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

FRIDAY, 28 NOVEMBER 2025

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Secretary to the committee:
Ms S Milne (Ph: 620 50435)

By authority of the Legislative Assembly for the Australian Capital Territory

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QLife on **1800 184 527** or www.qlife.org.au

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Amended 20 May 2013

The committee met at 9.16 am

BROOKS, DR ANNA, Chief Research Officer, Lifeline Australia
CARR, MS EMMA, Head of Government Relations, Lifeline Australia

THE CHAIR: Good morning, and welcome to the public hearings 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, as well as the ACT government.

The committee wishes to acknowledge the traditional custodians of the lands we are meeting on, the Ngunnawal people. We wish to acknowledge and respect their continuing culture and the contribution they make to the life of the city and this region. We would also like to acknowledge and welcome any other Aboriginal and Torres Strait Islander people who may be participating in today's event.

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 webstreamed live. When taking a question on notice, it would be useful if witnesses used the words, "I will take that question on notice." This will help the committee and witnesses to confirm questions taken on notice from the transcript.

As this hearing will touch on sensitive matters, some witnesses or people watching these proceedings might be impacted or triggered by what is said or heard, so 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 also have a duty counsellor onsite and available if needed. For those in the room today, please indicate to the committee secretary if you would like an introduction, or pop into the small committee room in the corridor. The counsellor is there to support you if needed, even if you just want a break or a cup of tea.

A support handout is available at the entrance to the committee room. 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 if more in-depth counselling support is needed. For those attending remotely, an electronic copy is available from the secretariat.

We now welcome witnesses from Lifeline. As touched on earlier, please note that, as witnesses, you are bound by parliamentary privilege and protected by it as well. You must tell the truth. Would you like to make a brief opening statement covering any matters not covered in your submission?

Dr Brooks: We would, thank you.

THE CHAIR: Please proceed.

Dr Brooks: Good morning; thank you for the opportunity to provide additional evidence here today for this important inquiry into men's suicide rates. As we know, men in Australia face significant mental health and suicide challenges. Not only do men account for 70 per cent of suicide deaths; almost 20 per cent of men aged between 16 and 85 have reported being diagnosed with a mental health disorder in the previous 12 months.

However, men are typically less likely to reach out for help. In fact, despite seven of the nine suicide deaths each day being men, only 40 per cent of calls to our Lifeline crisis support service are made by men. In saying this, the increased awareness raising and targeting of services for men is having an impact, with evidence suggesting that the help-seeking gap between men and women is narrowing.

At Lifeline, we draw on our frontline experience and our lived experience advisory group to continually examine how we can best meet the needs of people who rely on us for support, both through our targeted services, such as MensLine Australia and 13YARN, and through our general services and supports.

We are currently working with the University of Melbourne in a world-first randomised control trial, using help-seeker reported data to develop and evaluate a professional development module to further enhance crisis supporter skills in supporting male callers to 13 11 14, our voice-based crisis support service.

Beyond the services that Lifeline delivers and beyond the mental health sector more broadly, there is a need to focus more on wider contributors to suicide. Those include social isolation, cost of living and gambling, as well as promoting the protective factors that help people to maintain their wellbeing, such as strong communities, interpersonal relationships, physical health and financial security. For governments, this means a truly whole-of-government approach that brings together all aspects of people's lives to create a strong foundation for wellbeing and mental health.

Lifeline Australia and the Lifeline network stand ready to play an evolving and proactive role in supporting government to reduce deaths by suicide amongst boys and men across the nation.

THE CHAIR: Thank you very much. On risk factors, you touched on, and your submission references, gambling as a key risk factor for men. Can you expand a little bit on how this contributes to the rates that we are seeing, and what interventions would you like to see to address this issue?

Dr Brooks: Absolutely. In terms of gambling, we know there is an association with risk of suicide. One of the additional supporting points that I would share with you is that financial distress as a risk factor plays a significant role. That includes not just financial distress per se, so concerns about money and not having enough of it; it includes lack of control, lack of agency, a fear about continuity of employment—not knowing from one month to the next what the financial status will be for an individual or for the family. That financial distress component is wrapped up into the risks associated with gambling.

Another factor that plays into that association between gambling and increased suicide risk is that we know, particularly in the case of men, that impulsivity plays a significant role in the fact that 75 per cent of suicides are males. Impulsivity is also a factor that is common in terms of problem gambling behaviours. That impulsivity that is often a factor for gambling can be a contributing risk to the likelihood of death by suicide as well.

It is a complex landscape, but the thing that we can say with confidence is that, for those engaging in gambling, we also have to consider the risks that that poses in terms of suicide. Emma, do you want to speak to that?

Ms Carr: Yes. We would not tend generally to comment on things around advertising, the normalising of gambling within society, but I think we can all agree that there is something that needs to be addressed there. However, Lifeline centres around the country do deliver specific supports for people with gambling problems—in particular, free gambling counselling and financial counselling. Those do go hand-in-hand, obviously.

We would like to see more focus on those kinds of frontline services that can support people, and more promotion of them. As Lifeline centres around the country are not generally government funded for community services, they do have to fundraise for that, so if there is funding available, grants for that kind of thing, we would like to see more of that help.

THE CHAIR: What trends are you seeing when it comes to uptake of the gambling counselling service that you provide?

Ms Carr: Anecdotally, from our frontline counsellors, it is going up—both financial and gambling counselling, and the need for it. We have various drop-in centres around the country where people are able to go. I was at one in Broken Hill recently. People will come in, and they are under financial pressure. The centre will help them apply for non-interest loans and things like that. They might turn up not knowing that they are available, and they might turn up knowing they are available, but they are lost in the forms, and they do not know how to get the forms done. Simple supports like that are really helpful.

THE CHAIR: Is that a gap or is that something that you are trying to address where maybe you have someone who is getting counselling and who would really benefit from self-excluding from gambling, whether it is online gambling or gaming machines? Are you able to create those networks or is there some work that needs to be done there?

Ms Carr: Lifeline centres in local areas are very good at creating those networks. They are also very good at looking at and understanding the community and recognising where there are gaps. A Lifeline centre will generally assess where the gaps are, how we can fill those gaps, and how we can work with other organisations within the area to fill those gaps.

We have about 1.4 million contacts come in through Lifeline's telephone text and chat services each year. About 60 per cent of those calls are referred on to follow-up services.

They might be referred directly to community services, such as counselling. They might be referred to debt helplines and things like that, as the next step in helping them to get the help they need and be on a better path.

THE CHAIR: I want to go back, Dr Brooks, to your point about how much impulsiveness contributes at multiple levels. Is this one of the reasons that we hear more about men who have seemingly never contemplated a suicide attempt suddenly making one?

Dr Brooks: Sadly, yes.

THE CHAIR: Not having sought any support along the way?

Dr Brooks: Yes. The best data we have is that 50 per cent of people who die by suicide have not, in the 12 months prior, had any clinical support. Suicide can but does not always include a mental ill health component. That is partly because of the social determinants that we spoke about. One I would like to mention is major life transitions, particularly relationship breakdown; 25 per cent of male deaths by suicide involve specifically that. Those sorts of things that happen in life absolutely can play a major role in death by suicide.

The additional element that pertains particularly to men is that impulsivity. That, very sadly, can mean that those life events can quickly escalate into suicidal thinking. The choice of means is such that, very sadly, with people who die by suicide, 75 per cent of that population is made up of males. That impulsivity component absolutely plays a role.

THE CHAIR: With that 50 per cent figure that you mentioned who have not sought support in the 12 months prior, does that differ based on gender?

Dr Brooks: That is an excellent question. I will take that on notice. I would suspect that it is disproportionately going to be men, given that men engage in help-seeking at a lower rate than women, but I would need to confirm that for you.

MISS NUTTALL: Going back to the matter of gambling, I appreciate that you provide excellent services to support men who are struggling with gambling. Do you find that the prevalence of gambling advertising makes it difficult for those men to continue to engage with your services and get the most out of them?

Dr Brooks: I do not think we could speak specifically to that. In terms of exposure, absolutely, advertising plays a role in terms of being an accessibility enabler. If you see it, you are aware of it, and you are aware of different channels by which you can gamble—that is the reason we do advertising—it is more likely that people will engage in those behaviours. At a high level, absolutely, advertising will play a role. In terms of our specific numbers, I could not speak to those.

Ms Carr: For me, it is a little like when you get to the supermarket, and the check-out has a load of chocolate bars. You go, “I’ll grab one because it’s easy.” If it is less easy, you might not think of it.

MISS NUTTALL: On page 5, I believe, I was surprised that employment was listed as one of the factors that made men more likely to seek help, especially since you elaborate later on the negative impact that economic downturns have on suicide rates. Would you be able to unpack what you are seeing in regard to employment being a factor in suicidality?

Ms Carr: People who are unemployed are more likely to die by suicide. Also, there are protective factors around employment, in terms of socialisation and ability to recognise when they need to reach out for help.

Dr Brooks: Yes. Just to follow up on that, we often talk about risk factors, and that is a really important and legitimate line of inquiry when we are trying to understand suicide and how to prevent it. But those protective factors are really important to consider as well. As Emma said, one of the elements that is protective in employment typically is that it is a mechanism for connectivity with other people. Human connection is highly protective, as is sense of purpose. That is another element in the employment context that is a really positive one as regards suicide.

Ms Carr: Anna can speak better to this than I can, but the highest gender age group by population for death by suicide is men aged over 85. That sense of purpose that Anna mentioned there comes up a lot in discussions around that.

MISS NUTTALL: Is that the kind of thing that Lifeline provides support for, in terms of connecting with employers? How does that tend to operate? Do you engage people who would essentially operate as career advisers? Do you have those sorts of connections?

Ms Carr: At a crisis support level, one of the things that a crisis supporter will do, if somebody phones up and they are in distress, is to help them get through that distress. They will sit with them, with their pain, and help them, without judgement, to find a way forward. Part of the next step is creating a safe plan. The safe plan might address those kinds of things. It might talk about, “Okay, who can you talk to? How can you connect with people? What are your employment stresses? Do you have an EAP? Is that something you can draw on?” It is about those kinds of things.

Dr Brooks: At a high level, in terms of Lifeline, we are in the very privileged position that we have a platform for advocacy. One of the things that we focus on is speaking about some of those factors that impact on suicide risk, and some of those protective factors. Employment can be a vehicle for financial stability. In those discussions about financial distress and agency, the importance of those factors, we have the opportunity to talk about not only employment but also in terms of highlighting protective factors. Again, it is something that we can speak to, in terms of trying to drive policy. There is the service environment and then there are our advocacy activities, where we try to have impact on factors like employment.

MS TOUGH: I want to go back to men’s help-seeking. It is something that has come up a fair bit in the last couple of hearings. One of the reasons that has been given by previous witnesses for men not always seeking help or getting support after someone in their life has died by suicide is that they do not see themselves in the support services available, because often support services are run by women and there are not as many men in those areas. Do you have you any ideas on how we make the services more male-friendly, more appealing to men to access?

Dr Brooks: The data is slightly complex in that, absolutely, a signal of safety of a service is to see yourself in the people that are delivering it. There is that cultural competence signal. In terms of that, we discussed advertising before. In terms of how services like ours are positioned, it is incredibly important to have males in the images and—

MS TOUGH: In the ads, yes.

Dr Brooks: Yes. There is that level at which to tackle it. Once people are actually engaged with the service, there are data to suggest that it is not so much about whether—we are talking about males here—it is, in our context, a male answering the phone; it is more about the ability of whoever it is that is providing the service to meet the male where they are at. That can be mirroring, in the reflective process—using the same sort of language.

This touches upon the large study that we are running at the moment. We are adding training to our crisis supporter development environment so that all of our crisis supporters are better equipped to do that, to meet men where they are at, to make them feel like it is a safe space, to support them and, where appropriate, provide referrals. I think it is a multilayered thing. It is absolutely important to signal that it is a safe service with the external-facing stuff.

Once males are engaged, the first experience that they have, unsurprisingly, is highly predictive of whether they ever do it again. Particularly for a service like ours, it is incredibly important to consider ourselves a wide-open front door. It is free; you do not need an appointment. We are an early capture point for a lot of people, when they do reach out for support. That is why it is important that we make sure that our service is ready to meet them in a really effective way when they do that. Hopefully, we can be the launch pad for further help-seeking behaviours.

Ms Carr: Targeted services are really useful as well. MensLine Australia falls within the Lifeline family. We get about 6,000 to 7,000 calls to that service per month. That is a counsellor-based service. Lifeline’s crisis support is run by volunteers who are specially trained over a six-month period and have ongoing training, but MensLine has professional counsellors. They might be able to offer a different perspective and support them in that way. As Anna said, if men reach out for support and do not get what they need, they are significantly less likely to reach out for support again.

MS TOUGH: What are the hours that MensLine operates? I know Lifeline is 24/7.

Ms Carr: It is 24/7.

MS TOUGH: I will segue to specific services. 13YARN is also run by Lifeline.

Ms Carr: Yes.

MS TOUGH: Do you have any insight into why suicide rates have continued to increase in Indigenous communities?

Ms Carr: With respect to Aunty Marj, who is our Head of Indigenous Affairs, I have been with her when she has been having these conversations recently. She has talked about relationship, and relationship breakdown, being a big thing on the 13YARN line. Increasingly, there is talk of racism, abuse and some of the things that have been happening in the news driving up distress within the community.

Dr Brooks: Experience of discrimination more broadly is absolutely a risk factor. Very sadly and obviously, for Aboriginal and Torres Strait Islander peoples, it is often a very common experience, so that absolutely plays into the data.

MS TOUGH: 13YARN is 24 hours as well?

Ms Carr: 13YARN is 24/7. 13YARN is currently only a voice service. One of the things we are talking to funders about at the moment is expanding that into text and chat. We have learned through the Lifeline text and chat that it is significantly more likely to be used by young people, which is obviously a massive target area within the Indigenous population.

MS TOUGH: Currently, you have to call and actually talk to someone, but Lifeline—

Ms Carr: Yes. Apparently, 15-year-olds do not like to do that.

MS TOUGH: With Lifeline, you now have that texting service, don’t you? You have an online chat.

Ms Carr: Yes.

Dr Brooks: For the mainstream, yes, and we are looking to develop it for 13YARN.

THE CHAIR: What is funding looking like for 13YARN? What is the funding source, and is more needed?

Ms Carr: It is currently funded through a federal grant, and we are seeing numbers go up significantly higher than was ever predicted. I think we are getting around 100 calls per day to 13YARN from around the country. The initial planning was that we would be getting about 60 calls per day by now, three years in, so that is a lot higher than was expected.

We are able to keep up with that very well, thankfully, and with an entirely First Nations crisis support workforce. But whenever the team go out into community, they are spreading the word, and the more they spread the word, the more the calls go up, so more funding is always needed. The real focus at the moment is that text and chat, so that we can reach more of that young community.

THE CHAIR: I want to ask about another risk factor which you touched on in your submission, which is childhood abuse. How often, for people who are contacting Lifeline—you might not be able to give a quantitative answer—is this their first time disclosing an experience that has led to suicidality? Is that an issue? Do you feel that the service system is supporting people early enough?

Dr Brooks: In terms of our data, our data capture around the reasons for calling or the topics discussed is something that we are working on. The reason it can be challenging is that it is a confidential service; people do not have to provide any information. Typically, there will be a number of issues that are discussed in a contact. For the crisis supporter, trying to isolate what are the key ones can be a bit of a challenge.

There are a few caveats on speaking to our data in particular. In terms of the broader issue, very sadly, as our data maturity improves around suicide prevention, it has become incredibly clear that adverse childhood experiences are a significant risk factor. That includes abuse and neglect. I suppose, at a sector level, in terms of our understanding broadly about suicide risk and the risk of mental ill health challenges later in life, the data are now compelling that ACEs play a causal role in heightened risk later in life. I would speak to it at that higher data level rather than necessarily in terms of our specific Lifeline data.

THE CHAIR: Do you see an increase in people seeking support when there are higher profile public cases? Recently, there has been a lot about what has happened in early childhood settings across the country. Does that sometimes precipitate more calls?

Dr Brooks: In some cases, yes. It is often hard to unpack what is driving peaks and troughs in volume. To give you an example around the domestic and family violence marches which were held last year, we absolutely saw a significant increase in the numbers of people reaching out for support.

For some of those really big, national issues, we will see changes in the volume of people reaching out to us. We take between 3,000 and 4,000 contacts a day across the suite of crisis support services. The volumes are such that often it is only with those really big, national issues that we will see a change.

Ms Carr: Within 13YARN, we saw the same thing around the Voice referendum.

Dr Brooks: Yes.

MISS NUTTALL: You have covered a lot of different risk factors and protective factors in your submission. An overarching question on which I would like to know your perspective is how you feel that the ACT might differ from other jurisdictions in these challenges. I know ACT-specific data is sometimes difficult to disaggregate further, but have you received whether it is within that data or anecdotal evidence as to how ACT might differ?

Dr Brooks: I do not know that I would necessarily have any specific commentary about the ACT. One of the challenges that we face is taking a more holistic national approach to how we address suicide, and there is some amazing work. With the National Suicide Prevention Office, we now have a strategy that has been developed, in heavy consultation with the sector and people with lived experience. It is a really great piece of work.

