LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON HEALTH, AGEING, COMMUNITY AND SOCIAL SERVICES

(Reference: Inquiry into youth suicide and self harm in the ACT)

Members:

MS J BURCH (Chair)
MR A WALL (Deputy Chair)
MS N LAWDER
MR J HINDER

TRANSCRIPT OF EVIDENCE

CANBERRA

THURSDAY 24 MARCH 2016

Secretary to the committee:
Mrs N Kosseck (Ph: 620 50435)

By authority of the Legislative Assembly for the Australian Capital Territory

WITNESSES

BERRY, MS YVETTE, Minister for Housing, Community Services and Social Inclusion, Minister for Multicultural and Youth Affairs, Minister for Sport and Recreation and Minister for Women **1**

BRACHER, MS KATRINA, Executive Director, Mental Health, Justice Health and Alcohol and Drug Services, ACT Health **38**

CORBELL, MR SIMON, Deputy Chief Minister, Attorney-General, Minister for Capital Metro, Minister for Health, Minister for Police and Emergency Services and Minister for the Environment and Climate Change **38**

CUZZILLO, MS REBECCA, Policy Director, Youth Coalition of the ACT **18**

FISK, MR MARTIN, Chief Executive Officer, Menslink **27**

HOPE, MS SOPHIE, Youth Advocate, Youth Coalition of the ACT **18**

MANIKIS, MR NIC, Director, Community Participation Group, Service Strategy and Community Building, Community Services Directorate **1**

MATTHEWS, MR DAVID, Acting Deputy Director-General, Community Services Directorate **1**

O'DONOUGHUE, MR ROSS, Executive Director, Policy and Government Relations, ACT Health **38**

ROBERTSON, MS EMMA, Director, Youth Coalition of the ACT **18**

SHEEHAN, MS MAUREEN, Executive Director, Service Strategy and Community Building, Community Services Directorate **1**

THOMPSON, MR IAN, Deputy Director-General, Canberra Hospital and Health Services, ACT Health **38**

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Amended 20 May 2013

The committee met at 12.59 pm.

BERRY, MS YVETTE, Minister for Housing, Community Services and Social Inclusion, Minister for Multicultural and Youth Affairs, Minister for Sport and Recreation and Minister for Women
SHEEHAN, MS MAUREEN, Executive Director, Service Strategy and Community Building, Community Services Directorate
MATTHEWS, MR DAVID, Acting Deputy Director-General, Community Services Directorate
MANIKIS, MR NIC, Director, Community Participation Group, Service Strategy and Community Building, Community Services Directorate

THE CHAIR: Welcome, everybody, to this public hearing of the Standing Committee on Health, Ageing, Community and Social Services for its inquiry into youth suicide and self-harm. I assume that you have read the privilege card in front of you, which has been sent to you. Do you understand the implications of that statement? Yes?

Mr Matthews: Yes.

THE CHAIR: Before we proceed to questions, I understand, minister, that you are appearing between 1 pm and 2 pm. Is there a statement that you would like to make?

Ms Berry: Yes, thank you. I would like to start with a brief statement.

Young people have to face and manage a range of pressures in our society today. Some of these pressures affect large groups of young people; others are more specific to different groups. Our response to addressing these issues must involve the whole community. As minister for youth affairs, I am committed to making sure we all see mental health and wellbeing as a priority. Mental health and wellbeing are best achieved when young people feel included and part of their family, whatever that family looks like, and part of their community.

I understand Minister Corbell will be addressing the committee. He will address the committee on mental health services and supports available for young people. Minister Bourke is best placed to reflect on the work of the OCYFS in supporting young people.

As minister for youth affairs, my focus is on issues that affect young people's wellbeing and finding a way for them to access services. For example, the ACT's ministerial youth advisory council has highlighted significant challenges for lesbian, gay, bisexual, transgender, intersex and queer young people so that they can face the issues that occur in their daily lives. This includes reducing stigma in order to create a more educated and accepting society, which we are addressing through school-based programs.

There are common factors raised as contributing to the risk of suicide in young people, such as homelessness, contact with care and protection or youth services, drug and alcohol misuse and mental health. Sitting beneath some of these risk factors is

domestic and family violence. In one 12-month period, the Domestic Violence Crisis Service reported that 65 per cent of the crisis home visits that they conducted here in the ACT had children and young people present during the violence. This is one of the reasons behind the programs we run for young people who are facing homelessness.

The Youth Emergency Accommodation Network, YEAN, provides emergency accommodation to young people who are homeless or at risk of homelessness where all other accommodation options have been exhausted. The youth housing program assists young people to sustain a long-term tenancy and to engage with education, employment and the community. Our Place provides medium-term supported accommodation to young people aged between 16 and 21 years who are either employed or studying with the goal of transitioning into affordable, private accommodation.

