have been having this conversation for too many decades now.

Like I said at the beginning, I believe there is a deep disconnect between the public narrative that we are comfortable with, "Men do not get help," and the reality of men's experiences of suicide, which is often of desperately seeking and trying to get help and not being able to find the right help. I know certainly that was my personal experience, and I know it is the experience of many other men that I have encountered over the last 20 to 30 years.

MISS NUTTALL: I think your submission mentions that it is time to focus on our collective resistance to giving men help. Is that resistance that narrative?

Mr Poole: Yes, that is part of the narrative.

MISS NUTTALL: Yes, got you.

Mr Poole: I believe we reinforce it when we focus on the individual behaviour rather than our collective behaviour. We, collectively, are not taking responsibility, because we are placing the responsibility on the individual for reaching out, rather than asking ourselves, "How can we get better at reaching in to people in distress, to men in distress in particular?"

MISS NUTTALL: I see what you mean. It is diverting the narrative and the responsibility to the individual.

Mr Poole: Yes.

MISS NUTTALL: Okay.

Mr Poole: If we sit in an uncomfortable challenge, because we do not know the answer to it, then, in time, solutions arise. But solutions do not arise if we sit inside the narrative that is, "How are we going to get men to change?"

MISS NUTTALL: I want to clarify that in your stats you mentioned 75 per cent of suicides nationally are by men, but in the ACT, it looks like this drops to 70 per cent.

Mr Poole: Yes.

MISS NUTTALL: Although both of these numbers are—

Mr Poole: Very high.

MISS NUTTALL: Yes, they are very high. Do you have any theories for why the ACT

has that slightly lower rate than the national number?

Mr Poole: I do not, I am afraid.

MISS NUTTALL: Okay. Thank you, it is helpful to know though.

Mr Poole: Yes.

THE CHAIR: Ms Tough?

MS TOUGH: Given your role is a national role, I am assuming you have got some perspective of what is happening in some other jurisdictions. I know one of our submissions talked about, or a couple of them maybe, a Suicide Prevention Act—

Mr Poole: Yes.

MS TOUGH: or something in that space. I think New South Wales has one and South Australia does or is looking at one.

Mr Poole: That's right, yes. I think South Australia was first and New South Wales was—I think.

MS TOUGH: Yes, or the other way—it is somewhere between the two of them. Have you seen anything coming from this that has helped, from the experiences of how introducing those acts have gone, if the ACT were to follow that path? Are there things that are lacking in those acts?

Mr Poole: This is not an organisational position, but I am personally yet to be convinced that the Suicide Prevention Acts are making the difference. Maybe it is too soon to tell. I can point to two examples in recent years. I think from a men's suicide prevention perspective, Queensland is probably the best case. I think it is worth looking at what they have done, because they did identify men and boys as a vulnerable community, and they use those words, "vulnerable community", which in itself is unusual. They have men named not just as a bullet point in the policy but in a section in the policy about men, and they have then followed that by action to examine ways that they get research and some funding into projects. It is a 10-year policy, I think, 2019 to 2029, and they are currently consulting on the next phase, and men are in the conversation again. By putting men in the policy, it means that all along the way, they have had men as a specific focus—in consultations, in funding, in research—which has been really useful. I think Tasmania attempted to do a similar thing and men had a particular section in the last suicide prevention policy, but that seems to have disappeared in the latest one.

With the Suicide Prevention Acts, to go back to that, I think the principle is sound. I think, broadly speaking, the principle is about ensuring that all government—this is my view and take on it; it might not be entirely correct. My take on it is that it is an attempt to recognise that suicide is more than just a health or mental health issue and that by placing a duty on all departments to consider the impact of their work and how their work might intersect with suicide, it requires every department to take action.

There was a hint of that—I am sure you are aware of it, but it is worth looking at it again—in the work of Christine Morgan, when she was the National Suicide Prevention Adviser to Scott Morrison. I think some of the work that she produced was excellent and a lot of it has not been enacted.