The real challenge for all of the jurisdictions is to try and get the implementation of that strategy—to land that, I suppose, in such a way that we can take a coordinated national approach to how we do this. In the case of the Northern Territory, for example—that is the jurisdiction, very sadly, with the highest suicide rate—there are some particular considerations there. I am not sure that I would necessarily have any things that I would suggest that would be particularly unique to the ACT.

Ms Carr: I did look up the figures. I thought you might like to know. We get about 1.1 million calls per year across the country and about 22,000 of those come from ACT. That is about two per cent, which is slightly over your population base. You could see that as a bad thing, but I see that as a good thing. People are aware of the service and are calling. In areas like the Northern Territory, they have a lower percentage calling us than their population size, which is troubling, given the high levels of suicide.

Dr Brooks: It might be worth noting that, across the jurisdictions—this is a national effect, but I think it is important for each jurisdiction to consider it—there is absolutely a relationship between living regionally, rurally, remotely and risk of suicide. You see a gradient from metro out into remote areas of increasing risk of suicide. It is the case that people not living in the major metropolitan centres are at higher risk.

MISS NUTTALL: Does that map as well to help-seeking behaviours at all? Is it a similar gradient?

Dr Brooks: It is more about access to services. Obviously, if you are in Canberra or Sydney, if you are in one of those major centres, your options are far higher than if you are living more rurally or remotely. I think that is where the opportunity exists for us to try and address that issue.

Ms Carr: Social isolation is higher when you are outside the city, or it can be. You can be socially isolated and surrounded by people, but you at least have more opportunities for it in the city.

MISS NUTTALL: Absolutely; that is a compounding factor. When you talk about harmonising our approach across jurisdictions, we know that a couple of jurisdictions have implemented their own suicide prevention act. Do you think it is a productive way forward for the ACT to consider such an act or is it better for us to take our cue nationally in the first instance?

Dr Brooks: I think it would be in the implementation. If the ACT were to go down that route, it is about making sure, to the extent that it is possible, that it lines up with a national strategy. That would be the ideal scenario, in my view.

MS TOUGH: You have touched on loneliness. I note that the submission says that only four per cent of people calling state their reason as being lonely, but volunteers who are answering the calls say that loneliness is present for a lot more people. Can you elaborate on that?

Dr Brooks: That comes back to that challenge around how we record what is going on in those conversations. It may be a discussion about financial distress, but there can be a peripheral issue going on there with loneliness. The crisis supporter will record those obvious reasons, but they will also be aware that there are some fundamental drivers that are making those other issues more acute. It is a bit of a challenge in terms of how we record data at the moment, and it is an area that we are looking to mature into.

Ms Carr: Also, it is not something that people necessarily identify themselves. They feel down, they feel sad and, eventually, it gets into the conversation, “I’ve got nobody to talk to.” “Why don’t you have anybody?” “I never see anybody. I never go out.” There is a lack of social connection that they have not quite identified as a problem.

MS TOUGH: That makes sense. Thank you.

THE CHAIR: I want to ask about the National Mental Health and Suicide Prevention Plan. What is your assessment of the effectiveness of that? Do you have a view that is similar to that of the Productivity Commission?

Dr Brooks: My view is that it is great that there is the opportunity to rethink how that is delivered. We are keen to work with the National Suicide Prevention Office and the National Mental Health Commission in whatever ways we can to support making the agreement really fit for purpose in the next round.

Ms Carr: We would say that we would agree with some of the call-outs in the Productivity Commission’s report, particularly around transparency, outcomes data, identifying outcomes and making sure that those are achieved rather than just processes.

THE CHAIR: We are out of time. On behalf of the committee, I thank you for your attendance today. You have taken questions on notice; please provide your answers to the committee secretary within five business days of receiving the uncorrected proof *Hansard*. Thank you so much for the work that you do. We really appreciate it.

DELGADO, MR JASON PATRICK, Data Analyst, Suicide Prevention Australia
STONE, MR CHRISTOPHER, Executive Director, Suicide Prevention Australia

THE CHAIR: We welcome witnesses from Suicide Prevention Australia. Please note that, as witnesses, you are protected by parliamentary privilege and 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 also recognises that some of the issues raised in this inquiry are, of course, sensitive. If anyone is finding this hearing difficult, we can take a break. We do have a duty counsellor available onsite to provide support, if needed. The secretariat also has a support handout available.

Would you like to make a brief opening statement covering anything not addressed in your submission?

Mr Stone: Yes, that would be fantastic.

THE CHAIR: Go ahead.

Mr Stone: Suicide Prevention Australia is the national peak body on suicide prevention. Unlike many national peaks, we do not have a federated model. There are no state and territory suicide prevention peaks, so we operate both nationally and in every state and territory, including the ACT. We have ACT members, and we have an ACT committee representing those members that guides our actions in this jurisdiction. We hope that we can provide both an ACT perspective and insights into what is happening in other jurisdictions across the country.

I would like to start by trying to outline some of the scale of the problem by referring to some recent data that has come in. You may be aware that the Causes of Death data was released by the Australian Bureau of Statistics earlier this month. That covers the year 2024. We now know that, in 2024, 27 men died by suicide in the ACT. The year before, it was 26, and over the last 10 years that number has varied. Sometimes it has been as high as 40-something men dying by suicide, but it has never been lower than 20 in that period.

One of the things I should mention is that a better measure of distress in the community rather than deaths is attempts. We do not have good data for attempts in the ACT, but we do know that, in general, in Australia, for every death by suicide, there are perhaps around 15 to 20 attempts. We also know that, for every death by suicide, on average, it causes deep distress for around 10 to 15 people, and it in some way impacts a further 120 or so people.

Obviously, we do not have data for this year, but we can make some accurate guesses. The likelihood is that, in 2025, around 500 men will have attempted to take their own life, and that 20 to 30 of those men will die. Those deaths will leave around 200 to 300 people in mourning and around 3,000 others who have lost someone they care about.

All of that is to say that the work that is being done here, the work of this committee, is really important. We strongly welcome the fact that this inquiry is going on. We would urge this committee to make concrete recommendations for increased efforts to drive down suicides in the ACT. We have put forward some recommendations in our submission, and we are happy to answer any questions about those or anything else related to the topic.

THE CHAIR: Thank you. I was hoping to lead with a question about the Doing It Tough program. Have you had any conversations with the ACT government or any other jurisdictions? I understand that it is happening in New South Wales. Has this happened anywhere else? Is consideration being given to doing it elsewhere?

Mr Stone: We have had conversations, absolutely, and we have put it in pre-budget submissions in various jurisdictions to seek funding to do this. We will be putting it in our pre-budget submission to the next ACT budget round. It is something that we are constantly talking about with jurisdictions. It is one of the things that sits on our list of things that we would like to see happen.

THE CHAIR: If that is to be supported, what kind of funding are we talking about? What does it look like to get that program stood up?

Mr Stone: It is not a massive amount of funding. I do not have the exact figures with me, but it is in the range of—

THE CHAIR: Your data analyst is going to jump in with the figures!

Mr Stone: One of the things about the program is that it is not providing a service, so it is drawing together existing services. The major costs around the program are simply around running the website and keeping the website accurate, so that it is continually referencing services that are actually there. Obviously, things change a lot. At the same time, it is engaging with men with lived experience to make sure that men see themselves in it and that it is engaging with them.

It can be things like running a campaign over Christmas time, which is a particular danger period for suicides, that attempts to look at the sorts of negative thoughts that men may be having in that period, and reflecting those in a way that generates hope and encourages them to seek out a service, so that they say, “Yes, actually, I am feeling that way; I should possibly look at this website.” That is the sort of work. As I say, we can come back with details on exactly how much that cost in New South Wales.

THE CHAIR: Okay, you are taking that on notice; thank you. Why is that? What is the thinking behind that being a necessary program or offering? Is it that men do not know what is available? This is something that we are hearing throughout the hearings. Men do not know how to seek support, do not seek support and, when they do, they do not get it.

Mr Stone: Yes, that is it. With all the things that you are hearing, we probably reflect them as well. There is something of a myth around men not seeking support. It is absolutely true that men do not get as much support as women, but it is certainly more complicated than not necessarily reaching out. There is certain research that indicates that they do reach out, but they are less likely to be satisfied with what they encounter; then they do not reach out again, so they are less likely to try again. That is potentially to do with the way in which services are framed and the way in which they see them.

With this website, first of all, it directs them to services that are specifically geared around men and that are male-friendly, in that sense. It makes it more likely that they will have a positive experience. As I say, the website itself is designed by men with lived experience to be the sort of thing that they find engaging to use, so they are more likely to reach out for support through it.

THE CHAIR: How much of that reaching out for help but then not feeling satisfied with the help that is available relates to situational factors leading to suicidal thoughts? Something that we have also heard throughout the hearings, whether it is a relationship breakdown or loss of a job, is that there are these sorts of things. I am not sure if we have heard clearly that it is differential, in that more instances of male suicide are because of those factors than in women's suicide rates. I am curious about how much of that might involve that dynamic. It is a bit of a convoluted question.

Mr Stone: Jason, did you have something that you wanted to say?

Mr Delgado: No, I wanted to go back to the previous question. We have a community tracker that we run quarterly. We have data in our most recent tracker on barriers to help-seeking, specifically for men. One that came out, in around a third of the respondents who responded, was that they were experiencing extreme distress but did not seek any help.

Going off the data here, a third of these men downplayed their distress by saying they did not seek help, despite feeling extreme distress. It was really saying that they were feeling extreme distress, but they were downplaying their level of distress as the reason why they did not seek any support. The Doing It Tough website would help these men to break through and start talking about their mental health issues and other types of issues.

Mr Stone: Even the framing of the title "Doing It Tough" is designed around the ways that men will describe being in distress, and that comes from consultations with men, absolutely.

Going to your question on the extent to which a range of factors will be more likely to influence men, the Causes of Death data has some sections that speak to this, where it looks at risk factors that are associated with deaths by suicide. There absolutely are gender differences in the sorts of risk factors, but we see in both men and women a huge range of risk factors. One of the things that is worth highlighting is that suicide is complex. In the ABS data, on average, there are four risk factors identified for every single death, and we know that that is not capturing all the risk factors.

There will be multiple different complex factors for both men and women, and no doubt that is a factor, but I do think that, in terms of men's experience of services and not connecting with those services, it is probably more about, firstly, particular types of masculinities and downplaying problems—stoicism and that sort of thing—and, secondly, the design of services not necessarily engaging men or particular types of men.

THE CHAIR: Part of what I am imagining is that, if it is situational factors, men might have this perception, "I don't need to talk to someone, I just need my job back," or "I just need my relationship back." Do you know what I mean?

Mr Stone: Yes.

THE CHAIR: That becomes a barrier; they are looking for really practical—

Mr Stone: Yes, potentially. The really important thing is to have services that can cater to a diversity of circumstances, because there is always a diversity of circumstances and there absolutely would be some men out there who would be saying exactly what you are saying. They would be saying, "No, I don't have that problem, I have this problem. I want to focus just on the practical solution."

One of the things is about having an interconnected service system because, genuinely, their problem may only be that they have these things going on in their lives and the solution is not counselling but fixing those practical problems that they are facing. It is about suicide prevention services having the ability to link to other services, which they absolutely do. Also, other services need to recognise the potential for distress. Let us say that a man turns up to a financial counselling type service. While they are busy sorting out his finances, he is in distress, and they need to be able to recognise that and to be able to respond in the interim to make sure that he is okay.

MISS NUTTALL: I am interested in the Doing It Tough program. In terms of how you found this working in New South Wales, does the program allow for any differentiation based on different demographics? One of the things that we have heard through this inquiry is that, for example, trans and gender-diverse men and Aboriginal and Torres Strait Islander men will have particular needs and particular risk factors.

Mr Stone: Yes, absolutely, it does. The structure of the website is such that it tries to be very customisable to what the man seeking help needs, while not necessarily overwhelming them with choices. It does not, straight-up, say, "Enter in all of these details about yourself," but you can. It is designed so that you can filter down the results to look at LGBTIQ-focused services or Aboriginal and Torres Strait Islander focused services, or you can just get the full list. There is absolutely the ability to hone it down, but there is not a requirement to, in the way it is set up.

MISS NUTTALL: In terms of the overall messaging and approachability of the website, do you find that the language, "Doing It Tough," is tested to resonate with those particular cohorts as well?

Mr Stone: Yes, absolutely. We co-ran the website in New South Wales with Australian Men's Health Forum, who have strong links with the male community and the male suicide lived experience community. We had a panel of men who have lived experience of suicide from a variety of different causes and from a variety of different backgrounds, so that it was resonating across those different backgrounds.

MISS NUTTALL: I was interested in the discussion in your submission of the relationship between suicidality and natural disasters. Do you have any specific data on what impact this is having in the ACT, or whether there are any programs that are attempting to address that?

Mr Stone: I do not think I have a good answer to that question. In general, it is one of the many factors that can put people at risk of suicide. The importance is around planning for that aspect of the repercussions of natural disasters. Too often, rebuilding from natural disasters is purely focused on physical infrastructure and not on community resilience. It is really important to make sure that we are taking that into account as well.

MISS NUTTALL: Do you find that that is something on which people engage with you specifically? Do you think there are any service gaps in terms of the link between men experiencing suicidal ideation and supports that will specifically address the concern as it relates to natural disasters, climate anxiety and things like that?

Mr Stone: One of the things is about having effective suicide prevention training. There are a range of different training programs out there by various different providers that provide very short training, often as little as two or three hours, that simply sets a person up to be able to ask the question in a comfortable way, "Are you thinking of harming yourself?" and to be able to respond effectively if the answer is yes.

That sort of basic training is really important across a range of different contexts, because many people in the community can get into a conversation where they think, "I think this person might be in trouble, but I don't know what to do about that." Certainly, in emergency response workers of all stripes, that absolutely could be happening. While they are talking to someone who has lost their home, they could be in a level of distress that is unrelated to the financial impacts but just comes from the fact that they are distressed.

MS TOUGH: Looking at the recommendations you have made, recommendation 1 is to develop and implement a suicide prevention act. I know that a couple of jurisdictions have done that or are in the process.

Mr Stone: Yes.

MS TOUGH: Can you talk us through what that looks like in practice?

Mr Stone: Absolutely. Yes, we have an act in South Australia, and more recently in New South Wales. Both of those acts are very similar. There are three key things that legislation can do. The first is that it can set up a jurisdiction-wide plan. Obviously, a plan can be done without an act, but an act can enable that plan to have a bit more teeth in terms of its implementation.

The second thing that an act can do is require agency plans. In both South Australia and New South Wales, there is a requirement under the act that all departments—in the case of the ACT, it is directorates—must have a suicide prevention plan. That means parts of government that do not realise that they impact on suicide have to think about this.

We find that this is about unlocking the creativity of public servants. Public servants are there to help people, but they are also very concerned with doing their job, as they should be. If there is a clear parliamentary signal that suicide prevention is their job, it enables them to get engaged with this issue, and many of them are already engaged with this issue—say, in their personal lives. They can start thinking about things from the point of view of their particular expertise. They can start thinking about how we can structure gambling regulations to ensure that we are minimising distress, and implementing those regulations in a way that will work in the industry that they know well, for example. That is the second thing that it can do.

The third thing that an act can do is that it can embed lived experience in government decision-making. It can set up, say, a lived experience council or a suicide prevention council with lived experience representatives on it. Again, this is something that you could do without an act, but without some form of legislative instrument, those sorts of councils tend to be at the whims of political change. A new minister is no longer interested in that issue, and it goes away, whereas having it in legislation makes that body a more permanent part of the government decision-making process.

MS TOUGH: Coming out of South Australia, because that act has been in place for a little bit of time now, has there been anything that has come out of that act that has been what you were hoping would happen?

Mr Stone: These things move slowly. Certainly, in South Australia, they have moved slower than we would have ideally liked, and I think slower than the South Australian government would have ideally liked. The suicide prevention plans are in fact only this year beginning to come into place, coming out of that act. But what we have seen is departments engaging in a real way with suicide prevention, whether it is police or education, in a way that we have not seen before.

Some of those departments have signed up as members, for example, of Suicide Prevention Australia. We are seeing a lot more engagement and a lot more thought. In terms of concrete outcomes, we do not have any sufficiently recent data to see any concrete outcomes at this stage, but it is looking very positive.

MS TOUGH: That is really good to hear. We will see how South Australia goes, but fingers crossed.

Mr Stone: Yes.

MISS NUTTALL: When would you expect to see that data reflect the trends of the act?

Mr Stone: I am entering very much into the realms of speculation here, but we do know that there is a long lead time. For example, with the research on natural disasters, you see a peak in suicide rates two to three years after the natural disaster occurs. Distress can go on for a long time and can become gradually more acute, as it builds on other things. I would not expect it to be immediate—that the plans come into force and, in the next year, we see a dip in suicide rates. I would expect to see a longer year trend, hopefully.

The other thing that is worth noting is that the death data, as I mentioned in my introductory statement, is not a very good way of measuring distress, because it can vary so much. What we hear anecdotally is that whether or not someone's sister was in town that week can be critical in whether or not they lose their life. It is very impacted by random factors. One of the things we would like to see is better data around attempts, so that we can get more about which is a better measure of distress, and more likely to be responding more quickly to those sorts of both policy and external impacts.