We know that multicultural young people, especially those from refugee and humanitarian backgrounds, can be at greater risk of mental health concerns. Recent consultations with the multicultural communities in the ACT highlighted that respect, relationships and the awareness of supports should form the basis of any culturally appropriate service response. We are making sure that these factors are front and centre of our work with young people from multicultural communities, for example, as part of the better services reforms within the ACT multicultural framework for 2015-20.

As we all know, growing up can be one of the most stressful times of our lives. I am committed to ensuring that we do all that we can to provide support for our young people to ensure positive outcomes. I am happy to take questions from the committee.

THE CHAIR: Thank you for that opening statement. We now have a full contingent of the committee on this side; thank you for that.

You mentioned that we are meeting up with Minister Corbell later. I do not believe we are meeting with Minister Bourke, so I ask that if any of those matters are asked about, could you take them on notice on behalf of the minister—I am sure he will not mind you doing that—so we can get that information progressed quickly.

I would like to focus on a couple of things going to the terms of reference for this committee around the robustness and sustainability of community organisations and about how they are positioned to respond to a young person at risk of self-harm. More broadly, do you think we have got the right mix of community organisations, and are they well positioned, well supported and connected across each other to fill those gaps? This is really looking at gaps within our service provision. It is a very big question. We will have groups such as Menslink that have a particular focus in response and your homelessness services. Do you see from the community sector that they interlink and support each other?

Ms Berry: I might just start, chair, if I could, by mentioning that I think some of the services are moving outside their specific area of expertise and, realising that younger people need supports across a whole bunch of different areas in their lives, changing the way they provide their service to meet the needs of young people, whatever they are, or linking them into other services that might be able to support them. For more

detail on the actual existing services, I might ask Maureen Sheehan to give you a bit more detail.

Ms Sheehan: Thank you for that question, Ms Burch. The predominance of services funded through the Community Services Directorate that are addressing the needs of children and young people and families are funded through the child, youth and family support program. It is a program that is valued at between $11 million and $12 million a year. The funding technically sits in output class 4.1, which is the responsibility of Dr Bourke. But, as the committee would know, the Community Services Directorate is working very hard to operate outside of silos; so although those community organisations and programs are technically funded by one output class, in fact the organisations funded under that program are funded by many programs, including, for example, the homelessness programs which Minister Berry is responsible for, which David Matthews is responsible for administering and has the financial delegations for.

Those organisations are particularly looking at, I would say, the young person in the context of their family and their general circumstances. None of those services is specifically around the mental health of young people, but they are looking at the different needs that young people might have—for example, not for a clinical psychologist but for general counselling. Another would be to ask, if you take the young person in the context of their family, what are the parenting issues that the parents might have with that young person and how can those programs assist parents with parenting skills? It might be that the family is socially isolated. What are the services that can assist the family to have more contact with the community?

For example, if we think of the services and the initiatives under the human services blueprint or the better services initiatives, the initiative at west Belconnen, which is looking at how all of the services in the west Belconnen area work together to assist people to access services in the place where they live, Minister Berry was out there only this morning launching a round of grants which enable the people in the local community to come forward and say, "How can we assist to improve things in west Belconnen for areas of priority?" The people of west Belconnen and the services in west Belconnen have identified youth unemployment as a major issue which impacts on the wellbeing of young people. So in calling for those grants, in offering grants for people to come forward with good ideas, we are specifically asking for people to look at things that will improve the employment prospects of young people in the community.

Could I just give an example of a couple of organisations that are funded by many different programs that come out of the Community Services Directorate but are really assisting those young people. Let me pick Barnardos. Barnardos has recently been successful as part of a consortium winning the dollars that are available to support children who are in out of home care and, even more importantly, to prevent those children from entering out of home care. The sorts of supports there would be to assist families in their parenting skills so that young people are not in a situation where they are taken away from their families. As Minister Berry was saying in her opening statement, the sorts of stresses on children that impact on their wellbeing can contribute to a lack of wellbeing to the point where they self-harm and commit suicide. They are the sorts of pressures that can be addressed by an organisation like

Barnardos, which is trying to keep children out of the out of home care system.

Barnardos also provide youth homelessness services, and Mr Matthews could speak to one of the absolutely excellent services that are provided there to assist young people not just to have a roof over their heads but to gain training and then to gain employment.

THE CHAIR: Thank you. Mr Matthews.

Mr Matthews: Just adding to what Maureen said, it is really important to have that good mix of specialist youth programs but also to have all of our community services accessible to young people and understand the risks and challenges that they face in their lives.

Just quickly, before I talk about the Barnardos example, I would like to highlight the role of the Youth Coalition of the ACT in increasing that workforce capacity. They will be giving evidence to this inquiry later today or in the near future. One of the key roles they have is making sure that front-line workers have the right range of skills, training and professional supports to respond appropriately to young people that present in challenging times. I know that they have done a lot of work across the ACT government in identifying professional development priorities, whether it be mental health, first aid or the accidental counsellor model of support, all of which are designed to support that front-line work and go directly to the question that you asked, chair.