I think one of the excellent things that came out of that piece of work was the recognition of the multiple touch points that people who died by suicide come in contact with in government systems. It is something like 90 per cent of people who suicide are in contact with some kind of government system, whether that is the health system, Medicare, the justice system, whatever. But I think where it fell short was that the conclusion then became—it was a good enough conclusion—that we should better train people in the public service to know how to respond to people who are suicidal and distressed.

But I think there is a bigger picture. I think at the top of the system level there should be a requirement to understand how the way we, as a system, whether it is the justice system or whether it is the Centrelink system or whatever, are treating people through our policies—like an impact assessment. How might our policies be making people at greater risk of suicide? This is a much bigger challenge than saying, "How do we get better at responding to people who show up in our system with a bit more compassion." This is a good thing, but it is not actually changing the system; it is just changing the way a bad system engages with people.

MS TOUGH: Yes; thank you.

THE CHAIR: We are out of time.

Mr Poole: Thank you.

THE CHAIR: On behalf of the committee, thank you very much for your attendance today, for all your advocacy and for your submission to the inquiry. We really appreciate it.

Mr Poole: Thanks for the invite, and thanks for having this inquiry. As I said, I do believe it is the first inquiry of this type in Australia, certainly in the last 10 years. I am happy to be corrected, but I think you are ploughing new territory, and I hope it is useful for you, and I hope others follow.

THE CHAIR: Thank you, we appreciate that.

Mr Poole: Thank you for your leadership in that regard.

THE CHAIR: Thank you very much, Mr Poole

Short suspension.

LEICESTER, DR STEVE, National Clinical Manager, Schools and Communities, headspace
WILSON, MR MICHAEL, Research Fellow in Men's Mental Health, Orygen

THE ACTING CHAIR (Ms Barry): We welcome the witnesses from Orygen and headspace. Please note that, as witnesses, you are protected by parliamentary privilege and bound by its obligations. You must tell the truth, as giving false or misleading evidence will be treated as a serious matter and may be considered contempt of the Assembly.

The committee recognises that some of the issues raised in the inquiry are sensitive. If anyone is finding this hearing difficult, we can take a break. A duty counsellor is available. If you want to speak to them, if you are attending, we are more than happy to organise that, if it is a service that you want to access. Would you like to make a brief statement covering matters not addressed in your submission?

Mr Wilson: Nothing that was not covered already for me.

THE ACTING CHAIR: How about you, Dr Leicester?

Dr Leicester: I will not, either. I think we have covered a fair bit in there. We would probably be in alignment with Michael's contribution as well.

MISS NUTTALL: Mr Wilson, your submission mentioned gambling harm. I am interested in putting this question to both of you. Do you believe that the ACT should be doing more to limit the endless gambling advertising associated with any sporting event, whether that is in person or on TV?

Mr Wilson: Absolutely. The way we think about suicide prevention opportunities is functioning at multiple levels. There are individual-level initiatives where we can, for example, encourage individual people to limit the use of gambling, seek help in the context of problems or better regulate their emotions, and things like that. To an extent, individual-level interventions will only go so far, when there are commercial, more systemic, higher level forces driving the exact problems that people are experiencing.

I think that both need to go hand in hand. We need to support people with individual gambling problems and emotional problems, and suicide risk associated with that, while also targeting the higher level, commercial, systemic factors. What that looks like is reducing advertising and deconstructing the extent to which gambling, sports viewing, alcohol use and all these factors are normalised in young men.

MISS NUTTALL: Dr Leicester, do you have anything to add to that?

Dr Leicester: I completely agree and want to reiterate that targeting one component of preventing suicidality or suicide is a little fraught. We need to take a far broader approach. I certainly agree with Michael that gambling advertising, and similarly with liquor advertising, heightens access, and particularly with young men, where we can see a lot of gambling taking place, particularly in the under-25 age group, most of which is online. I have yet to see any benefit from it.