THE CHAIR: I asked the previous witness about the National Mental Health and Suicide Prevention Plan. What is your assessment of why that has not been effective? Is it your assessment that it has not been effective? What do you think the gaps or barriers have been to ensure that it has an impact on suicide rates?

Mr Stone: It has certainly not been as effective as anyone would have liked. I think we agree largely with the findings of the Productivity Commission, in terms of what has gone right and what has gone wrong. There has definitely been a lot of work, but whether or not it has achieved the goals that we want is much harder to say. Certainly, we are very hopeful that the next agreement—there is the early stages of planning around that—is looking to be a lot more engaged with the community than it was, perhaps, the last time around.

The critical thing is making sure that lived experience and service providers are engaged in that process, so that it is well designed to actually work on the ground, which will be important to state and territory jurisdictions, who are the ones who end up implementing a lot of this.

THE CHAIR: Is that part of what has gone wrong to date? Is it armchair policy? To be fair, that is what we are doing now; we are all in armchairs. Is it a matter of policy not being done with the people who will be required to implement it? States and territories are required to implement these commitments, but it is not the ministers implementing it; it is boots on the ground.

Mr Stone: Part of the difficulty is that, obviously, federal government has very lofty goals, which is good, but there needs to be this negotiation with the states and territories about how those actually get implemented. The more realistic the original process is, the easier it will be for jurisdictions to implement whatever is wanted. If the design at the outset is designed with service providers and with people who use the services in mind and involved, it will be a lot easier down the line. That is what I would say.

THE CHAIR: Impossible goals do not get achieved.

Mr Stone: Yes; and impractical ideas, and ideas without knowledge of what the barriers are and what is needed to be put in place.

THE CHAIR: One of our other submitters indicated that only three of the 117 actions in the national plan mention men. I am curious about your reflections on the importance of a gendered response. You have already touched on the fact that there are complex factors in all instances of suicide. Obviously, something that we are looking at through this inquiry is how important it is to have a male-specific response in certain settings.

Mr Stone: Can I clarify something? Are you talking about the National Suicide Prevention Strategy there?

THE CHAIR: I think he had said—

Mr Stone: The Mental Health and Suicide Prevention Plan does not have that number of actions in it.

THE CHAIR: I can check.

Mr Stone: I think that is the strategy and—

THE CHAIR: Yes.

Mr Stone: One of the things I should say about the National Suicide Prevention Strategy is that they have taken very much a determinants focus rather than a cohorts focus. Yes, there are not many of the actions that mention men. That is probably true of most of the other cohorts who are at risk of suicide, who would also not have a high number of mentions. Whether or not men are high enough is something to be debated. I do not think that the strategy should be judged that way. It needs to be judged more on its impacts.

There, the outcomes framework that the National Suicide Prevention Office is working on will be critical. It is critical that that outcomes framework actually measures the cohorts that we can. We absolutely can measure men. It is one of the easiest cohorts to measure, in terms of the data that we have. The way of addressing that is to make sure that the outcomes framework actually measures, "What are the impacts we are having on men?" to make sure we are getting to men.

It is absolutely important to have both a general response and a response that is focusing on at-risk groups. That is a little bit of a downstream approach. In practice, for all of these groups, whether it is LGBTIQ, Aboriginal and Torres Strait Islander or men, it is not the fact that they are in that group that is putting them at risk; it is all of the associated things that they are experiencing because they are in that group. The Aboriginal and Torres Strait Islander rates are higher not because they are Aboriginal and Torres Strait Islander, but because they tend to experience homelessness at higher rates, trauma at higher rates, legacies of colonialism, and those sorts of things. It is the same for men: they are experiencing a whole bunch of other factors strongly. Focusing on the factors can be just as important as focusing on the men, if we want to reduce male suicide. Does that make sense?

THE CHAIR: Yes, of course.

MISS NUTTALL: In regard to a commitment to co-design services with men who have personal experience or lived experience with suicide, do you have any information on whether there is any co-design commitment that the ACT government has already undertaken in some form? Essentially, how is the ACT government doing on the co-design front with this kind of thing?

Mr Stone: In general, the ACT government does well, but I am not aware of any commitments. The advantage of legislative instruments is that they embed that commitment in a way that is not subject to the winds of political change.

MISS NUTTALL: In terms of that co-design process more broadly, I am interested in how we set that up. Obviously, with a topic like suicide, there is a risk of re-traumatisation at times. What does a good co-design process look like, and how can we make sure that we meaningfully embed lived experience without re-traumatising people who have experienced it?

Mr Stone: There is quite a lot of literature out there about how to consult well. In general, with some of the key points, the first thing is about when to engage, and the answer to that is: always. You engage early, you engage during the process, and you engage late, so that you are not either coming in with a blank page and going away again, or coming in at the end, when everything is pretty much decided.

There is being clear about what can and cannot be changed. Co-design is not always possible. Sometimes all you can do is consult. It is important to be clear about when you are co-designing and when you are consulting, and how much can actually be changed.

The final point—and this is really important to avoid re-traumatisation—is about feedback about whether or not these recommendations were taken on board. Not everybody's input will influence the final outcome, but they need to know that they were heard, and they need to know the reasons why that was not done. All of that creates a comprehensive consultation that avoids the need to keep consulting because it is not actually being properly heard. That avoids, obviously, re-traumatisation through multiple cases of, "I'm telling my story but no-one is listening." That is what we need to avoid.

In terms of that, there are a range of lived experience-led organisations out there, and organisations who are expert within the space who can provide assistance. That is work that Suicide Prevention Australia has done, and work that a number of our members have done. Engaging with those sorts of expert organisations can be really helpful in avoiding those problems as well.

We have had situations in the past—and I know other organisations have, too—when we have been running consultations, where we have had to have a conversation about, "No, we can't ask that," or "No, we must ask this." It is important to have those sorts of conversations to make sure that the consultation is being effective and safe.

MS TOUGH: I want to touch on the grassroots and peer-led support services that you have talked about in your submission. We have heard evidence from both Menslink and Men's Shed during the hearings about the programs they are running and the preventive side that is provided, without some men even realising that that preventive factor is there.

Mr Stone: Yes.

MS TOUGH: Could you elaborate on what you have seen in those programs and other programs, and any data you have managed to get on how they work?

Mr Stone: Obviously, those peer support programs are incredibly important. There is a bit of a lack of evaluation data of those programs. One of the things that we as an organisation do is that we run the Suicide Prevention Research Fund, which has, fortunately, recently been re-funded. A lot of that research goes into evaluations of those sorts of programs. It is important that we have more research. We do know anecdotally that they are very effective, and we know that it is an important part of general resilience-building. This is very much an upstream approach, which is what we want. We want a strong community. We want men touching base with other men well before they get to points of distress. It is really important for all of those reasons.

Jason, do we have, in the community tracker, data about seeking support from peer-based services?

Mr Delgado: We have, in our community tracker, which has already run over 13 quarters, an average of around one in 16 men who seek help via community services. That is the figure that we have.

MS TOUGH: Was that one in 16?

Mr Delgado: Yes.

MISS NUTTALL: Who currently funds the research for effectiveness? Who contributes to that research fund and who do you think would be best placed to do so?

Mr Stone: It is currently funded by commonwealth government. It is absolutely something that could be funded by anything. We are always exploring who can fund research, whether that be philanthropic research or, indeed, other jurisdictions chipping in. For instance, in Queensland, there is funding there, not through us but funding for research in suicide prevention and mental health.

The critical thing is having the dedicated research funds that look at suicide prevention; otherwise it tends to get neglected or lumped in with other things in a way that is not as productive as what it needs as a solution. We know that when we have a particular social problem, we want to direct research at it. We have special funds for looking at domestic and family violence. We have special research funds for looking at, say, road deaths. This is another one of these problems that needs targeted research funding.

THE CHAIR: On specific cohorts—perhaps it would be similar to an earlier answer—I believe tradespeople or apprentices are 2½ times more likely to die by suicide than other men their age. Do you have any insights into why that is the case, and is there sufficient targeted support for that cohort?

Mr Stone: There is data in the Causes of Death around professions, but because it is not linked to the populations in those professions, we only know about numbers of deaths rather than rates. You are right; certainly, we know that there are industries that are particularly at risk, including trades. It is one of the reasons why an industry-based approach has been a really successful approach in a number of situations. The MATES program across a number of industries like mining and construction has been really effective.

To come to your question about why certain industries have certain factors that make them more at risk, if they are male dominated, because men die by suicide, there will be more suicides there. Also, they may be industries where people are more isolated, particularly if it is an industry where you have to move around or go to different sites, like mining, construction or trades. There is less of that kind of cohesive support that might be coming from the people around you. That is possibly a reason. Ultimately, the solutions are about industry-based approaches.

THE CHAIR: On behalf of the committee, thank you for your attendance today. Please provide your answers to any questions taken on notice to the committee secretary within five business days of receiving the uncorrected proof *Hansard*. Thanks for the work you are doing; we really appreciate it.

BECKETT, MR CAIN, Chief Executive Officer, Carers ACT
GIBBS, MR PAUL, Mental Health Carers Policy Officer, Mental Health Carers Voice, Carers ACT

THE CHAIR: We welcome witnesses from Carers ACT. Please note that as witnesses you are protected by parliamentary privilege and also 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 raised in this inquiry are, of course, sensitive. If anyone is finding this hearing difficult we are very happy to take a break, and a duty counsellor is available onsite to provide support if needed. The secretariat also has a support handout available.

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

Mr Beckett: We would, thank you. So thank you for the opportunity to speak today. My name is Cain Beckett. I am the CEO of Carers ACT, which also delivers the Mental Health Carers Voice as the peak body for mental health carers in the ACT. I am here with Paul Gibbs, the MHCV policy officer. I acknowledge today that we meet on the lands of the Ngunnawal people and pay my respects to their Elders past and present, and to all families with connection to the ACT and region.

Carers ACT represents the more than 58,000 unpaid carers in Canberra and the ACT. This inquiry shines a light on some of the darkest thoughts people may face in their caring journey. These conversations are often difficult to raise, and for us to hear, but they are necessary. These issues are not talked about enough and talking about them is one of the most positive steps that we can take. Carers ACT has been clear for a long time that when systems fail to recognise and support carers properly the consequences are serious.

The carer suicide data included in our submission is shocking. We hear from carers every day about how hard things can get but we still had to double-check the figures. They highlight that we have serious work to do for carers. Suicide Prevention Australia notes that 71 per cent of carers experience suicidal distress. In Canberra that is more than 40,000 people. To put that in perspective, that is eight whole suburbs of Canberra's carers who have considered suicide.

Caring can be meaningful but it also brings significant impacts. Research is consistent that carers report lower levels of wellbeing, high psychological distress, poorer physical health, more financial strain and social isolation. Each of these is a recognised risk factor for suicide. When combined with being male the risk is even greater. Although the ABS Survey of Disability, Aging and Carers reports that only around 28 per cent of primary carers identify as male, we know men are often more much more reluctant to describe themselves as carers for a range of reasons.

The gendered expectation of caring often leaves men isolated and waiting until crisis to ask for help. When male carers do engage with us, they describe how positive it feels to be supported and connected. When they open up about the issues they face, they are very similar to those faced by other carers. Reducing suicidality among male carers starts with addressing the basic issues they continue to face: recognition, belonging, information and access to a break when they need it.

Our recommendations in our submission centre around the key preventative actions that we can take: bringing in recognition initiatives that carers want, such as the carer's recognition card; updating the ACT's Mental Health Act so that it better recognises and includes carers; and addressing the ongoing issues with respite in Canberra that leave exhausted carers with no access to a break. These measures are not simply supports but fundamentals that prevent carers from harm. I thank the inquiry for your attention to our submission and for the time to appear before you today. Thank you.

THE CHAIR: Thank you. I want to ask about respite. Where are the gaps? Which cohorts are experiencing the largest gaps in the ACT?

Mr Beckett: In terms of respite, and thanks to our recent opening in Crace, our understanding is that we are now the largest respite provider in the ACT. Experience is that the demand across Canberra in all forms of respite is almost bottomless given the scale of services at the moment. But in terms of gaps, the two most obvious ones are—respite is more available when you are already funded as part of an existing system. So whether you are part of the NDIS or you have an aged-care package, it is much easier for providers to deliver those services because there is a funding mechanism in place. So the first gap is where people fall through or do not sit in one of those two buckets. So that might be you have a chronic illness, cancer, something of that nature, or for whatever other reason, you might be a young carer. The services for people in those cohorts are almost non-existent.

The second issue is complex care. Respite is extremely challenging. You are providing services to people with very short lead-in. You might not have much awareness as a provider of their specific health needs and so most of the providers focus on low to medium complexity of care. So if you have particularly complex needs, again, there is a shortage of available services. That is also particularly the case for things like dementia or where there are complex comorbidities and the provider might not have the capacity to deal with one of the particular issues that the person faces. So I guess to summarise, I would say it is an issue across the board in terms of supply, but particularly in those two areas, it is really dire.

THE CHAIR: Is there any gender difference in people seeking out respite? Obviously, there is going to be a difference because there are fewer men who are carers or identify as carers, but—

Mr Beckett: Yes, not from a gender perspective that we see, although obviously there is the differential between people that identify as carers and gender is quite significant. I suspect that differential is not real. We have 28 per cent of carers identifying as male. I suspect that is because they do not even identify, not because 28 per cent of carers are male, if that makes sense. I would suspect the differential is much closer to the population average but we have limited data. But what is obvious is the differential between different cohorts and severities of care. So as I said, we, for example, hear, at the moment, a lot of demand for people in the NDIS. Carers ACT currently focus primarily on aged care-related respite, things like that.

THE CHAIR: You touched on it briefly in your statement, but what is at the root of that reluctance for men to identify as carers, do you think?

Mr Beckett: I think it is societal, to be frank, and I am not the expert in that, but it is I think almost a societal expectation that the majority of carers identify as female, and that has been the case for a long time. Did you have any other comments, Paul, on that?

Mr Gibbs: The issue, I think, is around this perception of masculinities and self-identification, which is different for everyone. I think the experience that I have with that—I have been involved in men's policy advocacy space for a long time—and it is just the continual tension about the stereotypes. Men will also often find themselves in what I have observed to be a double bind. So on the one hand, they are encouraged to talk about the way they feel, and then the other hand that comes along with that is the level of discrimination that actually occurs when you do start to talk about the way you feel because that is not what is expected. So it is complex and it is—I do not think it just sits in one explanation or another. Does that help with that?

THE CHAIR: Yes, it does. Thank you. It sounds like that would be a real barrier then for men who are carers—

Mr Beckett: Yes, that is right.

THE CHAIR: —seeking support, but then also receiving support. I know it is hard to quantify.

Mr Beckett: Yes, I think particularly in the case of carers, you have got almost the combination of those two factors. One is the factors that make caring something which increases the risk of these issues, but also then the fact that if you are male as well. Also, 40 per cent of carers have a disability themselves, which is another factor. It all—I think in this case it is almost a perfect storm. But yes, difficult to put precise numbers because we do not measure these things very well. As I have said before, it is an issue which I do not think gets enough airtime, is discussed enough, because it is concerning to talk about and people tend not to talk about these issues, just in general. So I think even just having a conversation about it is a really good thing.

THE CHAIR: It is a good start, yes. Thank you.

MISS NUTTALL: You mentioned that one of the things you would like to see is including psychosocial wellbeing as part of the definition of mental illness. What impact are you hoping to achieve by including psychosocial wellbeing in that definition? Could you walk us through that in a bit more detail please?

Mr Beckett: Yes, at the most basic level, better recognition and better inclusion of not only mental health but carers in the Mental Health Act means that the system that we are going to create as a result will better respond to the needs of that cohort. I think the challenge at the moment is carers are not even recognised in the system that we have created. I go around commenting, for example, that carers are the national health strategy. The design of the system at the moment in keeping people at home implicitly is about carers taking on more responsibility, but we do not recognise that role in the way in which we have designed the system.

So those changes that we are recommending to the Mental Health Act in particular are about ensuring that we can create a system which better responds to the needs of the people that it is designed to support. If we are not even including that cohort in the definition of the system then it is not surprising that the system does not adequately cater for their needs.

Mr Gibbs: If I can add to that as well.

MISS NUTTALL: Yes, of course.

Mr Gibbs: One of the things about the ACT Mental Health Act as it stands now is that it gives a very clear definition of mental illness. That definition is actually what drives assessment and then the application of the act because you cannot actually apply the act in the absence of that. So by broadening the definition, then we can start to be more inclusive of assessment—when you have got a level of distress in someone that is actually impacting their functional impairment. So in that way, at the moment, you can have—you might not be psychotic, but you might be distressed enough to think that suicide is the only option that you have and we know what the impact of that is. So what we see at the moment is people being turned away after they have been assessed because they are not unwell enough. And by that, I mean not unwell enough according to the definition in the act. We really need to think long and hard about what that actually means.