In relation to Our Place, it is a good example of a partnership initiative which is around providing a nurturing environment for young people to live in. But one of the challenging issues for young people who are not living at home is how we can create that parent-like environment with the mentoring and support that are provided normally by parents with day-to-day living skills or working out your careers, goals and aspirations. That has all been built very heavily into the Our Place model. It is very good quality accommodation which allows young people to share accommodation and support each other but also to have case management and the use of what is called the outcomes star model, where we are able to identify goals and aspirations across the different domains in young people's lives, whether it be education, health or their wellbeing, their financial situation; do they want to save up to buy a car, for example? It is all of that support and assistance which a parent might provide in another context.

The other element of that is that it also includes a mentoring component. Rotary are involved in that as well, and have been since the outset. That is, again, about ensuring that young people have trusted people to go to. I think that is really what young people need in all of their different circumstances. They need support from their families, and they do rely on the support from their families primarily, and that is very good, but also, for young people who are—

THE CHAIR: But if the family is fractured they need that other.

Mr Matthews: Yes; they need other options and those sorts of opportunities. Trusted adults are key to making sure that young people can get that support and mentoring

when they need it.

THE CHAIR: That program has been running for a few years now, so you are seeing that positive outcome: young folk coming in distressed or confused and being stable when they exit, for want of a better word, through the program.

Ms Berry: One of the things with that program is that some of these young people have come from pretty dysfunctional family lives. They are really learning at a later age how to get on with their own lives. Some of the goal setting that Mr Matthews was talking about previously can be as simple as just getting out of bed in the morning, getting dressed and getting yourself some breakfast—some really simple goals that people can set and have some achievements around. Whilst some of the challenges that these young people face in their lives are quite massive, if they are able to see themselves achieving some of those small goals that they set for themselves, they can set themselves smaller and future goals to achieve. That is one of the outcomes of this program that is sometimes difficult for people to be able to measure. They seem like small, everyday, normal things for everybody to get through, but for these young people it is a significant challenge in their lives.

THE CHAIR: Thank you. Mr Wall has a question.

MR WALL: Minister, one of the big barriers that we often hear about that prevents young people from seeking help is that there is often a stigma attached to the issues that they may have that lead to suicidal thoughts. What is being done, particularly in the youth space, to try to address the issue of the stigma surrounding people who choose to go down that road?

Ms Berry: Coming up very soon during youth week is the national event that brings together all of the youth organisations to talk about ways to reach out to young people and break down the kinds of stigmas that you are talking about. That process informs the adults who make the decisions for and on behalf of young people and makes them realise that perhaps we should be listening to young people more about the decisions that we make in their lives and letting them have a little bit more control over those decisions themselves. I will ask Mr Manikis to give us a bit more detail about some of that work.

Mr Manikis: There is an LGBTIQ advisory council. There is also a youth advisory council. They have work plans and there is a focus around this very issue for both councils. They will be meeting shortly to look at some proactive work going forward in terms of reaching out to youth and possibly through an education program around that sort of topic, and particularly around the sort of information that can be made available. It is also about how you can reach young people who are in that situation. That is sometimes quite a challenging thing in itself. We are looking forward to some of that work going forward.

Also, throughout the year, as the minister has rightly pointed out, there are times when youth get to consider these things. There is National Youth Week. There are other events throughout the year which focus on providing a supportive environment for youth to get involved, to come together and, through peer-to-peer support, to raise these issues.

We have a strategy in place at the moment which involves the minister's listening tour, and talking with 15 or 16 youth groups. The community participation group is also talking with 16 cultural groups. In our Muslim community, for example, the Canberra Islamic Centre is workshopping leadership with 20 to 25 young Muslims locally who can provide support to their peers within the community. All of this will culminate in a youth summit early in August, to get around some of these issues as well. It is all about supporting young kids and looking at the barriers that stop them reaching their potential.

There is quite a structured approach to learning a little more and being a little more proactive with this. It does involve the Youth Advisory Council; it does involve the LGBTIQ council.

In the multicultural space we have some very good service providers. We fund, together with the commonwealth, Companion House, for example. In talking about refugees, young refugees and humanitarian entrants, we would all appreciate that there are greater mental health risks and concerns, such as anxiety, trauma and depression, in that group. These young people may have spent up to 10 or 15 years, or maybe all of their lives, in refugee camps overseas. These sorts of conditions can be compounded when they arrive here, for the simple reason that they may experience discrimination and social exclusion once they get here.

We are very fortunate in this city to have quality community organisations and service providers, such as Companion House, who do a lot of work with these young people. As I say, we fund these organisations, and the commonwealth assists as well in certain areas. But there are also more than 200 cultural groups. Most of us have been to their events, and a lot of children and young people attend those cultural events throughout the year. You get a sense of the support that is provided by those cultural groups. It is really about the role that those cultural groups play in the lives of those young kids, in instilling a sense of belonging, and particularly a sense of identity. I know some groups that are also very proactive in supporting kids that are at risk within their own group. So it is not just about the role that the ACT government plays; it is also about the very valuable role, in the multicultural space at least, that the cultural groups themselves play.