If the question is: should gambling advertising be limited? I certainly think so. Coupled with that, so much of it within the sporting arena is directly targeting young men under the age of 25. We will probably get to it a little bit later, but within that realm of social determinants, I certainly think this fits within that.

MISS NUTTALL: Do you track the pathway that predominantly younger men take through types of gambling harm? If you are talking about the online spaces, I am thinking about the early elements of games that are not gambling in their own right—things like loot crates, gacha and things like that, that might act as—whether it is a gateway or desensitisation—normalising that before young people are exposed to or find dedicated online gambling spaces.

Mr Wilson: Totally, yes; I can speak to that. We wrote a book that was published last year. There was a chapter on online gaming and young men, and the risks and opportunities with regard to young men's mental health and suicide prevention. There was also a chapter on gambling, which spoke about a lot of these things that we are talking about.

You are exactly right; it is a very insidious, early form of gambling that is normalised in online gaming spaces. We know that online gaming can be a source of protective factors in young men's mental health, but it also brings significant risks, when there are light burdens of gambling that are still very much activating the same pathways in terms of dopamine response and everything like that. Yes, it definitely has scope for more regulation, because it is a form of gambling that I think flies under the radar and just serves to normalise and ingrain these patterns in young men's experiences.

Dr Leicester: Once again, I am agreeing with Michael. It is a great question, and not one that will come up with an easy answer. If we think of gambling only in financial or monetary terms, it is one thing; certainly, within the gaming design, there is this concept of incentivising—taking chances, where there may be significant rewards, staying online within particular spaces and forums to gain rewards.

This idea of incentivising quick hits of potentially social and other token-based rewards has a very powerful effect for continuing the pattern of remaining in those environments. I think there are some benefits. There are opportunities to connect; we know that. But it is a complex space, and I think it certainly poses risks.

MISS NUTTALL: The Orygen submission cites some quite alarming but illustrative statistics from the UK on the link between gambling harm and suicide rates in the UK. I am interested in whether you have found, if it exists, any data on the link between gambling harm and suicide rates among men in Australia. Is that kind of specific research happening; are you aware of it?

Mr Wilson: A good question. I am aware of a researcher named Angela Rintoul. She has done some work looking at gambling-related suicides in Australia, not specifically focused on men but the majority of which were men. Essentially, the bottom line of her research that I have seen is that gambling significantly elevates risk of suicide in men, particularly with regard to the kind of acute aftermath of experiencing significant gambling-related harm.

Like many other risk factors for suicide in men, the acute aftermath of experiencing the loss or the show-up of the emotional upheaval ties to whatever event it is. That is the peak period of risk, and it is the same. My work is focused on relationship breakdown, for example, and we see that suicide rates peak in the immediate aftermath of separation.

It has not been the main focus of my work, but I would say it is a similar pattern with gambling, where the immediate aftermath of big losses is associated with peaking suicide risk. Again, it is speaking to the importance of timely and targeted interventions to help people to respond in a more adaptive way to these sorts of problems.

MISS NUTTALL: Are you connected in with, I think, the Youth Coalition? There was someone doing work in the ACT around the risks of gambling harm in young people. I am struggling to retrieve it from my brain, but are you connected in with that work at all? I am not sure if it was some kind of chatbot or website that perhaps provided some of that immediate, on-demand intervention for those—

Mr Wilson: I am not familiar, to be honest. I am happy to take that on notice and look into it further for you. We have not worked with anyone directly targeting gambling support in the ACT. Again, I am happy to look into it further, if needed.

MISS NUTTALL: Thank you. I am happy to take that on notice, too, and try and look things up.

Mr Wilson: No worries.