Mr Beckett: We had a discussion about that actually with the directorate yesterday as part of a working group from the community. If we think about carers and mental health as part of the health system, carers deliver more care every day than the entire hospital system combined and the system would collapse if they were not performing that role. So it is quite problematic then that in a sense the largest part of the system is not catered for in the legislation which drives the things that governments and departments and bureaucrats think about in how to respond.

Paul's point is a really good one, that that missing middle—I think that is the term that we are using—is one of the key issues. We have a situation where someone with a mental health issue might be too complex for carers and GPs to be dealing with but then are not viewed as complex enough to be supported by the primary and tertiary health system. So you have got a vast cohort of people in the middle that simply have nowhere to go.

One of the things that we have been talking about that would assist that is the primary challenge faced by carers and people with mental health issues, in particular, is that there is no system, there is no place where they can go to be assessed. In a sense we need a single no-wrong-door approach that you can go to one place and know that you will be able to get help from there. At the moment, you are redirected multiple times, you might not get support, you do not know where to go and it is really quite complicated.

If I can give my own personal example that I have been dealing with for the last couple of months. For the first time, my 12-year-old daughter has significant mental health issues at the moment. We have had two GP appointments, two presentations at ED, two specialist appointments in the last two months and we still do not know where to go or what is going on. That is not great.

MISS NUTTALL: No.

Mr Beckett: So an approach where you had a single comprehensive assessment and you knew that you could go there to get support that would direct you to the appropriate part of the system would be a really good approach.

THE CHAIR: Sorry to hear about that.

MISS NUTTALL: Yes.

Mr Beckett: Yes, and I am conscious that it is an epidemic. The stats are astounding and it is quite amazing that the system is just not able to cater for average everyday people's needs.

Mr Gibbs: So we talk about it in a variety of ways, but if a person, and I will use, if a man is distressed enough that he has pushed down all the stereotypes that are expected of him, and he has walked into an emergency department, and he has sat and waited for a very long time, and he has talked about how he feels and maybe because it is a chronic illness or a relationship breakdown or financial stress—all those issues have collided on him and he is told he is not unwell enough? I just think as a society we should be doing much better than that and I know that reviewing the Mental Health Act is going to cost money, but the potential for a more nuanced act to actually save lives is exponential and we really need to consider that. We will be asking for that again in the budget, as we have asked for that the last two or three years, and that is the reason why we are asking for that.

MISS NUTTALL: Absolutely. Just on that very quickly, I know another submitter has put forward the Distress Brief Intervention when it comes to presentations, which, you know, and level 1 obviously is that immediate compassionate response by trained frontline workers including in the ED. Is that something that has come across your plate before or is it the kind of thing that you think would be applicable here in the ACT as part of that compassionate response when someone reaches out for help?

Mr Beckett: Yes, I think the issue is, as I have described, when you are presenting with a mental health issue, if you do not fit in a particular box, then there is not anywhere to go. There is not that coordinated assessment or, okay, your particular issue is best dealt with by this particular place. I think that is one of the primary challenges. There are many—I was quite pleased, for example, when attending the community nursing clinic, the nurse actually said to my wife, "Did you know that there is this really great organisation called Carers ACT? They can provide a lot of help." And my wife happily said, "Yes, my husband is the CEO, but he will be really glad that you have mentioned that." I think even just being able to direct people to the right place to get help is a really good start.

Mr Gibbs: If I can just add really quickly that the research around brief intervention is extremely positive. So yes, of course, we would embrace that because there is evidence that speaks to its effectiveness. So yes, that would be a really smart thing to do.

Mr Beckett: There is a range of possibilities, but even, I mean, I have been talking about this for a while as well, our little thing here that we have got today about where you can get help from. We have been advocating for, again, to not forget the carers, that we should put the carers gateway number on the bottom of these things as well. So even just being able to advise people where they can get help from is one of the key things that I think we need. Because I think one of the challenges is that large cohorts of people are not even accessing the services that are available, let alone before we get to the fact that there are not services that are there.

MISS NUTTALL: Absolutely. Thank you.

MS TOUGH: I want to ask about the mental health of mental health carers. Obviously, caring for someone with mental health issues brings with it a whole range of emotional factors. It can be quite disruptive, being a mental health carer. Those carers, you have said in the submission, then report a lot of isolation, loneliness and significant uncertainty in their life, but there are less programs through which they can access respite, because of what we have talked about—

Mr Beckett: Underfunded.

MS TOUGH: with how the funding works and how mental health is captured, in a way. What happens with those carers, if they can no longer be carers because of their own mental health, and what happens to the people they were caring for? What is the downstream effect?

Mr Beckett: At the most basic level, everyone ends up in hospital. They fall through the cracks. There is not an appropriate response. It is a combination of, yes, when you are a carer, you experience these issues. When you are a carer who is also supporting someone with complex mental health needs, it is magnified. The societal response to those issues is not adequate. The health system response to those issues is not adequate.

It is also the case that you, as the carer, might require care yourself. I do not think there is an easy answer. It requires systemic and societal change, and a recognition that it is a serious issue that we need to deal with.

MS TOUGH: Unlike disability and aged care, where it is recognised that respite is something that carers need and having that recognition in place.

Mr Beckett: You can also see it, even in the way in which the NDIS is dealing psychosocial disability. That is one of the most problematic areas of the scheme at the moment. Carers come to Carers ACT for support with those issues as well. Even the systemic approach to the way those supports are funded and delivered is problematic.

Mr Gibbs: We know that mental health carers will predominantly put the person they care for first, over every element of their life, including their own mental health. Recognition of that is really important. We have talked about that in the submission.

The other thing is that the nature of mental health can be episodic and reactive to what is happening in a person's life, so things may be well for long periods of time and then they are not. That can happen suddenly. Again, you might be thinking, “This part of my life is over; my person is now settled,” and they have to start from the beginning again, with getting an assessment, going through the process and being with their person in an emergency department. I will say this again: at the moment, we do not have an act that is actually nuanced enough, nor is it nuanced enough to say that we should be expecting that carers have an opportunity to provide the history of what is happening for the person that they care for. And we do not. We need to change that. That is the third time I have talked about that.

Mr Beckett: An example, again, is helpful. I will use an example of a colleague of mine who I know is comfortable with me providing this information, but I will not share his name. A former colleague of mine on the Disability Royal Commission—he is a highly qualified lawyer—has severe mental health issues, to the point where, in the past couple of years, I believe I have saved his life on multiple occasions. He is currently trying to get access to supports through the NDIS. So far, he has spent more than $5,000 on reports that the NDIA have requested. They have most recently come back and said they need more information.

When engaging with the NDIS provider, the local area coordinator, to support him through this process, they suggested he should join a church group, in their response to how to deal with his mental health issues. That is just one person, but one highly informed person who should be able to navigate the system, and a lawyer with deep experience in disability. If he cannot do it, we are in serious trouble.

MS TOUGH: Thank you for sharing that.

Mr Beckett: I share that because that is the state of the system at the moment. It is in crisis.

THE CHAIR: We are out of time. On behalf of the committee, I thank you for your attendance today. Thanks very much. Thanks for your work.

Mr Beckett: Thank you so much. We really appreciate your time.

BARNETT, DR BELINDA, Senior Policy Adviser, Australian Psychological Society
MURRAY, DR ALEXANDRA, Head of Policy and Research, Australian Psychological Society

THE CHAIR: We welcome witnesses from the Australian Psychological Society. Please note that, as witnesses, you are protected by parliamentary privilege and 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 also recognises that some of the issues raised in this inquiry are sensitive. If anyone is finding this hearing difficult, we can take a break. We do have a duty counsellor available to provide support, if needed. The secretariat also has a support handout available.

Would you like to make a brief opening statement covering anything that is not in your submission?

Dr Murray: Yes, please.

THE CHAIR: Please go ahead.

Dr Murray: Yes, thank you. Good morning, members of the Standing Committee on Social Policy, and other people joining or listening to this hearing today. I would like to begin by acknowledging the traditional owners of the lands on which we meet. For my colleague Dr Belinda Barnett and I, it is the Turrbal and Yuggera people, and I acknowledge elders past and present, and extend that acknowledgement to any First Nations people in attendance today.

We know that our First Nations Australians are disproportionately affected by suicide, and hope that this inquiry can help work towards addressing some of the causes of this unacceptable gap. I would also like to acknowledge those with lived and living experience of suicide and the ongoing impact it can have on families, kin and communities.

I join you as a representative of the Australian Psychological Society, which is the largest and longest-standing professional association for psychologists and psychological scientists in Australia. We thank you for the invitation to appear today. We commend the ACT government’s commitment to addressing this critical issue and welcome the opportunity to contribute further.

In our submission, we highlight how psychologists and psychological scientists are uniquely positioned to be at the forefront of suicide prevention in Australia. As experts in human behaviour, psychologists provide evidence-based, effective and trauma-informed assessment and therapeutic interventions for individuals at risk of suicide and support for those experiencing suicidal distress. Importantly, psychologists attempt to address not only the symptoms, but also the underlying causes of suicide ideation.

We need to ensure that there is sufficient, affordable access to psychologists as a priority. As we have discussed, the psychology workforce is under significant strain, and we have previously advocated to the federal government that there are a number of ways that can help to increase the pipeline of psychologists graduating and being eligible for registration.

In addition to this, there are a number of ways psychologists can be used to their full scope of practice to make the best use of the workforce as it stands. This includes allowing psychologists working in the public sector the scope and resources to provide evidence-based treatment, not just case or risk management; and, as we have advocated in our response to the scope of practice review, allowing psychologists to refer directly to psychiatrists, and a prevention and early intervention approach. There are psychologists across all sectors, such as schools, forensic, organisational and community settings.

Thank you again for the opportunity to give evidence today, and we look forward to your questions.

THE CHAIR: Thank you very much. Your submission mentions that Canberra lags behind other capital cities in the number of practising psychologists per capita. Where do we rank compared with others?

Dr Murray: It depends a little bit on how you classify it. Is it a metro area, border, regional area, and so on? Of course, if you look across jurisdictions, the ACT is quite high, but that is because it is small and there are not too many regional or remote areas. Those types of statistics may give an impression that there are more psychologists than there are, compared to other metro areas. If you are just looking at metro areas, off the top of my head, it is in the bottom third.

THE CHAIR: Where are the gaps? In terms of a patient's or a client's experience, where is the gap? We have heard a little bit about a gap where someone is essentially in a suicidal crisis, has not made an attempt and is not being admitted to hospital. We have heard about gaps at that kind of level, where it is beyond scope for certain practitioners, but I suppose below scope, so to speak, for others.

Dr Murray: Yes, that is an excellent question. There are gaps all along the way. Of course, we would like people never to get to that point. Anything that can be done in that public health context in terms of prevention, like raising awareness, reducing stigma and improving health-seeking behaviour, of course, is a first step to get people recognising when they are in a bad place, that they do need support and they need professional support. It is about getting that support early.

It is about being able to afford access to care and access to appropriate care at the right time. We know, of course, that time is critical. For patients who can see a psychologist and get the evidence-based length of treatment that they need, it means that they might never need to go further—we hope that they never need to go further—into more intensive support.

With the gap that you might be referring to, if someone does not have a treating psychologist and they present at emergency, we see more and more presentations at emergency departments that are not equipped to do that kind of longer term care. Often they are then risk managed, I guess, to a point where they are able to be discharged. But if there is no further follow-up, the cycle, unfortunately, continues.

There are also people who may have been seeing an appropriate mental health professional, but they are still escalating; of course, more intensive and more concentrated care may be appropriate. It is about the availability of that and providing, again, the right course and the right concentration of that care.

THE CHAIR: What do you see as the cause of the focus on that? If someone has presented at an emergency department and has been discharged basically into no care or plan, is that because of the lack of practitioners to discharge to, in order to provide support? Is that because hospitals are under pressure? What is going on there? Obviously, we want to address things far earlier, but what happens when someone is in such an acute state? I have heard terrible stories of this happening, and the person does go on to die by suicide, when we know they are at risk.

Dr Murray: It depends. Every situation is slightly different. In my understanding of the normal way that someone goes through that process, a letter is written. It is usually addressed to a GP. Of course, we know that people who, from a social determinants perspective, are at greater risk of quite acute distress and in mental ill-health, often do not have things like a regular GP and a psychologist. A letter may be written, and it would be sent to a GP; then, if they are seeing a psychologist, there is a gap there, because the psychologist may not even be informed that the patient presented to the emergency department.

The other component is that there is no real capacity, in my understanding of the system, for that follow-up care, in that they are just discharged back into the community and have to almost start from the bottom up again—going back through the referral to a GP, then to see a psychologist. There is this missing middle.

MISS NUTTALL: Your submission observes that this committee should have a particular focus on trans and gender-diverse men. Could you please elaborate on the APS's understanding of the specific challenges faced by trans and gender-diverse men in this space, and about any potential service gaps that might exist in the ACT when it comes to supporting this cohort?

Dr Murray: Yes, absolutely. My understanding is that the ACT stands relatively well, when we are looking at other jurisdictions, in terms of dedicated support within the ACT government to draw attention to these issues. I do have to commend the ACT government there.

From our perspective, we know that transgender and gender-diverse people are at much greater risk of mental ill-health and suicide, and there is a whole range of reasons for that. Unfortunately, we know that there are much greater levels of discrimination and other aspects essentially of poor treatment, which contribute to mental ill-health and suicidal risk.

I drew attention to it because I did not see, particularly in the terms of reference, how they stood, in that they were very focused on men and boys. I wanted to draw attention to the fact that this particular cohort may have even greater risk than the greater population of men and boys at large.

MISS NUTTALL: In terms of the cultural safety aspect for psychologists, for example, we have previously heard evidence that trans people are less likely to reach out over the phone, because there is a risk of almost instant misgendering, when people assume the gender of the person on the phone based on voice. Are you finding that that is a challenge, either within the ACT or more broadly, in making sure that intake services, crisis support services, are trained to be able to support trans and gender-diverse folks?

Dr Murray: That is a great question. You may be aware that, from 1 December, we have a new code of conduct that is coming into effect for psychologists. All registered psychologists have to abide by that code of conduct. Through the Psychology Board of Australia, there are associated competencies that psychologists have to practise. In one of those, there is a much greater emphasis on cultural safety, and being able to adapt practice and be accommodating of diverse clients.

It is relevant to all psychologists. All psychologists need to be able to work with gender-diverse and transgender individuals to their scope. That may be providing a safe and welcoming environment to be able to identify whether they can provide support, and that they have the appropriate scope and competence to provide that support; and, if not, to refer to an appropriate service who can provide that support. All psychologists need to be able to do that.

Of course, there are psychologists who have more advanced expertise in this field. They undergo ongoing professional development, they have peer supervision, participating in communities of practice and so on, that build on that expertise, so that they are able to provide the most appropriate care for transgender and gender diverse. Not everyone can do everything—that is clear—but it is in our code to be able to provide at least that kind of safe, welcoming environment and be able to then refer others onwards, if appropriate.

MISS NUTTALL: Obviously, the code is just coming into place. For a lot of people, when they were going through their training, it might not have reflected that expectation to be such a welcoming service to trans and gender-diverse people. What are the expectations, I suppose, of updating your training so that you are brushing up on professional development and community of practice for psychologists? Is that readily available and is there an expectation that psychologists will do it?

Dr Murray: This is the Psychology Board of Australia. There is an expectation of cultural responsiveness and culturally reflective practice. For psychologists, it is a very individual process of maintaining that competence and being able to demonstrate that they have reached that competence. Everyone will have a slightly different way of feeling that they need to work to reach that competence.

We are not at a point of mandating training or things like that. How it stands is that it is up to the individual practitioner to be able to gauge. The APS provides training. We provide professional guidelines to our members on how to interpret the code, how to implement the code in practice. That might mean XYZ; that might mean having professional development in this area. It might mean partnering with local organisations in lived experience, or whatever it may be. It gives examples of how to implement that in practice.

MS TOUGH: I want to pick up a bit on what you were talking about earlier with Mr Emerson about the referrals. We talked about where someone presents at hospital and they are discharged and referred, usually back to a GP, but sometimes, if they do have a psychologist, the psychologist might not actually get the referral. If they do not have a regular GP, the GP to whom that person is referred might not actually have contact with that person. There is that gap.

I am also interested in the general referral pathway. If someone has to see a GP, and then they get referred to a psychologist, there can be quite a long wait time in that time period; the psychologist they are referred to might be full and you need to find other providers. There are community-based services that a person might be engaged with at the same time. How do you see that framework working for better communication between all providers?

Dr Murray: A fantastic question. Of course, having a GP as the central point of primary care, and ideally having a consistent GP, is a particularly useful coordinator of care, services and so on. For the reasons you have just identified, that sometimes is not a reality and it is not possible to have that kind of ongoing, consistent relationship.

There are a number of ways. Yes, we have advocated streamlining the process. If someone does present at their usual GP, they can have a mental health treatment plan created, which would then give them access to a psychologist under the MBS. The number of sessions is limited annually, and only a certain proportion of the rebate is provided under those items. With the psychologist, there is the waiting period, which we hope is as short as possible. But when they do see a psychologist, they do have to go back to the referring GP for review. Again, that can interrupt treatment, there are additional costs and so on.