Ms Berry: Can I talk with the committee about a couple of things that have been happening over the past couple of years regarding how Youth Co have been trying to engage young people in a conversation with government. They have been running their annual "speak out" conferences. I think you have been along to them, Mr Wall. A couple of years ago they had one and they invited politicians to come along. Politicians got to tell the young people about what was happening in politics and what was important in the community.

We had a chat with Youth Co and said, "Don't we really want to hear from young people? Isn't the whole problem that young people feel that they're not being listened to or heard?" Youth Co then switched it around, and I think you were there last year—

MR WALL: Last year.

Ms Berry: That is right. Last year young people told us their stories. That is when we got to hear some incredible stories from young people about the sorts of issues that were affecting them. There was one in particular that I found quite moving, and we heard about some of the gaps that the chair mentioned earlier regarding how young people are being able to access support. A young man called Joel Wilson—I do not know whether you remember him—talked about the impact of social exclusion on him as a trans person in our community. He described the small ways in which our society can misunderstand the issues that face young people, and particularly trans people, and how that had undermined his own feelings of dignity, respect and pride in himself. It was an opportunity for adults in the room to take stock and listen to what young people had to say.

Another thing that I wanted to mention was also mentioned by Ms Sheehan before. I refer to the launch this morning of the $5,000 grants. One of the focuses of the west Belconnen leadership network group is around employment for young people. Those grants are open to young people for any ideas that they have around improving employment opportunities for young people in west Belconnen.

It was really timely this morning, because we talked to new teachers who are being employed in schools in Belconnen, and they can then talk to their students about any ideas that they can bring forward. So there are lots of things happening; we just need to get the word out a bit more, so that young people can have the chance to tell us about what is going on in their lives and what we can do to make some improvements.

MR WALL: We often hear of the increasing numbers of young people who are getting a formal diagnosis of anxiety or depression-like illnesses. Does the government in this portfolio area have any evidence that suggests why this might be the case? What sorts of strategies have you developed to try to address that?

Ms Berry: That would be a question for the health minister.

MR WALL: Those sorts of areas are purely being looked at in the health space?

Ms Berry: It is not an area that I am responsible for as minister for youth.

MR WALL: The question, as it was framed, was around—

Ms Berry: You were not here for the opening statement, when I tried to clarify the kinds of areas that I would be responsible for. We can take questions on notice, as the chair has requested.

MR WALL: The health minister is appearing this afternoon, so I can direct the question to him. With respect to the statistics, I do not know whether you provided those in your opening statement, minister, or whether that is something, again, for Mr Corbell.

Ms Berry: Statistics on what?

MR WALL: Around the numbers of youth who attempt to take their lives each year. Are those questions best directed to the health minister?

THE CHAIR: I think there is some data within the terms of reference. Ms Lawder has a question.

MS LAWDER: In the discussion we had in the Assembly when we were talking about this inquiry, we heard that on average 35 Canberrans die by suicide each year, and there was evidence that some population groups are at a higher risk of developing mental ill health because of additional stresses. Minister, you referred to some of those in your opening statement, and Mr Manikis then went on to talk about young people who might have spent a lot of time in camps. In terms of the additional stresses for people from a multicultural background, is that the major cause of those additional stresses? Can you expand on what some of the additional stresses for people from multicultural backgrounds might be, that might lead to mental ill health?

Mr Manikis: It is not just the fact that they were in a refugee camp, although the conditions there are absolutely woeful, I would imagine. It is dual thing. It is when they arrive here with raised expectations of a better life; they get here and, for some young people, it is a very positive experience—family reunion in some cases, and better educational and employment outcomes. So, some go well. However, for others, it can be traumatic and it can fail to meet their expectations. They arrive here and, for various reasons, and in the context of this inquiry, the process of adapting to this new culture can, in itself, be a stressful experience, particularly when there are wide differences in cultural beliefs, language, values and customs. So some young people do not cope well with that adjustment. Some young people who are socially isolated suffer health problems, they may be unemployed, they are separated from their culture and their land of birth, and that is also a traumatic experience which sets them on that path.

Ms Sheehan: The Prime Minister's advisory council on refugee matters about three or four years ago had a longitudinal look at the outcomes for the refugee population that had come to Australia for the previous 10 years and then the 10 years before that. There was quite an extraordinary difference in the areas from which refugees have come 20 years ago compared to 10 years ago and until now.

One of the major differences in the past 10 years has been the predominance of the humanitarian refugee population coming from war-torn areas such as Africa. As Mr Manikis was saying earlier, children will have been born in a camp and will have spent their whole lives in a camp. They will not have had access to any education, much less proper health care or nutrition. So the deficit that those children arrive with when they come to Australia is completely different from, say, the deficit suffered by children who came 20 years before, and who may have come from a country that endured a particular conflict or maybe where there was prejudice against a particular religious group. Those children would have lived in families where there was an income, they were housed and they went to school; so they would have had very different needs when they arrived in Australia.