MS TOUGH: I thank both of you for being here. One of your submissions talked about more work needing to be done to normalise and encourage men's help-seeking behaviour. Do you have any specific ideas or ways that we could encourage men's help-seeking behaviour? We have heard a lot today and in the previous hearing that a lot of men who do suicide have never reached out, or maybe they do not have those touch points before they are in a crisis situation. Do you have any thoughts on how we encourage that help-seeking behaviour?

Mr Wilson: I think you were referring to my submission, so I can speak to that first. What we are talking about here is the link between cultural norms of masculinity, in many ways, and men's likelihood of seeking help in the context of severe distress. We know from the research that has been done, much of which is in Australia, that there is a strong link between men's conformity to masculine ideals of self-reliance and restricted emotionality and all these traditional masculine norms.

Greater conformity to these norms is linked to reduced likelihood of seeking help. Cultural problems in many ways demand cultural solutions. Different opportunities here could be different public health campaigns, aiming to normalise and encourage help-seeking—particularly early, more proactive help-seeking among men, given, as you mentioned, that men often delay help-seeking until the point of crisis. With a broad public health approach aiming to shift social and cultural norms that can limit or prohibit men's help-seeking, there could be real opportunities there.

I have one other point to add, which you may be going to ask about soon, so I do not

want to jump ahead too much. Encouraging men to seek help should only be one side of the coin here, or one part of the picture. We need also to look at what happens when men do. You mentioned that a significant proportion of men who die by suicide have made contact with mental health services, with primary care services. We need to understand those different touch points across the health system to identify where these men are slipping through the cracks and how we can best make sure that services are male friendly and are meeting the needs of men that do seek help.

MS TOUGH: For men who might be gay, gender diverse, queer, First Nations—a minority group within males that do not necessarily conform to what they see as masculine, how do we work with those groups to make sure they are not slipping through the cracks?

Mr Wilson: That is a great question. First, I would not necessarily say that traditional masculine norms are only embodied by heterosexuals.

MS TOUGH: Sorry, that was a really bad way of phrasing it.

Mr Wilson: I just think it is important to point out that there are different ways that intersectionality can influence the extent to which men's masculine identities show up and the extent to which that influences help-seeking. In my research, I have spoken to a lot of young queer men about their experiences of navigating the emotional upheaval of relationship breakdown. In many ways the narratives that they report align pretty neatly with exactly how you would expect a stereotypically masculine man to respond. I think there is a lot more similarity here than maybe we would expect.

Having said that, I think there is a real opportunity for services to be co-designed with the particular minority populations that they aim to serve, so that we are not trying to provide a one-size-fits-all solution to a group as large as men. There is so much diversity within and between men there, so co-designing solutions with end users is the main solution there.

Dr Leicester: I think we added some of that content within the headspace submission as well. As Michael said, there are a lot of similarities as well as differences within different groups. High-risk groups can potentially comprise a very large proportion of the population, a large proportion of men—First Nations groups, different cultural identities that might be a minority within the population that they live in, remote and regional communities, through to LGBTQ+.

One of the things is: can services be sensitive to that intersectionality, be adaptive and have a workforce that is responsive? I think that is really important. That is not a small ask; I think it is a really big one.

The other thing is that, right across the board, male help-seeking tends to be more delayed within the progression of difficulties than with females. We see this within primary care, in accessing GPs, in primary mental health. From my own clinical experience, working in tertiary mental health specialist services, by and large, by the time a lot of young men were coming into services, they have been experiencing significant difficulties for a very long time. Two big things happen, or several big things happen. Their level of disconnection from aspects of education, society and friendships

are often, unfortunately, further down the track.

The progression of their difficulties has been sustained for much longer; therefore, the level of intervention actually needs to be substantially more. We are, unfortunately, seeing so often that this is beyond only prevention, with a lot of those asking for help. Michael raised a really important one: what is the response from services? If it is, "Get back to us in X amount of time," and particularly if that is the first experience, it is not overly inviting and can be a huge deterrent.