If, for whatever reason, the psychologist feels that there is a need for inpatient care, intensive care or psychiatric care, the psychologist would have to send the patient back to the GP, because the psychologist cannot refer directly to a psychiatrist—again, creating an extra step. It goes even to the point where there is a provision under Medicare in terms of case conferencing. This pays for three—currently, it is three—practitioners to be able to discuss a particular patient and their needs, and what might be the appropriate next steps.

The issue is that psychologists cannot initiate those case conferences. If a psychologist is in a situation where they have a patient in front of them who is increasingly acute, they will just have to call the GP. That can be outside the normal session. It is not covered by Medicare. And they are relying on the GP to then follow up and get them into the appropriate care. There are lots of opportunities for delays, costs and so on along the way.

MS TOUGH: On the MBS, although we are the ACT and do not have control over the MBS, I am still interested in its flow-on effects. From memory, during COVID and slightly after, the sessions available increased from 10 to 20 and some could be accessed by telehealth.

Dr Murray: Correct; yes.

MS TOUGH: So there were additional MBS items to make it more flexible in how people could actually access a psychologist. When those sessions increased to 20, what response did we see? Were people using up to the 20 sessions, because they were available? Was it impacting how much other people could access a psychologist? What were the practical impacts of that doubling?

Dr Murray: It did increase to 20. Psychologists can still provide psychology services by telehealth. So that is still in place. But you are right: the number of sessions that are covered in any year was reduced back to 10. There are a number of issues with that that we have consistently advocated to the federal government. It is not evidence-based. Ten is quite an arbitrary number; it is not based on clinical judgement and it is not based on need.

There may be some patients for whom that is sufficient—it will cover what they need; it is an appropriate course; and they are back in the community, as they should be—but, for many patients it is not sufficient and so, depending on their personal circumstances, they pay for additional sessions either completely out of pocket or with the help of private health insurance if they are fortunate enough to have that. Psychologists tell us that often they are trying to space out those sessions. So, again, it is not according to clinical need and it is not according to the judgement of the treating practitioner. It is basically about stretching out resources across the year to minimise the financial burden, which of course is significant at the moment in our cost-of-living crisis, so to speak.

There are implications for this, of course, in the long-term. Not being able to provide a full course of treatment means that, for whatever reason—that spacing is not appropriate, the concentration is not appropriate, the length is not appropriate—people can come out of that process not being fully treated. They might be able to continue on for a while, but often what happens is there is relapse or something else happens in the future and then they are back again into the system. To see the full benefit of being able to provide a full course of psychology treatment is important. There are also the long-term effects of actually getting people well and not re-entering the system at a later date.

MS TOUGH: You mentioned that someone does their 10 sessions, but they have to go back to the GP at some point. Is that four or six? What is the number? How does that work?

Dr Murray: My understanding is that it is after six sessions. There is an initial session with the GP. They have up to six sessions and then they have to go back to the GP for review and then they can have the remaining four. There are some exceptions to that—for example, people who have been diagnosed with an eating disorder. But that has other rhythms of review and so on. Again, the review is arbitrary. That is not a clinical judgement on, "It would be helpful to go back to see your GP now." It is arbitrary. Then, when there is maybe a need for the psychologist to be in contact with the GP, the case conferencing items can constrain it as well.

MS TOUGH: When it was increased to 20, were there people missing out on seeing a psychologist or having longer wait times because of the 20 sessions, or was it really still the same and it just meant that people who needed it were actually getting a more thorough treatment?

Dr Murray: My understanding of that data is that there was no evidence to suggest that people were missing out. There were increased wait times and increased demand. There was a global pandemic and there were other reasons why there were a lot of people trying to see a psychologist, like the ongoing effects of disasters and so on—this is nationally. So there was increased demand but, from my understanding of the data, it was not the case that there were people missing out.

I mentioned those longer-term benefits of getting people to do a full course of treatment. I have to be realistic, though: some people would need more than 20 sessions, particularly for complex cases. There are situations where a person would need more than 20 anyway. Again, 20 is arbitrary but it is a better situation than 10.

MS TOUGH: Thank you. I appreciate it.

THE CHAIR: On behalf of the committee, thank you both very much for your attendance today and also for your submission. We really appreciate your work in this area.

MS TOUGH: Yes; thank you so much.

Dr Murray: Thanks for the work of the committee too. We appreciate it.

Short suspension

STEPHEN, SMITH, MS RACHEL, Minister for Health, Minister for Mental Health, Minister for Finance and Minister for the Public Service

ALOISI, MR BRUNO, General Manager, Mental Health, Justice Health and Alcohol and Drug Services, Canberra Health Services

HUDSON, MS ROBYN, Deputy Director-General, Health and Community Services Directorate

MASHHOOD, DR AHMED, Acting Director of Clinical Services, Mental Health, Justice Health and Alcohol and Drug Services, Canberra Health Services

NAGLE, MS DANNIELLE, Acting Executive Branch Manager, Mental Health Policy and Strategy, Health and Community Services Directorate

THE CHAIR: Welcome back to the public hearings for the committee's inquiry into men's suicide rates. We welcome Ms Rachel Stephen-Smith MLA, Minister for Health and Minister for Mental Health, and officials. 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 recognises that some of 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 available on site to provide support if needed. The secretariat also has a support handout available. Minister, you have indicated that you are keen to make a brief opening statement—so fire away.

Ms Stephen-Smith: Thank you, Chair. I want to start by acknowledging and recognising those with lived and living experience who have presented to this inquiry. The ACT government is strongly of the view that policy is strengthened by being informed by the voices of lived and living experience, and that is something we are strongly committed to.

In preparing for this inquiry, I cast my mind back to a town hall in 2016, in the lead-up to the 2016 federal election, where the then Leader of the Opposition asked a very crowded Albert Hall for people to put their hand up if they had been directly affected by a suicide of a family member or friend, and more than a third of people in the room raised their hand. So I recognise that this is an issue that not only touches individuals but also ripples across our community.

I am one of those people who has a lived experience of having lost someone close to me to suicide. It is 10 years this month since my then partner Michael died by suicide. While Michael's circumstances were somewhat unique—and I am very, very cautious in taking lessons from his or my own experience or assuming that they are more broadly applicable—I know what it feels like to live with the "what ifs". What if I had done something differently? What if someone else had, or what if he had?

I am also aware that Aboriginal and Torres Strait Islander people live disproportionately with the reality of suicide and suicidality in their families and communities. I want to acknowledge specifically the level of trauma, distress and ongoing anxiety that this creates, and to particularly acknowledge the strength of First Nations communities and the organisations who work in this space. I want to recognise the other organisations and advocates who have given evidence to this inquiry, and whose views you will be considering, and who work with people, families and carers and the wider community who have an experience of suicide or suicidality every day, and thank them for the work that they do.

THE CHAIR: Thanks, Minister. I appreciate you making that statement and sharing that with us, particularly around the timing for this inquiry and hearing. I want to ask about gaps in the service system. The Capital Health Network indicated—I am not quoting them verbatim—that they are not aware of any specific services that target someone or intend to support someone experiencing an acute mental health crisis where suicidal ideation is present but a suicide attempt has not yet been made. Does the government agree with that assessment and have plans to address this specific gap?

Ms Stephen-Smith: I will hand over to Mr Aloisi, but I think for many people the first port of call if you are experiencing suicidal ideation but have not yet attempted suicide is likely to be someone close to you in your circle, a professional—whether that is a psychologist or a counsellor—or potentially your GP or other primary healthcare provider. So I do not think it is accurate to say that there are not services available that support people who experience suicidality who have not attempted suicide. In terms of specific supports, I will hand over to Mr Aloisi to talk and then maybe the directorate to talk about what is available.

THE CHAIR: Thank you. Just to clarify: it is really focused on a very acute crisis point.

Ms Stephen-Smith: Okay, yes.

Mr Aloisi: I would agree with the minister; I do not think it is accurate to say that there are not services available for those people who experience suicidal ideation in the absence of an attempt. A large proportion of the people who we see who present in some form of crisis actually fit that category.

There are multiple ways in which those people might access our service. Obviously, one pathway is the Access Mental Health Line where we will frequently receive calls from people who might be experiencing thoughts about self-harm. That is one common pathway. It might be the individual themselves, a family member, a GP or another referrer. So that is one pathway.

Another common pathway that people enter the acute system is through presenting through an emergency department—again, not necessarily following an attempt at suicide. But, often in the absence of that, they might present because they are feeling vulnerable in a way that they feel that they need to access help. So there are those services in terms of access.

In terms of the follow-up, the follow-up is a very individualised thing. I would say that the follow-up for a person who might present after an attempt or a person who is just experiencing ideation can actually be quite similar. It is not as though the follow-up needs to differ. But, in saying that, it is individualised. It obviously is based around the assessment of that individual and their circumstances in terms of the factors that I suppose are predisposing them to feeling that way and what the protective factors are for that individual—so looking at what are the strengths of things that will protect that person. That is done across the board.

So, regardless of whether the person has actually attempted suicide or not, a follow-up plan is developed. There is a safety management plan that is developed for that individual and that follows that person. For example, if a person presents with suicidal ideation and, because of the assessment, indicates that the risk is too high for that person to be transitioned back to their normal sort of home environment or support in the community, they might be admitted to an acute mental health facility, and obviously the treatment, care and support will be provided through that avenue until that person is safe for discharge.

Alternatively, if that person is assessed either through Access or in an emergency department and it is assessed that person can be supported safely in the community, that might be their pathway too. There is follow-up that is provided to that person post-presentation, and that can come in many forms—depending on whether the person is a new client to the service or are a known client to the service, for example, in terms of which particular part of our service they will be linked with. So I would say there actually are those supports definitely at the acute end in terms of follow-up and support for people who present in the absence of an attempt.

THE CHAIR: Who is providing those follow-up supports? We just had the Australian Psychological Society appear and they were talking about discharge plans after a hospital presentation generally being, I suppose, prepared and then essentially the responsibility of a GP. We know in Canberra that lots of people do not have a GP. How does that work here? I understand what you are saying about there being services, but I certainly have heard from people who say, "We have not been supported by those services." What is your assessment of what that gap might be?

Mr Aloisi: The services and the supports can vary markedly depending on the individual in terms of the level of support they need. Again, there is no one-size-fits-all approach. For example, if someone is well connected with a GP or has a private psychologist or a community agency they are working with quite closely and has a good relationship with them and you can expect that person to reasonably engage with them post our assessment, then that would figure quite strongly, I would envisage, in any of their discharge planning.

In the absence of those things, there might be other supports that the clinical services might provide directly. That is not to say that, even if all those services or supports are around people, we will not be involved. Often, because of potentially the risks involved with that person, we will have some form of ongoing contact until that risk profile is ameliorated to the point where we feel it is safe for that person to rely on those supports alone.

So it is a combination of direct services we provide as well as those supports identified for the individual. In the absence of those types of supports, part of our job might be connecting that person with referrals with various agencies—again, depending on their particular need.

Ms Stephen-Smith: I do not know if Ms Nagle wants to talk briefly about the work that the directorate supports, including Safe Haven, which obviously is a specific response to this.

Ms Nagle: I agree with Bruno what has said. There is also Lifeline, which is for anyone that is in acute crisis. Lifeline has those referral pathways to services, including Canberra Health Services, where they can make those direct links. For the other services that we fund, particularly those that may have interventions or clinical interventions, the expectation is that those services, as part of a good risk assessment, also do suicide risk assessment. The expectation is that any of those services that we fund have referral pathways as well to appropriate care, including when someone is in suicidal crisis. Those mechanisms are built into the community services that we fund.

Also, under the National Mental Health and Suicide Prevention Agreement, there are things that the commonwealth and the ACT government fund. We co-fund some things and there are also some things that the commonwealth funds separately. In universal aftercare, the ACT government and CHN have been funding the Wayback Service. That is the voluntary non-clinical suicide aftercare program. It provides 12 weeks of outreach to support recovery. That was established in 2023. We also fund Minds Together, which is an online and face-to-face training program for families, friends and carers who are supporting someone who is in suicidal distress. Sometimes with suicidal distress, it is not just an in-the-moment thing; it can be continuing as well and can have peaks and troughs. So it helps support those families and friends to be able to support the significant other in that.

We have also just recently entered into a contract with Roses in the Ocean. They are establishing a Peer CARE Companion in Community program to provide lived experience and peer service in the ACT. That will be a dedicated peer-based service. The minister also referred to Safe Haven. That has out-of-hours support, and they often see people in distress. Sometimes it is suicidal distress. They have a very close working relationship with Access and with HAART to be able to make referrals and be able to provide that onsite immediate support.

As far as postvention, we have StandBy. That is a commonwealth-funded telephone and face-to-face support for members of the community and organisations affected by suicide. They have an extensive range of online resources. Thirrili National is funded by the commonwealth to provide a national postvention service. Our clinical and community sector services are very well connected and well aware of Thirrili and use it quite extensively.

THE CHAIR: You mentioned the commitment through the national agreement to the objective of achieving universal aftercare services to support individuals following a suicide attempt and/or crisis. I have heard from the family of a young man whose life was recently tragically lost to suicide. They described aftercare as non-existent and said that there was no contact from anyone to the young man or his family after his attempts. Why am I getting that feedback?

Ms Nagle: I am sorry to hear that. I think that there is always room to improve. The Minds Together program—which we have recently refunded—is a good example of that service being made available. We also recognise that there is a space for youth and we have asked the Youth Coalition to lead a co-design for a youth aftercare service for young people aged 12 to 25 during suicidal crisis. They have commenced that process as well.

THE CHAIR: On this promise of universal aftercare, do we have data on the number of people who are engaged and receiving that and the number of people who are not? I am just trying to understand the gap between the reports I am getting and the number of programs and so on that I am hearing from officials.

Ms Nagle: I do not have the numbers on how many people are engaged in those services or have been engaged in those services. We can certainly take that on notice and get those. I think it is also about the work that we do to try and get the message out to people about the services that are available. We have a collaborative that includes over 50 organisations who are involved in suicide prevention in some form across the ACT. Part of the work that they do is to work with other organisations and to make sure that those organisations that would come across these people are able to actually make those referrals and are aware of what is available.

THE CHAIR: If you are taking on notice how many people are engaged with the service or have been engaged, can you also take on notice—and I do not know how the data would be tracked—the number of people who have presented to a Canberra health service of some kind, having made a suicide attempt? I guess I am trying to get at the proportion of people who have made an attempt and have then received aftercare support.

Mr Aloisi: I think we can take the question on notice. But I would just point out that it is challenging with the data, because the way things are coded into the Digital Health Record and how it is based on the international classification for diseases. So the way it is actually classified in our system might not necessarily indicate whether there has been an attempt or not. It does not include the specificity of that. So you might look in the actual file that would give you all that information about an attempt, but my sense is that, in the way it is actually coded in the system, we do not have that level of granularity in being able to extract that data. For example, a person could be coded as presenting with depression or an acute psychosis and a suicide attempt might actually be part of that presentation or suicidal ideation might actually be part of that presentation as well. So, with the way it is coded in the system, I think we would have challenges in providing that data. But I am happy to take that on notice.

Ms Nagle: We would be able to provide the number of people accessing the services that the ACT government funds.

THE CHAIR: Yes, sure. That seems like a pretty big data gap. I understand what the DHR is supposed to do, but if we are not able to track how many people who have made an attempt or considered making an attempt have then completed an attempt, that seems like a massive gap. It makes it hard to deliver on the commitments made under national agreements, local plans and so on, don't you think?

Mr Aloisi: There was some work done a few years back with the Health Directorate at the time, in terms of trying to work out how we could pull that data out of the system. This was pre DHR; I know there was quite an extensive investigation. It involved things such as looking for keywords in initial triage documents at the emergency department, for example; it would search for specific language or words. There have been previous attempts to do this; again, it is challenging because of the way that these presentations are coded through our system.

Ms Stephen-Smith: Also, you are looking at a very incomplete dataset when you are looking at Canberra Health Services. Pre DHR, just to be clear, you would have been looking at multiple different data systems. Mr Aloisi mentioned ED; that will be, obviously, the presentation point for many people who are in crisis, acute distress or have a physical injury as a result of a suicide attempt. Again, the way that the emergency department gathers that information might not be conducive to being able to pull it all together.

In addition, someone may have had a suicide attempt or come close and then ended up presenting to a private provider, like a GP. I think we need to be a little bit cautious about the idea that if CHS could gather a set of data around its knowledge of suicide attempts and its knowledge of completed suicides, that would give us a full picture of what was going on in the community. I am not convinced that that would actually be the case.

THE CHAIR: Absolutely not. What I am saying is that when the ACT government knows someone has made an attempt, that is a critical intervention point. I am hearing about services being provided at that point, but I am hearing from families who feel that those services have not been provided. If we do not know how many attempts that we should know about, or actually do know about but are not tracking, if that is the gap that I am speaking about, it would be hard to paint a comprehensive picture of the entire situation. I will pass to Miss Nuttall.

MISS NUTTALL: On page 6, among the cohorts and groups more at risk of suicide, suicidal ideation, you mention men with a slightly higher education level as being more at risk. On balance, a lot of submissions have identified a lower education level as a higher risk of suicide. I am interested in what you mean by a slightly higher education level in this context, and the evidence that you drew on. What evidence brought you to that conclusion?