The issue for us as a community is always about where those children and families come from, and the different needs that they will have at different times. We should not have just a standard response to these children, young people and families when they come in. We should not have the same program running for 30 years; there are

different families with different needs. We need to be really smart in looking at the needs of those different communities and how we respond differently to those needs.

You can really see that in a group like the Multicultural Youth Services, which is housed with Nic in the Theo Notaras building. If you go to their centre, you will see young people from African backgrounds getting the type of response that they need from that service, which is a different response from what other kids might need in particular circumstances.

MS LAWDER: With respect to the terms of reference for this inquiry, and given that the ACT has reasonably small numbers, are young people from multicultural backgrounds more likely than some other groups to commit suicide?

Mr Manikis: I do not have any evidence of that. However, given the circumstances which these people have come from—

MS LAWDER: We hear that in some multicultural groups young people may be, but I wonder whether there is a crossover between the two.

Mr Manikis: Compared with locally born young people? I do not have the evidence regarding that. In the health context there may be some statistics that might be able to help there.

Mr Matthews: One of the areas where there is some emerging evidence is around early childhood trauma, whether that is in terms of the refugee experience that Mr Manikis was speaking about or in terms of early engagement with the child protection system or domestic violence at an early age. Over the recent decade there has been a much stronger awareness of how those early traumatic experiences affect brain development and affect people's lifelong trajectories. In the context of the "a step up for our kids" work in out of home care, a lot of emphasis has been placed on trauma-informed practice, which is understanding how those early childhood experiences manifest in behaviour as children start to age. Linked to that is the concept of attachment theory. Children that have experienced early trauma can have difficulty in forming longer term attachments and building those relationships.

One of the initiatives that have been introduced by the directorate is the Melaleuca Place trauma recovery centre. That is about working with zero to 12-year-olds about some of these issues as they manifest. That behaviour can manifest itself in areas such as dysregulation, impulsivity, impaired relationships and social functioning, high levels of aggression and suicidality. That is the behaviour that often exhibits and that people see. The trauma-informed approach is about understanding how therapeutic intervention can address the causes of some of that behaviour and help with people managing their responses—helping children to develop coping strategies and to develop different types of relationships so that they can be a strength for them as they get older.

You talked about our small numbers, Ms Lawder. We have to rely on wider evidence bases. There is this issue of how early childhood trauma impacts on lifelong outcomes for children and young people, and particularly how it might start to manifest again during adolescence, as young people are also dealing with hormonal changes and

identity changes. That is an area of evidence that we need to understand. I think that, across our service delivery system, we are building an understanding of what good trauma-informed practice looks like.

Mr Manikis: There may also be some evidence. A fair bit of work has been done around the impacts of detention centres on children and young people, and on those that have come to our community from those places. There might be some evidence around impacts as well, if you are looking for an evidence base.

MR HINDER: I have a question about seeking help and where it is that young people go to get that help. There are a huge number of organisations providing all sort of support, perhaps to the extent that it becomes very confusing for young people who, by definition, are struggling with issues themselves, to be able to access that support and to understand which particular organisation provides what sort of support. Has there been a concerted effort to raise awareness of these support services and is there some sort of triage of which services are appropriate for which sort of circumstance?

Ms Berry: I will get Mr Matthews to give you a little more detail about some of the work that is happening in that space. But I was having a conversation with the Canberra Rape Crisis Centre this week about some of the people who come to their service, and it does include young people. I think young people, or anyone really, will go to somewhere that they feel safe, not necessarily whether or not is best suited to support their needs. The Canberra Rape Crisis Centre was saying that when people come to them, they feel better if they are talking about their situation to a stranger who has had nothing to do with them in their lives. There are support services there. I am only speaking just from that conversation but I would say that other organisations would have had that same sort of experience: that young people will go somewhere where they feel safe, whether or not it is appropriate for their needs. It needs to be somewhere where they feel safe, that they can feel—and maybe they do not want other people to find out that they are getting support—that that affects them in getting well or stopping them hurting themselves even more. But I will let Mr Matthews talk to you a little more about that.

Mr Matthews: What we know about young people generally is that they still get a lot of their information from their families and peers, which is a really important starting point. They will go to their families and they will go to their friends and seek recommendations and information from them. Therefore, it is really important that young people generally have good access to information so that when their friends reach out to them in a time of difficulty they will then be able to help them as well.

We also know that young people highly value confidentiality and anonymity, as the minister spoke about. They want to be able to access the information that is very personal to them, that can be very confronting for them as they are working their way through in a way which works for them. So phone-based services and online information are still very important sources of information for young people, certainly not to supplant the role of face-to-face services but the availability of online information is there, as we all know.