The other part of this within mental health services is that we are not fantastic at saying what we do, unlike other health disciplines, such as physiotherapy and so forth. There is still a little bit of mystery as to what is involved, and as to what is the point of engaging in, say, a talking discussion or connecting with others. I think we have some work to do on our own behalf in communicating a lot more effectively to young men that this can be a much more adaptive, inclusive and welcoming space than just sitting in a waiting room and waiting to talk to a stranger.

Mr Wilson: I totally agree.

THE ACTING CHAIR: I have a few questions around the data that was referenced. I think it was in the headspace submission. It is around a significantly higher number of young people in the ACT calling in and experiencing suicidal ideations. Do you know why it is higher here? Is it because the population is smaller?

Dr Leicester: I cannot comment directly on that, so I will take it on notice, as to why. If we think of other risks, social determinants and the level of connection, there may be some aspects at play. I am looking at some of the data that we have submitted. Certainly, it looks like there has been an increase. I am wondering whether that may have been from the Kids Helpline data, where it looks like there was an increase in 2023.

Regarding the causal association, one of the things with looking at things like suicidality is that we need to be very cautious about single-cause theories. When we go down that path, we start getting awfully subjective and not looking at the whole picture of things. I am sure Michael can comment on that one as well.

Mr Wilson: It is one of the most complex outcomes to study—suicide—and one of the most consistent truths is that there is never a single cause for an individual's death by suicide. Individuals who are interviewed about their lived experience of the reasons underpinning their suicidal thoughts, or attempts, for example, will often cite particular factors as the things that, in their own subjectivity, are the causes. When we understand the full picture of people's underlying vulnerabilities and the acute stresses that they are experiencing, it is the complex interplay between those two that can be considered to be the cause, not one isolated factor within that interactive map, if that makes sense.

THE ACTING CHAIR: I had a conversation with, I think, representatives from the Kids Helpline, and I think they did a survey. I could be wrong in recalling that conversation. I want to get your views on whether this is something that you are aware of. In the survey, they asked, "What causes you the most distress?" and the number one factor was education. I do not know if you have heard anything around education and why that is a big stressor for young boys. I want to get your views on that.

Dr Leicester: It could be multi-layered. I am looking at a survey conducted through Swinburne university.

THE ACTING CHAIR: I think it was that one.

Dr Leicester: They were between the ages of 12 to 18 in the secondary school period. We are also talking about one of the most rapidly changing periods in people's lives—psychologically, physically and developmentally—with educational expectation, social norms and social skills-building, and a transition to adulthood that, at the best of times, is challenging. A couple of things that may come up in further questions is that remaining and connecting with school can be one of the most protective factors of connecting with community, pathways to the future, and so forth. Particularly in mid to post senior secondary school, there are significant pressures regarding what is laying ahead—all that occurring in this transition period from late childhood into adolescence and early adulthood. It is a multipronged area.

THE ACTING CHAIR: What are your views on how the system can better adapt and support young people through this transition period?

Dr Leicester: One of the biggest things—and ORIGINS has led a lot of this research over the years—is the age between, say, 16 to 21, which is the most common period for the onset of mental health conditions, hence the need for adolescent and young people focused mental health services rather than only child and adult services. There is a whole lot of things going on there. A couple of things—and this is certainly an area where headspace is committed—are age specific. We work in this space of 12 to 25—age-specific services. Nationally, we have seen much more uptake in this rather than the separation of child services and adult services. Even within the ages of 12 to 25, there is a huge difference developmentally. So I think we need targeted training for practitioners, but, more than that, for communities and for families. I am cautious of using the word "training", but we need accessible information about not just prevention but also protective factors. This is really important.

We see a lot in the space of suicide prevention where we are only talking about: how do we prevent it? The foundations of a lot of prevention are good community wellbeing—meaningful connections with people, whether it be family, community, education, clubs et cetera—and purpose. What I mean by "purpose" is that we are working towards something—"There are people around me with shared goals"—things that are future focused. When those are disconnected, we can get into some very tricky spaces. This is not about formal prevention per se for suicide, but it is about the foundation of good community and good factors, which we know contribute to long-term wellbeing.