Ms Nagle: Could you ask that question again, please?

MISS NUTTALL: I will give it another crack.

Ms Nagle: Thank you, yes.

MISS NUTTALL: On page 6, and I will find the page in the submission, so that I can see—

Ms Stephen-Smith: It is quite a long list. The paragraph in question says that, in Australia, those most at risk are men, Aboriginal and Torres Strait Islander people, LGBTIQA+ people, people who are not married, including separated or divorced, individuals living alone, without a partner or children, people aged between 45 and 54, those with a slightly higher education level, people who are unemployed or not currently working—who clearly would have a lower income level and engagement in work activities—individuals with specific occupations, most notably labourers, machinery operators and drivers, and people with comparatively lower income levels, and those requiring assistance, such as disability support, government pensions or income support.

We do recognise the comparatively lower income levels as well as the slightly higher education level. When you look at some of the occupations, a number of those occupations would be occupations where the formal education requirements for those occupations would be less. It is an Australian dataset; I do not know whether—

Ms Nagle: One of the things that we have seen over time in suicide prevention is that we know there are sometimes cohorts that are more at risk. For example, we know that, particularly through the time of the bushfires, veterinarians were more at risk of suicide. This was particularly in New South Wales.

Ms Stephen-Smith: That is still the case.

Ms Nagle: That is still the case now. We know that pilots can be more at risk of suicide. There are times when doctors, particularly more junior doctors, can be at risk of suicide, because of the pressures of the job. There have been interventions around that. In fact, through the work that we have done with the ACT Coroner, looking at cohorts et cetera, and through the data and responses done with CHS, we knew that, a few years ago, we were seeing increased suicides amongst the university sector, amongst students as well. We have set up a tertiary education provider working group to be able to look at that and address that. It sometimes seems to be certain cohorts with that education where there are particular pressures and stressors around the job, because of the nature of the work that they do.

Ms Stephen-Smith: That data, Miss Nuttall, is drawn from the National Suicide Prevention Office, and there is a link to that information, so I am not sure that we would be in a position to say how that conclusion was drawn, given that we are just quoting the data and information that is available from the national office.

MISS NUTTALL: I probably misread the placement of the footnote on that one.

Ms Stephen-Smith: I will correct the record. That is not where that data comes from, because I recognise that the footnote is on the previous paragraph. I think that has probably flowed over.

MISS NUTTALL: Is that the explanation—that it is not necessarily by virtue of having a higher education level, but it is the specific professions that you end up in that require a higher education level, where you would expect to experience some specific distress?

Ms Hudson: I recognise the privilege statement. It is really important to understand the difference between causality and association, and this is not a causality. You could not necessarily make that statement—that, because you are higher educated, you are more at risk than for any of the other components.

MISS NUTTALL: That is really helpful to understand; thank you.

MS TOUGH: The government submission talks about the Chief Psychiatrist undertaking a review of the Mental Health Act 2015. What is the status of the review and when will it be completed?

Ms Hudson: The requirement is that it will commence somewhere between August 2025 and August 2026. The Chief Psychiatrist is in the process of gathering together a workforce to help him to execute the requirements of the act. I believe that it will commence early next year.

MS TOUGH: Is there a timeframe for how long it might take?

Ms Hudson: It is two years from the start, as stated in the act.

MS TOUGH: I am wondering when it will start.

Ms Hudson: You have a window, as a deadline; then you start counting from the commencement date within that window.

MS TOUGH: That puts it at the start of 2028; it should have finished, roughly, by then.

Ms Stephen-Smith: It is fair to say, though, that work has already commenced. While the review will formally commence, work has already well and truly started in relation to the review of the Mental Health Act. Probably, we will be looking to try to complete it in a tighter timeframe than the maximum two years that is allowed. We are obviously conscious that there will be some amendments to the Mental Health Act that are coming through outside that—quite likely, anyway. There are some existing recommendations that will probably be wrapped up into the review, and we want to act on those recommendations sooner rather than later. We will try to get the work done in as timely a way as possible.

MS TOUGH: With the timing of this inquiry, recommendations may be able to feed in. That review will be ongoing as we wrap this up?

Ms Stephen-Smith: Yes.

Ms Nagle: Correct.

THE CHAIR: I want to ask about the ACT Mental Health and Suicide Prevention Plan 2019-24. The plan promised annual reporting on implementation progress, including latest data, lived experience, input and case studies. Where are these annual reports?

Ms Nagle: That is the regional plan. With Capital Health Network, while we develop it together with them, they have responsibility for developing reporting against the regional plan.

THE CHAIR: It is fully in their court. I asked them about it and they had to take it on notice.

Ms Nagle: We do know that they are doing a review of it at the moment, because they have talked to us about that. They involve us; of course, we are involved in that. But with the responsibility for reporting against it, CHN lead that.

THE CHAIR: Are you aware of whether those reports have been prepared? I think the plan promised three progress reports before the final report. That review is the final report; that would be my assumption.

Ms Nagle: Yes.

THE CHAIR: With data and progress towards outcomes, reporting on the experiences of consumers, carers and the workforce under the plan. I understand what you are saying—that it is their responsibility to do the reporting—but I think the government would be pretty invested in what the report has found.

Ms Nagle: Yes, and we absolutely have been; we are involved in that, and we work with them on it. But we do not do the reporting ourselves.

THE CHAIR: Have you been provided with any of those promised progress reports—the three progress reports?

Ms Stephen-Smith: We will take that question on notice. Apologies; it is before our time, in terms of the conclusion of that in 2024.

THE CHAIR: The Productivity Commission's interim report on the National Mental Health and Suicide Prevention Plan recommended that Australian state and territory governments publish all implementation plans and jurisdictional progress reports developed under the next agreement. Is this something that you are anticipating playing a more active role in, under any future agreement—the publication of these reports?

Ms Stephen-Smith: Certainly, from my perspective, it is part and parcel generally of engaging in these processes that we would report regularly. My record is one of instituting new reporting and making sure that we do report regularly on things. I do not see why we would not do that. Obviously, we do not have a new national agreement at this point. We have only just received the Productivity Commission report.

Health and mental health ministers were briefed by the Productivity Commission on its interim report earlier this year. We have had some conversation about the work that needs to be done to develop a new agreement, including the degree to which we need to separate out some conversation around suicide prevention versus mental health and suicide prevention as a single issue. My expectation would absolutely be that reporting would be part of the process.

THE CHAIR: On the regional plan, Capital Health Network indicated during their testimony that a revised or a new plan has been drafted currently. They said they were in the final stages of drafting and that it should be finalised very soon. Do you know where that is up to, and what role is the directorate playing in the drafting progression on that one?

Ms Stephen-Smith: Yes, a framework plan has been finalised. I thought we had just released it.

Ms Nagle: It has not been released just yet.

THE CHAIR: To be fair, they were one of the—

Ms Nagle: Capital Health Network are doing the finishing touches.

Ms Stephen-Smith: Okay.

THE CHAIR: They were one of the first witnesses.

Ms Stephen-Smith: It has been agreed, and it is up to Capital Health Network to determine the timing of release in that case.

THE CHAIR: Okay.

Ms Stephen-Smith: It has been agreed by the ACT government and Capital Health Network.

THE CHAIR: Okay. Is that a new plan?

Ms Stephen-Smith: Yes, it is—

THE CHAIR: A new five year—

Ms Stephen-Smith: Yes, that is right. Dannielle can speak more to this, but what has been agreed at this point is a framework plan, and that will sit above a—I cannot remember what the Capital Health Network called their part of it.

Ms Nagle: Their aims and—

Ms Stephen-Smith: Their aims and implementation strategy. It will also guide and support our commitment to a mental health services plan that we have committed to finalising by the end of next year. We have been doing this work with Capital Health Network to support what is the ACT government's mental health services plan, and that is something we committed in the election to finalising by the end of 2026.

THE CHAIR: We asked organisations, including Meridian and A Gender Agenda, about their consultation on the new plan. To be fair, this was during our first hearings, a couple of weeks ago.

MISS NUTTALL: The middle of October, I think.

THE CHAIR: A few weeks ago. A month ago, or something like that. They said they had attended a roundtable about the new plan in early 2025 and anticipated more consultation. But at that time they had not heard anything further. I assume, since the plan has been developed, finalised and approved by the government, there was no further consultation beyond that roundtable?

Ms Stephen-Smith: There has been a bit of an adjustment of our approach. Part of the previous consultation, of which there was a bit, was around the development of a new mental health strategy for the ACT. There was also a requirement in relation to the work with the Capital Health Network and for it to produce and take carriage of a regional plan. It appeared to me, coming into the portfolio late last year, that there was quite a lot of duplication between those activities.

We had made the election commitment around a more concrete mental health services plan that was really focused, rather than repeating the same nice words in a strategy that we all aspire to, but they are already embodied in national agreements and strategies. Our focus was going to be on a practical delivery document, and we could embed the vision and the objectives into the joint work with the Capital Health Network, which is the one we were just talking about; we had previously been consulting on the development of a strategy.

All of that input has fed into the work with Capital Health Network about the framework and it will feed into the next round of consultation about the mental health services plan. There will be consultation in 2026 that is more specific around ACT government mental health services planning.

THE CHAIR: I am confused. Why is there a regional plan? Obviously, there is a national agreement; the Productivity Commission was very critical of that and basically called for a complete rewrite. We are going to develop an ACT mental health services plan, but there is also a regional mental health and suicide prevention plan. There are a lot of plans.

Ms Stephen-Smith: This is why I—

THE CHAIR: I can tell you share the—

Ms Stephen-Smith: This is why I said we are not having another strategy.

THE CHAIR: Yes. What is the plan for integrating all the plans? The criticism that the Productivity Commission made—or my read of it—was, “Looks fantastic; kind of hard to deliver.” It has not been delivered. “Let’s go back to the drawing board and prepare something that can actually be delivered.”

Ms Stephen-Smith: Yes.

THE CHAIR: In the meantime, people are dying by suicide. I know I am joking about plans for plans, but—

Ms Stephen-Smith: All of this also sits under the National Suicide Prevention Strategy, which is relatively new. Part of the challenge that we face is that there a lot of words on paper. Going to your specific question, the reason that the regional plan is important is that it is the place where we had that conversation with CHN, as the representative of the commonwealth funding arrangements for primary care, and as a funder and co-commissioner of a range of mental health services.

It is really important that we collaborate with CHN around who is doing what, so that we reduce the number of overlaps and gaps, and the siloing across the mental health system. The Albanese government has been investing in new mental health initiatives, like the Medicare mental health centre and the Medicare Mental Health Kids Hubs. Recently, there was Gidget House, in relation to perinatal mental health, and we fund the perinatal mental health and wellbeing service. Of course, the commonwealth funds headspace. We fund a range of child and youth mental health services. There is an absolute need for us to work together and figure out who is doing what across the whole landscape and, where we can, to collaborate in the commissioning of those services.

Also, we need to ensure that our relationship is maintained, so that when they are unable to fund things that they have previously funded, we get early advice about that. In the most recent budget, we provided ongoing funding for WOKE, at the University of Canberra, for MindMap, which was an agreement, as part of the collaboration with the commonwealth, for the Stepping Stones program run by Marymead CatholicCare. Both WOKE and Stepping Stones were programs that were originally funded by CHN. The funding then ran out, but they had become embedded, as part of our ecosystem, and highly valued in the community. Now the ACT government is funding them.

We want to try and avoid that situation in future and build a system where we are investing consistently for the medium to long term and not have both sides running a whole range of different pilots that then do not come together in a cohesive way. Again, it is about having that navigation. I have not had an opportunity to watch most of the hearings, but I am sure people talk about navigation in the system and having certainty about what services will be available from one year to the next. Certainly, that was something that came up at the Mental Health Community Coalition AGM yesterday.

My view is that we need to try to build a more consistent service system, and not have this next shiny new thing investment, without thinking about how it fits into the wider existing ecosystem. I am sorry; that was a bit of a rant. You just got me on my hobby horse there.

THE CHAIR: I love to know. I have taken up a lot of the call, so I will pass it on. Being new to the portfolio, you will obviously look at what looks like, frankly, a bit of a mess, in terms of the service system. There are three entities responsible for different things and a whole bunch of plans.

Ms Stephen-Smith: Just to be clear, no-one is suggesting that the previous minister has left it in a mess—

THE CHAIR: No.

Ms Stephen-Smith: Everybody is so passionate about it. Everyone is doing work, but that work is not necessarily as well coordinated as one might hope, which is what the Productivity Commission alludes to as well—particularly the agreement. The agreement is not a strategy; it is an agreement about how to deliver better. That is what it should be doing.

THE CHAIR: I guess my question was: what is the key thing to do moving forward to address this and actually see a turnaround in the data, because things have been getting worse? Is it that coordination that you are talking about? In your assessment as a minister—

Ms Stephen-Smith: I think it is about building a more integrated system in which it is easier for people to find the right support at the right time. That is absolutely key, and we should be able to do it, but it is not easy. It is not as easy as it sounds.

THE CHAIR: It sounds tricky.

MISS NUTTALL: The submission outlines quite a comprehensive list of programs for mental health promotion and prevention that are available in the ACT. I appreciate that you have provided a breakdown of the list of programs. I was interested to observe that the project grants that are not men-specific in the name saw a minority of clients identifying as men. It ranked at around 13 per cent to 49.5 per cent. Why do you think this is?

Ms Stephen-Smith: Do you have a page number in the submission, Miss Nuttall?

MISS NUTTALL: It is not necessarily on one page; it is throughout the list of programs that you mention. It is from page 8 through to—

Ms Stephen-Smith: I see what you mean.

MISS NUTTALL: It is embedded within those paragraphs.

Ms Stephen-Smith: As a general proposition, what we tend to see is that women may be more likely to undertake help-seeking behaviour, and the stigma associated with mental health and the sort of stoicism that men are expected to exhibit are barriers to help-seeking behaviour. But, of course, we also have specific programs that are aimed at supporting young men in particular.

Ms Nagle: That is correct. One of the reasons we see men disproportionately affected by suicide is that they are less likely to talk about it, less likely to seek help, less likely to go to their GP, and less likely to even have a conversation with their family members. This is part of the challenge of suicide prevention work. There is no doubt about it. This is one of the things that we are trying to improve and we struggle with. The conversation around stigma and shame is really important, and being able to recognise when things go wrong for a person, particularly a man. Often feelings of being trapped and that there is no way out cause suicide. They might not necessarily go to those services first of all.

There are a number of services that we fund that are for men. The Health and Community Services Directorate funds Menslink. They have the Silence is Deadly program. There is Men’s Table as well. The Capital Health Network funds that. We have one for tertiary education students, regarding programs that are particularly targeted towards men. The other thing in trying to improve and trying to understand this is that, recently, Men’s Table initiated a men and boys’ wellbeing—

THE CHAIR: Summit.

Ms Nagle: Was it a summit or forum?

THE CHAIR: Summit.

Ms Nagle: Some people here were present. Since then, we met a second time. It is in its infancy at the moment, but it will be forming a collaborative of the willing, to ask, “What are we missing? And how can we turn the dial?”—recognising that there are services that more men access—and "What can we do in those spaces to have this conversation?" so that we can start talking about this, particularly around suicide prevention and the wellbeing work.

MISS NUTTALL: A couple of submissions have pointed to this. A lot of the reference is done by Slade and other authors. It talks about the lack of evaluation of programs that support men across Australia. Something like 20 per cent of programs are evaluated in the way we would like them to be. Do you see a role for the ACT government in providing support to evaluate the programs that we currently have, on a rigorous evidence based or research level?

Ms Nagle: Under the work that we do with the commonwealth, under the National Mental Health Suicide Prevention Agreement, there is a data evaluation group. The ACT is a member. In February this year, they released the national evaluation framework. That evaluation framework is particularly for commonwealth funded services that they would like to use. It is a very good framework that we, in mental health and suicide prevention, have taken on board and started to implement. It is well developed. It has been developed with lived experience and Aboriginal and Torres Strait Islander input as well. The expectation is that we want to do better evaluation and have better data collection as well. It is really important. Also, under the work and strategy of the National Suicide Prevention Office, data and evaluation is a big part of it. They have just released their strategy and will be providing data and work reports.

Ms Stephen-Smith: This was something that came up again yesterday at the Mental Health Community Coalition AGM, and it speaks to something Mr Aloisi said earlier about data capture in clinical records. There is a real step-change opportunity in relation to the use of AI and technology to do better outcome data reporting. There is the ability to use large language models to go through actual clinical case notes to pull out changes or patterns that would take a really long time if a researcher were trying to do it. It would be really hard for a human to draw out those patterns. That is not necessarily on the agenda for this week, but there is a real opportunity to think differently about how we capture data and then evaluate genuine outcomes rather than the counting widgets thing, which is often what we do in terms of the reporting that we ask our partners to do.

MISS NUTTALL: Thank you.

Mr Aloisi: Definitely from our service perspective, we are very keen to get more client-rated measures of their experience. For a long time, we have relied on the clinician-rated measures, in terms of outcomes. We have introduced things like the YES survey, which is the Your Experience of Service survey. That is where the consumer gets the opportunity to provide their feedback on the service, in terms of how safe they felt and whether they felt their needs were met. We are starting a pilot in CAMHS for a carer experience survey, because that informs our service improvement. The more that we can capture information about people's experience, from both the consumer and the care perspective, really assists us.