We have all heard of the Dr Google phenomenon and I guess one of our challenges is that there is so much information out there that young people can access whatever

they want. The question is: is the information reliable, is it evidence based and is it helpful? Therefore, one of the important strategies is to make sure that we are encouraging young people to have good, help-seeking behaviours and good skills about accessing what they regard as important information, reliable and relevant to them.

In the context of the better services work—and Ms Sheehan and others might wish to add to this—one of the things that we are working on is making sure there are very clear and obvious access points for the community and for young people as well to be able to say, "This is where I can go to get credible information and then self-service my own needs. I can explore the information online or through some self-service delivery or go and speak to somebody and find out exactly what I need." But those clear and obvious front doors for reliable information sources are really important to young people. But, equally, it is important to encourage all young people to have a base level of information so that when their peers do come and talk to them and approach them they are able to also assist and help people out.

MR HINDER The process of contacting someone perhaps at the rape crisis centre is a slightly lucky-dip approach in terms of them having adequate knowledge of the breadth and depth of services available to be able to then triage that in the right direction.

Ms Berry: Yes.

MR HINDER: But it is about an acknowledged gateway within that industry about where to go to absolutely get access to all of those services that I was asking about. I accept that peers are probably the best. But then the report raised the issue of increasing awareness within schools about those services and those things. Realistically teachers and family doctors and those sorts of people need to identify something is possibly not right sometimes, and then they act or offer that initial advice or option.

Mr Matthews You are right. Parents and teachers are often in the same situation: where do I go to find reliable and credible information? So it is very important that there are those sources of truth, of quality information, that exist for health professionals, for teachers, for parents and, of course, for young people. We are building those up under better services and making sure that people know where they are. As you have also pointed out, we also want workers to know where to direct people.

But there is a lot of information out there. So we also do need people to be very discerning and to make sure they are able to look at information online in a critical way as well and work out what passes the smell test and what does not.

Ms Berry: One of the ways that we want the better services network to work—and it is about providing people with the right service at the right time for as long as they need it, in and out, whenever they need to have that service—is that they only have to tell their story once to one support service, whether that is education, health, housing, justice or community services. They tell their story. All of those government services as well as community organisations, members of the community, networks and

everything can work together to figure out what it is that best supports that person at that time, and that would include a young person as well.

This morning out at west Belconnen when we were launching the grants there were new teachers starting work in Belconnen schools, and they were being fed an enormous amount of extra information on top of being amazing teachers in our community. But they are really engaged in that. They really do see themselves as on that front line of being able to connect people up to the support services that they need but making sure that we are not going, "Oh, you could go here, or here or here or here. Here is where you go, and then we'll connect you up with whatever support services that you need."

Ms Sheehan: The minister launched this really fantastic web-based product which we are funding Contact ACT and Volunteering ACT to produce. It is one of those great products that were actually developed in the community sector in Queensland. The Queensland community sector made contact with the ACT community sector, and the minister launched that product, at, I think it was, just the end of last year. At the moment through the better services work we are actually able to fund an even better tailoring of that.

We are trialling it with, I would say, model questions that people in the ACT might ask about how to access services. It could be a young person who is having some mental health issues but they can just go on line and ask a question and then that information portal will give them some options about where to go for services. It will ask them questions like, "Where do you live?" Then it will tell them, "Here are some services in the place that you live." Particularly bearing in mind what Mr Matthews was saying about us needing to give information to young people in a form that they like to get it in—and we know how tech savvy young people are—having access to those sorts of web-based ways of navigating the service system is really important. We are delighted that the Queensland community sector was able to come forward with that suggestion and that we have been able to put a bit more money into tailoring it particularly for the ACT situation.

Ms Berry: But it is even more than that, which is what makes it really cool for young people and everyone else. When you ask the question or make the request, it will map out all the things that are in that area that might be of interest to you. We did one in Belconnen. We put in "bike club" or something. It came up with the BMX bike club in Melba but it also came up with everything that was around it—where the chemist was, where the nearest doctors were, where the ACT government services were and everything around it. So you just had to look at that page and you had the map in front of you of where you needed to go. It was pretty cool.

THE CHAIR: I understand you are also minister for social inclusion. Does that have an overarching framework that would capture your community service sector? We are meeting with Minister Bourke but we will not have the minister for education in front of us. Given what we have said about the involvement of schools and their role, there are two very quick questions. One, does the agenda for social inclusion cover enough, given that it has been in place for 12 months now, and do we need to fine-tune that a little? Then the second, very unrelated question, is around carers. What is the level of support for the families and the carers of people that suicide and self-harm? Two

quick responses, because I am conscious of the time.

Ms Berry: Thanks for the question. I think the inclusion work is something that will continue to evolve, grow and change as human behaviour changes and as we become an even more inclusive community. That is the challenge that we are all up for. It is always easier to describe exclusion than it is to describe inclusion because it means different things for different groups of people.