THE ACTING CHAIR: You have pre-empted my next question, and you kind of answered it when you talked about purpose. One thing in conversations I have with my children—particularly my son and his peers—is around the sense of: what are we here for as a society? Because society is telling us: if climate change does not kill you, you will probably not be able to buy a home; if you work, you probably will not earn a good enough wage to live on. What is the sense of aspiration that we are giving our young people that would help them contribute to society and want them to have that sense of

purpose? And I want to get your views on where we are lacking in building that aspiration for young people. One thing is building communities and building connections, but, as a government or as a society, where is that lacking?

Dr Leicester: I will speak briefly, because I do not want to go on for too long. I will allow Michael to contribute in this space. You are not asking the small questions, are you? I think it is part of service delivery models as well. We need to step away from only one-to-one service delivery in mental health and thinking that is the way that we will therapy our way out of things, or something like that. The aspect of connection with community is a huge challenge. It is a worthwhile challenge for services to think about how we can aid connection but also share ideas of forward thinking and purpose.

I will come back to risk very briefly. In my clinical work, often in the space of risk assessment—which I think we are getting a little better on, but it is not an exact science—one of the areas is hope. I am not always focused on immediate distress, only coping and so forth; I am looking for future focus. It may be very small. It might be what is happening next weekend—"What are you aiming for," and so forth. It is in the space of "mental wealth", if you like—sometimes people use that term: "I am looking towards something. I have people who are aware of this and are sharing that." It is a really important factor for communities.

THE ACTING CHAIR: Michael, was there anything—

Mr Wilson: I totally agree with everything Steve said. I want to come back to the point on school based programs for a second. I think it is really important to call out what an important target for school based programming can be. Steve spoke a bit about school based mental health service provision but more from an early intervention and universal program perspective. There are a lot of great programs out there that do a lot of amazing work with young men in schools. There are programs like The Man Cave and Tomorrow Man—those sorts of programs. The collective active ingredient in those programs is a focus on the social and emotional wellbeing of young men, and particularly the capacity for young men to identify and regulate emotions, and relate to one another in a pro-social, adaptive way. That is really important to call out. If we are looking to the future of what school based early intervention programs can look like and what sorts of things they should aim to achieve, improving emotion regulation and the capacity of peer supports is critical.

On the point of purposelessness and the sense of almost nihilism among young people, I would say that, to an extent, it is a gendered phenomenon. Data shows that young men are much more likely to be what we call "neat"—that is, not in education, employment or training—relative to young women. It is about focusing on improving young men's outcomes and the extent to which they are contributing to society. For a long time, focusing on the problems facing young men has been considered to be at the expense of the problems facing young women, but it is not the case at all. All boats can rise at once. I am not the only one with that perspective. It is something we, as a society, are agreeing on more.

In terms of how to help with nihilism, specifically among young men, it is about creating policies and opportunities for young men to contribute to supporting both their own wellbeing and the wellbeing of each other. Peer support is a huge opportunity,

especially for young men who have navigated mental health challenges or significant life experiences. Men want to support others and support each other. It is a masculine norm to be a provider and protector in all these sorts of things, so we can use that in a strength based and adaptive way and create opportunities for young men who have been through really challenging experiences and learnt from that—create opportunities for them to support other young men, and not exclusively young men but anyone going through those difficult challenges.

There are a lot of amazing organisations that do lived experience and peer support focused suicide prevention work, particularly postvention—after there has been a death by suicide—with whole-of-community and family support. There is the work of Roses in the Ocean, for example. They are amazing in terms of peer support. I am not sure whether they have contributed to this, but they would be great to speak to. That is what I would say about the value of peer support in building up young men's sense that they are contributing to society. They experience better mental health as a result.