MISS NUTTALL: Does that go to their experience if they are in a particular high-risk group? Obviously, there are men, but, for example, does it go to whether the experience of the service was gender-sensitive, if you are gender-diverse, or your experience if you are an Aboriginal or Torres Strait Islander person?

Mr Aloisi: It has some questions that are universally applicable to all mental health consumers, and it is based on where the service is delivered. People can complete the survey at our sites. That information will be collected in respect of the service, whether it is an adult community mental health team or a perinatal mental health service. It is collected on site. It applies to the particular service, but there are very universal questions that allow for comparison across areas as well.

MISS NUTTALL: Is there an opportunity to test cultural safety and cultural sensitivity? It seems to me that, if we are asking those questions, if we can ask them in the appropriate way, it gives us a better picture of the services people currently feel safe accessing.

Mr Aloisi: In terms of the YES survey, it is a fairly standardised assessment. We use that. But, absolutely, there are other opportunities where we interface, not only through evaluation of our services, where we can tease out those particular issues, but also through other feedback mechanisms that we use. We have consumer feedback processes that people can feed into as well, and they are always available for people, particularly if they have had a negative experience in relation to an issue like that.

MISS NUTTALL: Do you know if services are proactive in talking to people? You can imagine that, when someone comes in, they might not actually feel that they have had a culturally safe experience. If you are transgender or gender-diverse and people have not necessarily been understanding, you might not be in a position where you seek to proactively make a complaint. There is a tendency for a lot of people to minimise their experiences. Do services actively seek out that feedback?

Ms Stephen-Smith: I would have to say that it probably relies on the person coming forward, for the most part. In any type of interaction with the service, we will often invite the person—for example, if they raise a concern—to either speak directly with the service manager or, as I said, if they feel more comfortable, go through the feedback pathway. There are probably a lot of those types of questions we could ask people on a more proactive basis, but there are challenges in doing that across a large service.

MISS NUTTALL: Thank you. That is helpful to know.

MS TOUGH: I want to touch on perinatal mental health. I know we do a lot in the perinatal mental health space, and I have disclosed before that I have benefited from a lot of the services that have been funded in that space, particularly at the Perinatal Wellbeing Centre. We heard some evidence on the first day of hearings about fathers' experience of perinatal mental health, especially in the first couple of years, because there are huge life transitions that come from becoming a father. What support services are there for new dads—dads of any age but particularly in that perinatal phase?

Ms Nagle: That was actually one of the topics of discussion at the summit that we talked about, with regard to what can be done. There was broad recognition that that is a time when more can be done. In the Health and Community Services Directorate, we do not fund anything specifically for fathers. The Perinatal Wellbeing Centre does work with the families, though. We fund them to do that work with families. As part of Community

Services, there are parent programs and family programs. I can take the question on notice with regard to what is actually done for fathers and parenting.

MS TOUGH: That would be very helpful.

Ms Stephen-Smith: There are some dad programs at the Child and Family Centres. There are probably two elements: there is what is being done to support men's mental health in the first couple of years of having a child, and we have made a commitment around expanding access to parenting programs—the work with parents-to-be before the child comes and disrupts their life, around what the change will potentially look like and trying to ensure that expectations are more closely matched to what the reality might look like, so that they understand what the reality could be—a lot of different things—and the support that is available prior to being in a situation where you are stressed out and need it. It comes back to, as Miss Nuttall was saying earlier, early intervention and prevention. Preventing the crisis in the first place will be—

MS TOUGH: Yes—having those preventative things in place, even though parenting programs do not look like mental health programs. It is about management. If you could take that on notice, that would be great. Thank you. I appreciate it.

THE CHAIR: When Vinnies were here, Ben Fitzgerald said that a couple of years ago there used to be an assertive mental health outreach worker from CatholicCare who worked with people who were sleeping rough. They engaged through the Street to Home program. He indicated that this role no longer exists. He said they really need what Street to Home does from a case management perspective. Do you know if that role was ACT government funded? Was it de-funded? Is there any plan to reinstate a role like this?

Ms Stephen-Smith: I cannot speak specifically to the Marymead CatholicCare role, but I know that Marymead CatholicCare continue to work with Vinnies and Street to Home in relation to their AXIAL Housing program. While they continue to lobby for an expansion of that program, it is specifically focused on ensuring that people with significant mental health challenges who are sleeping rough can be housed through a housing-first approach. I am also aware—and I will hand over to Mr Aloisi—that the City Mental Health team has a Homelessness Outreach Team that works with a number of people who are sleeping rough in the city in particular.

Mr Aloisi: We have the Homelessness Outreach Team. In the last few months, we started a collaborative with Marymead CatholicCare, particularly knowing that we have a large number of mutual clients that we see, more from the clinical mental health perspective, in terms of psychosocial support. We are developing a key relationship in terms of how we support each other. That is a way of looking at the person more holistically. Supporting a person from a mental health perspective helps them with other psycho-social determinants. That relationship is one that we highly value. The Homelessness Outreach Team also works more broadly across the homelessness sector. They have established relationships with a number of community agencies in this area.

THE CHAIR: What does that look like in engagement on the ground? The sense I was getting from the witness is that they feel that—and the Street to Home is an amazing program—they almost have to go beyond scope when they are engaging with someone.

It is supposed to be a housing service, fundamentally, but they have to also do the mental health stuff. It seemed like you would like to have someone there with them who is focused on that side of things.

Mr Aloisi: Yes.

THE CHAIR: I am curious about what it actually looks like in engagement on the ground.

Mr Aloisi: There will absolutely be times when we do joint visits, for example. We find where that person might be rough sleeping or we find common places that homeless people might attend, whether it is for meals or other support. We try to organise joint visits so we can provide that support. Sometimes we have to acknowledge that our availability to support might be a bit stretched. I absolutely acknowledge that there will be times when they are providing a lot of that wraparound support and are doing a lot of heavy lifting in terms of getting a person the appropriate support. We have to acknowledge that. I agree with the statement that these programs do an amazing job in very challenging circumstances.

The key for us is engagement. Sometimes coming in as a government service, and particularly a mental health service, can be met with specific reactions. Sometimes people are less likely to engage with us by the virtue of the fact that we are a government service and we are a mental health service. It is unfortunate, because of the stigma and perhaps some of the associations that go along with that. As much as possible, we try to build engagement through our connectivity with those community agencies, because that is a really good way for us to get our foot in the door.

MISS NUTTALL: When the Homelessness Outreach Team goes to support someone, is there a threshold of mental ill-health or complex need beyond which the outreach team would not feel equipped to support someone who is sleeping rough?

Mr Aloisi: We would tend to see people more at the acute end. That would be our focus. It is fair to say that a lot of homeless people experience a spectrum of mental health issues. Our involvement is probably more at the moderate to severe end of the spectrum. That is where we engage. In terms of the types of circumstances we might have challenges in engagement, that might if there are issues around safety to staff, for example. That will be where we unfortunately might need to engage another service. That might be a team like PACER or the police, for example, to help us gain access in a safe way. We deal more at the acute end of that spectrum.

MISS NUTTALL: You mentioned Policing and PACER. When there is a threat to staff safety, will you sometimes engage community organisations who are specialised in the area or make referrals to them?

Mr Aloisi: It would depend on the circumstances. It often depends on the relationship. Sometimes the aggression and violence are unfortunately targeted towards our staff because of what we represent to that person. We have to acknowledge that. We would not refer a person to a community agency if we felt we were just transposing that risk over to them. We would not want to do that. It is assessed on an individual basis. If the person has a well-established relationship with that community agency and has no history of, for example, aggression or violence in that space, that might be where a community agency might feel more comfortable. Again, that would not be a predetermined outcome by us; that would be by agreement with the community agency. As I said, we would not want to place them at risk that we would not expose our own staff to.

MISS NUTTALL: Thank you.

THE CHAIR: You mentioned police. The Alcohol and Drug Foundation spoke about the benefit of local drug action teams. They have six such teams in the ACT, but said that ACT Policing is neither an elite partner nor a supporting partner in any of those teams. They said the nearest police-led local drug action team is in Wagga. Is this something that would help? Obviously there are people who need support here in the city. Often their contact point might be police as opposed to a service provider. Is that something that you would be supportive of? Have you had any conversations about that?

Ms Stephen-Smith: I have not had any conversations about it. I am not sure of the extent to which it is a matter for this portfolio versus policing. I will take the question on notice, Mr Emerson, and will try to find some further information.

THE CHAIR: Thank you. A more general question on that is: what is your understanding of referral pathways when police come in contact with people? I am thinking about people who are using substances, perhaps are sleeping rough and have mental health challenges. These are the people we struggle to get to the most, and they might end up in a suicidal situation. The public just call the police. What are the connection pathways with ACT Policing?

Mr Aloisi: There are very direct pathways for us. There is our relationship through PACER—the joint collaborative with Policing and the Ambulance Service. That is one such mechanism. Referrals through that pathway can happen. We often get calls from police directly in those types of circumstances, where they have come across someone who may be sleeping rough and, from their interactions, they detect or assess that there might be some concerns around the person's mental health and/or alcohol and drug issues. We get referrals directly in that way. Those pathways are pretty well established. We have a lot of mechanisms in place in terms of direct access through PACER and Access Mental Health. We have regular governance frameworks which include police. Our relationship with police is fairly well established. Most police, in terms of the mental health literacy training they receive, would be educated in those pathways as well.

Ms Stephen-Smith: It is really important to reflect that—Mr Aloisi, you can correct me if I am wrong—a number of the mental health challenges that people would face in the community or in sleeping rough do not necessarily mean that they are experiencing suicidal ideation, either at that point or as part of their mental health experience. At the same time, police are often first responders where there has been a suicide or an attempted suicide. Their role in this space is critically important. The work they do is extremely challenging. I want to acknowledge that.

MISS NUTTALL: I completely agree with your assessment that the queer community is one of the cohorts that needs additional focus in this inquiry. I appreciate that, on page 13, you mention having developed resource guidance to support gender-affirming care in mental health in line with government and community partners, including the Office for LGBTIQA+ Affairs. How closely do you work with the Office for LGBTIQA+ Affairs to coordinate additional support for the queer community in this space?

Ms Nagle: As part of any of our consultation processes, we work with the Office of LGBTIQ+, and they have input into our policy and our programs as well. That is a key part of it. LGBTIQ+ were identified as a priority group in the strategic investment plan, recognising that they are a community group with high mental health needs, and also in suicide prevention.

MISS NUTTALL: Thank you. We have heard from other witnesses that one of the challenges that trans and gender-diverse people face and what might compound the risk of suicide or suicidal ideation is the fact that you cannot always predict which health services might, and often unwittingly, misgender people on the phone or are not willing to support them on an ongoing basis because they are not confident to do so. How closely do you work with health providers across the public sector, but also community and private sectors, to support trans and gender-diverse people accessing those services?

Ms Nagle: A lot of that work sits with the LGBTIQ+ office. We also ask, as part of our funding of services, that they maintain and update the development of their staff training. Many of those services access training from Meridian, for example, who provide that. Many of the organisations that we fund are also seeking Rainbow Tick accreditation and put that in their tenders. While it is not something that we may directly ask of them, it is something that we discuss with them—how they are doing that and the expectations that they are developing in providing those services.

MISS NUTTALL: Thank you. One of the recommendations that we have heard from stakeholders is a dedicated crisis line for queer folk here in the ACT. Is that something that you have ever scoped? And is it a call that you have heard from the community yourselves?

Ms Stephen-Smith: I am not sure that I have. I am also somewhat surprised that it does not exist at a national level. What the ACT tends to do from a cost-effectiveness perspective is to work with national organisations, particularly services that deliver 24/7 crises support outside of Canberra Health Services. It is certainly something that we would be interested in considering, but it is not something that is currently a commitment or on the agenda.

Ms Nagle: We work with Meridian and A Gender Agenda on any key initiatives that we are doing. We work with both of those groups. As part of the co-design that the Youth Coalition is leading and we are funding, regarding the youth aftercare service for those aged 12 to 25, this has already started to come up as part of the discussion about how we provide appropriate care.

MISS NUTTALL: Queer stakeholders have mentioned QLife as currently the best existing alternative, but I do not believe that is 24/7. Sometimes, they run into the same challenge that you get with a number of crisis lines, where, for a certain immediate attendance, they will ultimately refer to Access Mental Health. For some queer people, being referred to a government service might not be what feels right for them. That may be helpful context.

Ms Stephen-Smith: Yes. Thank you.

THE CHAIR: On behalf of the committee, thank you for your attendance today. If questions have been taken on notice, please provide your answers to the committee secretary within five business days of receiving the uncorrected proof Hansard.

Hearing suspended from 1.02 pm to 2.02 pm

KELLY, MS LISA, Chief Executive Officer, Mental Health Community Coalition ACT

NAIK, MS SMERA, Policy and Training Officer, Mental Health Community Coalition ACT

THE CHAIR: Welcome back, everyone, to the public hearings for the inquiry into men's suicide rates. We welcome witnesses from the Mental Health Community Coalition ACT.

Please note that as witnesses you are protected by parliamentary privilege and bound by its obligations. You must tell the truth. Giving false and 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 discussed 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 too. Would you like to make a brief opening statement before we go to questions?

Ms Kelly: Yes, thank you. We would like to make a statement. Thank you for your inquiry into male suicide in the ACT. We are very pleased to provide a submission. We would encourage you, in your deliberations around the submissions and the findings, to really consider suicide within a context of the broader space in which male suicide—we do know—has a higher rate of completion, but we know that thoughts of suicide and risk of suicide are equal across a range of demographics.

We would also encourage you to consider suicide as a spectrum and to really consider where along that spectrum we need to influence service delivery and changes. For us, suicide prevention is in preventing suicidal thoughts from occurring to start with and in looking at how community supports people. It is in how we meet the social determinants of health; how we decrease loneliness and increase community connection; and how we build the informal supports around people in order to prevent thoughts of suicide occurring in the first place.

Suicide intervention occurs when those thoughts start to occur and when people are aware that those thoughts are happening, and we can assist somebody to find alternative options than self-harm when they are feeling those levels of distress. Then we have suicide crisis, when those thoughts of self-harm are actually starting to cause behaviour or are likely to be an imminent cause of behaviour.

Then there is suicide postvention, which is the support we provide to people who have attempted suicide or come close to attempted suicide, and their families and friends, because we know that without good suicide postvention, we create another group of people who are at risk, who have been exposed by that suicide to start with. In the context of that is our submission of making sure we are looking at a broad system response to suicide, rather than just pointing to one particular part along that spectrum.

THE CHAIR: Thank you. I am going to be a pest and ask about one particular part along the spectrum.

Ms Kelly: Sure. I figured you would, but I wanted to lay a context first.

THE CHAIR: Your submission does make clear reference to the need for more assertive aftercare services. We have been asking about this through the hearings. What are the aftercare services currently like, and where and how does the ACT government need to improve this area?

Ms Kelly: There are two primary aftercare services. One is called StandBy, which is the service that is enacted usually following the death of somebody by suicide. That provides postvention support to the people most affected, so generally immediate family and friends. It is a national program and runs nationally. It is often enacted by the police and brought in when the police attend a death by suicide or are aware of a death by suicide. The second service—and I am going to desperately try and recall its name—is run by Woden Community Services.

Ms Naik: Way Back.

Ms Kelly: Thank you. It is is the Way Back service, and that is a project that was first started through an agency called Everymind, which is part of the Hunter Institute of Mental Health. It provides support for somebody for the first three months following an attempt, because we know that those first three months are the most dangerous for a second attempt and, possibly, consequential completion.

The challenge with the Way Back service is that we do not do good referral points through, and I would say that is true of most of our service system. What often happens is that somebody presents at emergency, having made an attempt at suicide; they are referred to the Way Back service, and that referral is sent to the Way Back service, but the person is then discharged from the hospital, and they go home, and the Way Back service then tries to contact that person through phone calls. Now, most of us, in this day and age, do not answer calls from numbers we do not know. If I am distressed, as well, or I have had an emotionally distressing moment, the chances of me answering a call and engaging in that sort of way are probably quite low. Then there is a follow-up email or a follow-up letter sent, and, again, the onus is on the person to have to engage back in with the service. We would like to see that service engage with carers more, because it is more likely, if the carer is aware that that service is available, that they will support the person to be able to access it in a more efficient way and in a more timely manner.

We fail to deliver service systems that recognise the consumer and the consumer's way of approaching help. Ideally, Way Back would operate at the hospital. It would be there. It would be able to be in the emergency room at the time the person presents. It would make a connection with the person there and then, and an agreement for a follow-up in that moment. Certainly, we know having things like Safe Havens on hospital grounds would also help facilitate those sorts of connections so that people are leaving the hospital with an ongoing connection to support and help.

THE CHAIR: And knowing that—"We are going to come and see you tomorrow, in the morning, and see how you are doing." That sort of thing. This is what you mean when you say "assertive". That is the gap, right?

Ms Kelly: Absolutely, yes.

THE CHAIR: "Assertive" means they are coming to you and not expecting you to call back.