I guess we started at a point 12 months ago talking about what we do for different types of communities and how we work to make them feel more included and feel less excluded. These things can happen in all sorts of different ways. Schools have multicultural morning teas—and I attend regularly at my local primary school—but one of the great things about that was, when I first started, it was described as a multicultural morning tea. All the people that turned up were from different nationalities and had English as a second language but none of the English-speaking parents would turn up. The whole idea is about bringing people together, networking and building a stronger community amongst the new parents, into our country and into our schools and bringing everyone together. Now it has changed and all parents come along, because we are all multicultural and we all have different cultures to share.

I guess that is an example where the community has taken it upon themselves to be more inclusive and bring people together, and the government certainly has a role to play with our policies about how we can put in place different policies to provide a more inclusive community for different people at different times in their lives. Did you want anymore?

THE CHAIR: Very quickly on carers, are they under your—

Ms Berry: What sort of carers?

THE CHAIR: The families of someone who has suicided or self-harmed. You go in and put some support around the young person but what about the family in which they sit? Does Carers ACT have a—

Ms Sheehan: The ACT government does fund Carers ACT. It is a general allocation. It comes out of a specific output class. We have funded Carers ACT for support for people with a disability, the carers of people with a disability. And I believe that the home and community care program funded by the Health Directorate has previously provided support for carers as well, though we could certainly confirm that. But whatever output class it comes from, it goes into the general coffers of Carers ACT to enable them to provide more general support. With respect to carers of people with a disability—of course there are young people with a disability, adolescents with a disability—that funding does go towards providing support to those young people.

THE CHAIR: Perhaps that is more of a health question—the families of people who have got identified mental health issues and are at risk of self-harm. Mr Wall.

MR WALL: Minister, how are the existing programs that are funded by CSD in the youth suicide space assessed to ensure that they are, in fact, getting results and are

offering a service that is getting results?

Ms Sheehan: Thank you for that question. I guess the first point that I need to make—and it is a very important point—is CSD does not fund any programs specifically to address youth suicide or to stop youth suicide. But as the minister said in her opening statement, because of our responsibilities more generally to support families and to support young people in their society generally and in their community, we have lots of programs that assist young people to be part of their community. If there are some issues for their parents particularly, their parents need more support to support the young person—and that really is a fantastic program, the children, youth and family support program, which is that $11 million to $12 million a year program; it is all about funding that sort of non-clinical support for young people and their families so that they can get the services that they need—as Minister Berry was saying, it is the right service at the right time, as we now say "and right for you", for the right period.

An example of those sorts of services is: it can be a general community participation thing. You would not even think of it as a service but it does provide core funding for lots of things like even the scouts and the Duke of Edinburgh scheme. You might say, "Well, that's not particularly going to the mental health of young people," but it is just a general background thing in the community that young people can participate in. That is on the very general end of the stream, right up to counselling services that are funded through places such as the YWCA, which is for young people at the higher end of need and who, you might say, would be part of that group of young people who might be at risk of self-harm or at risk of suicide. But any targeted, clinical services for young people at risk would come in through the Health Directorate.

But the other point that I want to make is that because of our work generally with better services—and we are working right across the board, not just with ACT government departments but also with the organisation funded by the commonwealth that supports general practice—we are taking that really broad approach to supporting families and young people. There is not much point in having a clinical service for young people just after they have committed suicide when you do not think about all the things that have contributed to the lack of wellbeing of that young person and never think about early intervention, not just clinical early intervention but early intervention in the life of problems for that young person and the family.

That is why in better services we are trying to join everything up so that we are taking a more holistic approach. This is probably an indelicate description but we do not want to be the ambulance at the bottom of the cliff; we want to be providing those support services generally for young people and families so that you do not end up at that critical situation at the end.

MS LAWDER: Following on from that a little, you talked about supporting families and young people. I think we know that for young people there are transition points at which they are more at risk of homelessness or suicide. It might be from high school to work or uni; it might be family breakdown, those types of things. Are you able to provide a bit more information about how you specifically target young people at those transition points?

Mr Matthews I will make a start with that, Ms Lawder. I think you have really identified a very key point in terms of youth strategies, which is recognising that young people are growing and maturing, and as they get older they face quite different challenges. We need to be very responsive to what is happening in their lives and make sure that as they get older and mature, and those issues change, the interventions are right.

The interventions can, of course, be part of a number of the areas that you have raised. Those key school transition points are a very good starting point. We know that making effective transitions from early childhood environments to primary school are very important in terms of educational and other outcomes, as is the case in making the transition from primary school to the high school system. In the youth services that are funded and supported by the ACT government, there is a lot of focus particularly on those transition points. Primary school to high school is a really important area for young people that may have struggled during the primary school years. They might be falling behind with some of their educational outcomes and also struggling socially. So there is strong emphasis in the youth programs on those key transition points.

But also, those critical life events that happen to us all can really throw young people for six. Whether it be their parents getting divorced or a relationship breakdown where the family unit has broken down, there might be a situation where there is some temporary period of homelessness. It is very important that young people are supported to understand those changing times in their lives.