THE ACTING CHAIR: That was a really excellent contribution from both of you. Thank you.

MISS NUTTALL: This is probably related to when you talked about the need to engage in the community. Something that came up earlier today was that, in the ACT, there is diminishing access to community spaces as part of foundational work—places where young people can just be, where it is air-conditioned and accessible, and you do not have to pay money. Is that something that you have heard? Have you looked into foundational—not even preventative—community work as part of this?

Dr Leicester: This is a broad question about service design. One of the big challenges is how to create something that is open and welcoming but also clear on what it is offering. There is an in-between space that we maybe have not all landed in, where it can be open and there can be some creativity and fluidity in how things are run, as well as having really good governance and remaining within a very effective foundation.

I think what you are talking about or hinting at a bit in this space is how we can bring people together and simply connecting in different ways. Whether someone is in distress or otherwise, it can still be a welcoming space. One of the ideas that I have often been very interested in is that sometimes we think that is just the first entry into health services—having easy and open access—but, regardless of where people are in the stage of difficulties, those approaches are just as important. It should not only be for them. It is step one in a staged care framework, and so forth. That is a really big challenge. Part of the approach is bringing multiple services together—health services with other services that contribute to social justice, economic equality, housing, education, and so forth. Co-location is really important. There have certainly been many examples of that.

One thing I also want to mention—and Michael touched on it a bit—is postvention. Some people might not be aware of that, but it is about supporting communities and individuals following a death by suicide or a major critical incident. We have a very large program doing that within headspace called Schools and Communities. Other programs do it around the country, including StandBy, Roses in the Ocean, Thirrili and others. We see it as a really important component within the prevention framework

because, tragically, it is often after a major incident that we are asked to come in. Unfortunately, that is very often when the door opens. There are a couple of ideas that we would hope reduce the likelihood of further death occurring, but that is a profoundly difficult thing to measure. One of those other aspects is short-, medium- and long-term support in communities. We work a lot within schools. There is an immediate response to support school communities to get back to functioning, and there is the longer term focus on recovery, with a community that is welcoming to all. I wanted to mention that we put postvention within the prevention framework.

Mr Wilson: That is a great comment. Regarding creating more community spaces where young people can interact and support each other in everything, it is a really important question when we know that the social media ban/pause—whatever you want to call it—is forthcoming. We really need to think proactively about this. If young people hopefully spend less time alone, where will they go instead? In many ways, we lack the social infrastructure that will support valuable IRL—in real life—engagement. There is real value in creating opportunities for more community connection and engagement. Also, a risk here is that, without effective co-design of in-person solutions with the young people that they aim to benefit, resources are put into developing programs that no-one will turn up to. If something new is to be developed, then it needs to be co-designed with the users it aims to support. If something new will not be developed, then maybe another approach is to go where young men are already. We know that one of the core tenets of gender-responsive programs that aim to support young men's mental health is going to where they are already and removing barriers to entry. That means building in mental health resources and support in online gaming spaces, for example, and working with online masculinity influencers to promote healthy content, ways of regulating emotions and healthy depictions of masculinity online. It means not necessarily reinventing the wheel but working out what already works and engages young men—going where that is and building in positive mental health support in those spaces, if that makes sense.

THE ACTING CHAIR: That was really good. Thank you. That brings us to time. On behalf of the committee, thank you for your attendance today and the contributions you have made. If you have taken any questions on notice—I think there was one.

MISS NUTTALL: I actually found the link, which I am happy to circulate to everyone, about the specific SD based youth gambling harm reduction thing I was talking about. I will send that through.

THE ACTING CHAIR: If you have taken any questions on notice, please provide the answers to the committee secretary within five business days of receiving the uncorrected proof *Hansard*. Thank you for assisting the committee through your knowledge and experience. We also thank broadcasting and Hansard staff for their support. Thank you very much for your contribution today, and thank you for the work you do.

The committed adjourned at 5.02 pm.