Ms Kelly: Yes, or to take a random call from someone you have never met before. But instead, you and I have met, and you and I have met in my lowest moment. You have connected with me. You have promised me that you are going to come and see me tomorrow. Then you are going to turn up at my house tomorrow, and the chances that I am going to open the door and let you in are quite high.

Otherwise, you are turning up at my door, or you are calling me, and I do not know who you are. I am already in a vulnerable state, and you are asking me to engage with you. I think we need to be thinking about how we engage with people in aftercare at the hospital where they present, or wherever they are presenting, in a way that we can engage them that is more meaningful.

THE CHAIR: We just had the ACT government, and they were talking through the six-hour service that is available. I have spoken with a grieving mother who lost her son. She said aftercare services are non-existent in the ACT. Do you think that is why this particular person made that assessment?

Ms Kelly: Yes. Certainly, I have spoken to people who have found correspondence from Way Back—under beds, in cupboards—months after somebody has completed, who then expressed, "Well, if we knew that the service was there and if we knew that service had been attempting to contact our person, we would have intervened—

THE CHAIR: They could have helped, yes.

Ms Kelly: and we would have made sure that support was there, or we would have encouraged that support to be there." We know that the other new service being put in is a postvention service for family members and carers through Everymind—I think it is called "connecting minds"—has some information to help carers in that sort of postvention space, but, again, it does not necessarily connect with service. It does not have that connection point, and we continue to develop service systems that require the most vulnerable people to reach out for help, rather than the service system to reach in and provide help. I think, if we want to really make some difference, we need to find ways that service systems reach in, rather than waiting for vulnerable people to reach out.

THE CHAIR: Particularly once they have had a contact with the system.

Ms Kelly: Yes, absolutely. And we need to stop assuming that every consumer does not want their carers or their family members involved. We tend to have this base assumption that we cannot involve family. Even when family have presented at the hospital with the person and are aware, we do not then reach back out and assume that family can be involved. We hear everything from, "It is a privacy breach," which I struggle to see how it is, to "We are respecting the consumer's right," or "The consumer did not consent." And I think, "Did the consumer have capability to consent at that time?" The consumer has consented to their mum bringing them to emergency, so why do we now think that they are not consenting for mum to be called the next day to see if they are okay? We assume that that consent is not there, so we do not engage family, and family, or family of choice or origin, are going to be the people who are going to support that connection to care, absolutely without a doubt.

THE CHAIR: Over to you, Miss Nuttall.

MISS NUTTALL: Thank you. I am interested in talking about the Distress Brief Intervention model. It sounds like a very promising program, and other submitters have talked about the promising evidence that underpins it. In terms of the logistics of implementation, you have identified that community-based NGOs are well-placed to deliver this service. Could you please provide us a bit more detail about how you see the service working in the ACT context?

Ms Kelly: Yes, certainly, and I will get Smera as well, who has done the research. I was fortunate enough to be in Scotland and spent a day with the creators of the program, understanding how it operates and how it looks. I came back from that experience very committed to it and saying, “This is a model we need to sit within the ACT, because it fits with a number of things that I think we are missing.” What it does is that it stops the medicalisation of distress. In Australia, really, we have created a distress response that is medicalised.

What do I mean by that? I go to the doctor because my relationship is breaking down. He tells me I have depression and anxiety and puts in a mental health care plan to send me to a psychologist to have six sessions of therapy. So now, instead of having an emotional reaction to my relationship breakdown, I have got depression and anxiety. We are not allowing people to experience the pitfalls of life, and the ups and downs of life, and to have a support system around them to manage that as normal life, rather than as a medicalised diagnosis.

What I really liked about the Distress Brief Intervention model is that it acknowledges and recognises that most of us have distress in our life. Most of us have events that will cause distress in our life and for some of us, we have a natural village around us that will help us through that, and for a lot of us, we do not. The model then builds that village. It comes in through a central phone line; the service asks the person where they are most comfortable to meet with somebody—it might be at a pub. We send somebody not because they are a mental health professional but because they are compassionate, and they are trained, and they have got a natural empathy for people. We send them to the pub, and they talk about the distress. They talk about it and look at how they can problem-solve and how they can help get you connected back into your natural coping mechanisms. The more distressed we are, the more we lose touch with the things that we naturally know make us feel better, and we often need to be reminded of them again. That is how the program works.

If the worker goes out and discovers somebody is quite distressed beyond what is in the realm of their help, they refer them back into the system for more mental health professional support. We see it operating through a phone line system connected in with the Access phone line, where ambulances, doctors, police, family members and individuals can refer in for some support. The community agencies have a network of supporters who can work with those people for short periods of time, help them through the moment of distress, refer them back in, if need be, and, if not, connect them back into community as they have worked their way through their distress. That is the model we are proposing.

We know that this model has been implemented in different parts of Australia but not as true to the design of the model as I have seen it operate in Scotland. People are using it as a distress model or an intervention model for people who have become distressed with mental illness, and that is not what it was ever designed for. It was designed for people experiencing the normal distress of life and not for somebody who has got a mental illness who is having a distress moment. That is how we have been using it a bit in Australia, and it is not working as well, which is not surprising because it is not what it was designed to do.

The worst thing we could do with it is put it in the ACT but have it run through MHJADS, who will then have a very clinical diagnostic assessment criteria to it. It needs to sit in community mental health, where we can have a more psychosocial view of it and look at how we connect the person back into their social network.

Ms Naik: I think the easiest way to explain it is that, overwhelmingly, you have the response to suicide as a very clinical response to a person's attempt to take their life, so that is the thought that we need to fix. Whereas, if you take the example of a single mum who has just lost her job, she is worried about how she is going to feed her kids, and that is a very real, basic needs kind of problem that she is facing. So, instead, you would have her be connected through level 1 of the DVI, and she may be intercepted by an ambulance or something like that first, but then they will connect her to level 2, which is someone—like Lisa said—on the phone line in community that can help her connect to the food bank or help her with the Centrelink process and with finding work and that sort of community support that is required to get her to the next stage. The doctor cannot give you that, but the community can. That is really the best way to illustrate what it would be as well.

Ms Kelly: This is probably where the data is a bit divergent by gender, but we know, for the bulk of people, suicide ideation starts as a thought of an option in amongst multiple options, and as those other options become less available to people, the thought of suicide becomes more available or becomes louder. We know that good intervention or prevention starts when there are still lots of other options available and somebody can help with access to those options. Because if I can change the circumstances that have made me start looking for the options, then I will not necessarily have that suicide ideation there anymore. The mum who cannot feed her kids is a really great example. If we get food, if we get a good income, then the thought of suicide goes away, but if we cannot get those things, that thought increases.

Where it does change a little bit is that we do know that there are a group of men in particular who become quite impulsive, and the time period between thought and action is incredibly short and often fuelled by drug and alcohol consumption as well. They are probably the group that is the hardest for us to intervene in, because it can be an incredibly short period of time with very little lead-up. That is not all male suicide. I think it is really important that we say, "It is not all male suicide," but we do know—and, historically, for the time I have been working mental health—there is this group that is very difficult for us to intervene in because it can be very rapid and a very rapid progression. Really, the only way we might be able to intervene in there is to be thinking about how we engage innovatively with clubs and pubs and nightclubs and places where we can circumvent the thought. Because we also know if you can delay the thought, you often prevent the action from happening as well. I will say that this sort of Distress Brief Intervention is probably not going to work for that group, but we see great potential in it working for the majority, where you can see the progressive nature and the long lead-up from first thought to action on that thought.

MISS NUTTALL: Brilliant, thank you. I am interested, too, in where you see the implementation. Do you foresee that it would integrate with services like PACER and Safe Haven?

Ms Kelly: Yes, absolutely.

MISS NUTTALL: Beautiful.

Ms Naik: Yes, because they would be the level 1 of that model, the primary responder.

MISS NUTTALL: Awesome. Thank you.

THE CHAIR: And very quickly on that point you just made about this cohort of men who first think of suicide and shortly after there is the action, or relatively shortly after. Does that basically not exist among women? Is it less common?

Ms Kelly: It is less common in women, and we also know the reason is that women tend to use less lethal means. Often the period of time between taking an action and dying for women is longer, so therefore you can get a medical intervention. They are more likely to take an overdose; they are more likely to use cutting as a means, whereas men are much more likely to use a more lethal methodology.

The theory behind it is a weird one, and it is that women do not like to leave a mess behind and will try and die with less amount of mess. We do not have the data as strongly on women who are impulsive, because often the impulsive behaviour is not seen as impulsive because there is a period of medical intervention that can happen, as opposed to the young man who leaves the pub and wraps his car around a tree, which is much more lethal and much harder to see the pattern to.

THE CHAIR: Yes, thank you.

Ms Naik: I think the point, as well, that might be interesting to you is that we have seen evidence with the capacity for violence and risk-taking in men compared to women. Men are over-represented in suicide rates but also in homicide rates against other men and women. We mentioned Man Cave, which is a program that speaks with young men on identity and early development, basically tackling the comfort with violence from a young age so that that is not as much of a risk as they grow up. I think maybe that might be what you were thinking of as well.

THE CHAIR: Thank you. Ms Tough?

MS TOUGH: I was also going to ask about the Distress Brief Intervention model, because I was just so fascinated by it.

Ms Kelly: It is a really good model.

MS TOUGH: Reading it, I like that idea: everyone experiences distress, and you do not want to be medicalised in that moment; sometimes you just need someone to sit there with you.

Ms Kelly: Yes.

MS TOUGH: But I am also interested in the 4MH compassion and suicide training modules in workplaces and what they entail and how you would like to see that becoming standard and evaluated.

Ms Kelly: Smera has been running our 4MH program, so I will get her to talk to that.

MS TOUGH: Awesome.

Ms Naik: Yes, sure; 4 Mental Health is the full name. They are an organisation based in the UK, and they run the Connecting with People program. That is compassion-based suicide prevention training, as opposed to risk-based suicide prevention training, which is overwhelmingly what we see in the sector and in the clinical space as well.

That program has been funded by the ACT government right now, so we have delivered it all year, basically. It is currently delivered to community organisations and sector staff in two modules. The first one is Compassion at Work, or Compassion in Action: breaking down what the science behind compassion is, and where compassion sometimes leads to burnout as well and managing that. The second module is Community Suicide Awareness: what the safe language is to use with somebody who might want to speak about the suicidal thoughts they are having. What is language that might open that conversation for them? How to respond to distress and that sort of thing. How we plan to deliver it next year is still, I think, a work in progress.

Ms Kelly: What we see is the potential in this program to take it outside of the sector, rather than training mental health workers in how to be compassionate to people who present suicide, which there is a place for—

MS TOUGH: Yes, there is a place for that.

Ms Kelly: we see there is a broader place where this could sit. Interestingly, since we wrote the submission, MIEACT has launched their DoNOHarm training. One of the things we know is that people often will not ask about thoughts of suicide even if they are concerned about it in someone, because they do not know what to do and how to respond. This training actually takes away that need to have this checklist, risk response for people to intervene with and says, “When somebody tells you that they are thinking about suicide, the best thing you can do is just respond with compassion.” You say, “Mate, this must be really tough. Talk to me about what is really tough,” rather than where we have gotten, which is, “How are you going to do it? When are you going to do it? What are we going to do to keep you safe?”

MS TOUGH: “How am I going to intervene in this moment to stop you doing it?”

Ms Kelly: Yes—not actually recognising the profound statement that somebody has just made to you and being really compassionate and empathetic in that space. So we see that there is a place where 4MH could roll out through places like Men’s Table and Running for Resilience but also in workplaces and more broadly, in the building industry and places where we know there are high-risk populations, as a way of training people to say, “It is actually okay. It is okay to ask the question. It is okay for somebody to tell you this, and this is how you respond.”

The advancement, since we wrote the submission, is that I think there is a line between the 4MH and the DoNOHarm training, where we are saying, “This is how you compassionately respond to thoughts of suicide,” and the MIEACT DoNOHarm training is how you, as a listener, put boundaries in so you do not feel like you have to rescue this person. That allows you to do the limit you are prepared to do and nothing more than that. One of my fears is that I hear from people, who are part of running groups and walking groups and things, where they have had this encounter where somebody has told them after their run or their walk or at the coffee that they are thinking of dying or they are thinking of suicide, and I worry about the profound impact that has on the person who just went for the run.

MS TOUGH: They might have their own things going on and are not ready to hear that.

Ms Kelly: And they are then carrying it around for weeks thinking, “Did I do the right thing? Did I say the right thing?” And when people know what I do, they will often say to me, “I had this encounter, and I don’t know if I said the right thing, and I don’t know if I did the right thing, and I’ve been worried about it ever since.” Then I worry about what would have happened if that person had acted on that as well. What is left with this person here? How are we equipping the general public to be okay in having those conversations, and in not feeling responsible or taking the responsibility on, and in being able to say, “Mate, that is really heavy. I heard you. That is really big. I need you to go and tell somebody else that. I need to get you to some help around that. I am not going to be the person that can help you on that.” I think that is what we are seeing would be a really useful thing now: how we take the 4MH work and introduce a new way of responding to suicide and match it with some of the DoNOHarm training in workplaces in particular.

MS TOUGH: Yes, it does not sound that radical, really, when you talk it through.

Ms Kelly: It is not really. It is not. I think what we have done is that we have traditionally in Australia invested in assist training, which is great training. It is very valuable training, but it does push into this risk assessment space, and it assumes that people can be taught how to do risk assessment and will then stop on the bridge and do the risk assessment. And I am not necessarily sure that the general public can and will do that, and I know that it is not the best response to necessarily give at that time either.

Ms Naik: You kind of need a medium ground because there is also, I think, a general understanding—and we have heard it a lot from our attendees of our training as well—that if you ask somebody about having suicidal thoughts there is the concept that you are going to be putting that idea into their head, which is the opposite of what it is. It is more likely that they will have relief from being able to speak about it and then be more able to be directed to seeking help. But a lot of people are just scared to say it out loud, like a lot of stuff.

MS TOUGH: Scared to say it in case the person will then start having the thoughts—

Ms Naik: Exactly, yes.

Ms Kelly: I think if we are going to make a real difference with suicide prevention, really, we need to make sure everyone has some form of skill and education around it, and workplaces are the ideal place for adults in some ways.

MS TOUGH: The way to do it—yes.

Ms Kelly: I also think we need to be encouraging where community groups are at the grassroots and coming up and becoming wellbeing spaces, which we fully support. We do need to just recognise, though, that they then become places of vulnerability, so how do we make sure people who are in those groups are not putting themselves into places of vulnerability, where we are causing a mental health problem or a wellbeing problem because they are just generally being helpful people? How do they feel more skilled in that space?

MS TOUGH: Thank you.

THE CHAIR: We are out of time. I had a very quick question—maybe I will just ask it in a very quick way.

Ms Kelly: I will try and do a quick response, how is that?

THE CHAIR: Sounds like a good plan. I have asked you previously—I think it was during the estimates hearings—about the unmet need for psychosocial supports in the ACT.

Ms Kelly: Yes.

THE CHAIR: There are 4,000 people with severe unmet psychosocial needs, 4,000 with moderate. This was reiterated in the Productivity Commission review of the national Mental Health and Suicide Prevention Agreement a couple of weeks ago that was published. I asked you then if you had seen any action on meeting those needs. Have you since seen any action?

Ms Kelly: No. What we understand is that there is an agreement between the state and territory ministers and the federal minister to address the unmet psychosocial need through the National Mental Health and Suicide Agreement, which is due for a renewal, although the Productivity Commission has delayed that. We are asking for an immediate investment in an uplift in unmet psychosocial needs. My understanding is that that is all held up a little bit with the health agreement and some of the joys of us living in a federated country!

But we will continue to push that. I will say, we need the funding, but we also need to understand what the service ecosystem needs to look like too. Just uplifting that funding into existing services I do not think is the way to meet the unmet need. It will meet some of it, but we are still missing a range of services and infrastructure that we will need as well. In the meantime, we are working hard to say, "What would it look like in the ACT, and what do we want to fund across the spectrum? But, no, ultimately there has not been any movement since we last spoke about it.

THE CHAIR: Okay, thank you.

Ms Kelly: Not a problem.

THE CHAIR: We are already out of time, so on behalf of the committee I thank you for your attendance today. We did not have any questions on notice, did we?

MS TOUGH: No.

Ms Kelly: Thank you.

THE CHAIR: Also, thank you for your support in helping shape the inquiry and how we have carried it out. That is greatly appreciated.

Ms Kelly: No worries. Thank you.

THE CHAIR: And thank you for all the work that you are doing on the ground across the community and for all the conversations that you are having, which I am sure you are carrying as well.

Ms Kelly: Thank you again for having the inquiry. I think we have to be brave and have some courage every now and again and say, "These are the conversations we need to have out loud, rather than behind doors all the time." Thank you.

THE CHAIR: My pleasure, and I will do the final closing remarks. On behalf of the committee, I thank all our witnesses who have assisted us through their experience and knowledge today and throughout other hearings. We also thank broadcasting and Hansard and the secretariat for their support. If a member wishes to ask questions on notice, please upload them to the parliamentary portal as soon as possible and no later than five business days from today. This meeting is now adjourned.

The committee adjourned at 2.32 pm