A lot of the emphasis on youth case management is about understanding what is happening for young people at a particular given point in time and what they need right then and there. It could be very practical assistance—just somebody to talk to, assistance getting to football training whilst the family situation settles down—or it could be deeper in terms of counselling and other forms of intervention.

The transition from school to the workforce is another critical area for young people who are not going on to further academic study. Addressing their requirements to get the prerequisite skills has been a key focus of the education system—the introduction of vocational education and training in schools to give young people that starting point to make those connections to industry.

More broadly, it is about understanding, during those changing phases in people's lives, that that is when often there is uncertainty, that is often when they need that parent-like support and guidance and access to real-time information to make good decisions and to understand that things will settle down. That is what maturity gives you as well. As we all get more mature, hopefully, we understand that we can go through periods of turbulence and things will be okay. So it is building that sense of resilience and those coping skills.

Whilst the focus of youth work is often about dealing with those presenting issues, I think the key issue and key point are that it is about skills development at the end of the day, providing that scaffolding to allow young people to navigate those key transition points. And when people do reach a phase of crisis, knowing that they can reach out and get that support and knowing that things will get better are a very

important part of giving young people a sense of hope and optimism.

THE CHAIR: Thank you, Mr Matthews. If you do not mind, Ms Lawder, I might go to Mr Hinder for the final question. Thank you. Mr Hinder, we are rapidly running out of time.

MR HINDER: Thank you, chair. I will be brief. Until recently the federal government provided some excellent programs to prevent bullying in schools. How much work goes into making sure that the collective dollars, both federal and territory dollars, are best spent, not to cover the same territory and services but to provide the best services outcomes for the dollars available. I suppose that is the question.

Ms Sheehan: Thank you for that question, Mr Hinder. The short answer is that there is not very much overlap at all between what the federal government are funding and what the ACT government are funding. The reason for that is that there is a clear delineation of who is responsible for what. Sometimes the commonwealth—and this is quite annoying, I have to say, for the state and territory governments—decide that they have got a particular priority and might just come in over the top of whatever programs there are without really inquiring into whether that particular priority of theirs might already be adequately covered in the ACT.

We try to talk to our colleagues department to department, from the ACT across to the federal government. It is not always possible to get it 100 per cent right, but it is something that we are very aware of. We try to minimise it. In particular, we have a commonwealth representative from the Department of Social Services on the Joint Community Government Reference Group, which is the main committee with the community sector and the ACT government which looks at the best way to provide services. We have got the commonwealth there so that they can see what is important to us and, hopefully, minimise the sort of duplication that you are talking about.

Ms Berry: Can I quickly say something, chair; I will be really brief.

THE CHAIR: Yes; we have the next group here.

Ms Berry: I know; I can see that a group has entered the room. I just wanted to quickly mention the say no to racism project, which was implemented by you as education minister. That was a program that was run across 42 public schools in the ACT, about delivering that anti-racism message. More recently, there has been, federally funded, the safe schools program, which was a really great program for young people—to be able to go to a safe place, get advice when they need it in their school. Around 25 schools, I think, signed up to that program. Of course, it is not in my portfolio area, but it does affect young people; it is really great to see that the ACT government has committed to continuing to fund that program in the ACT.

THE CHAIR: I agree with you on that. Just on that note, whilst you did not take any questions on notice, on programs such as safe schools, if the committee members have additional questions, we might put them through to you. We will do that in a matter of days. Thank you for appearing, minister and officials.

CUZZILLO, MS REBECCA, Policy Director, Youth Coalition of the ACT
HOPE, MS SOPHIE, Youth Advocate, Youth Coalition of the ACT
ROBERTSON, MS EMMA, Director, Youth Coalition of the ACT

THE CHAIR: Good afternoon, and thank you for coming along to the public hearing of the Standing Committee on Health, Ageing, Community and Social Services inquiry into youth suicide and self-harm. The privilege card is on the table in front of you. Do you understand the implications and accept those? Yes? Thank you. Before we proceed to questions, is there an opening statement?

Ms Robertson: Yes, we would like to take that opportunity. I would like to start by acknowledging the Ngunnawal people as the traditional owners and continuing custodians of the lands of the ACT. In particular, I want to highlight that we think this is a very important issue that the Assembly is considering, so thank you for your time. I also want to highlight that, particularly for Aboriginal and Torres Strait Islander communities, looking into the issues of youth suicide and self-harm is very important. It is a little unusual that we are appearing before you today and then we will be putting a submission in.

THE CHAIR: Yes, time lines do that.

Ms Robertson: Thank you for the opportunity to do both, and I also acknowledge that we have a bunch of young people with us today, including Sophie, who is appearing and will speak shortly. I want to acknowledge them because they are passionate young people who are activists in the area of youth mental health who we have bumped into in the course of our work. I really want to acknowledge that it is an area about which young people do have a lot to say, so there is a really good opportunity for the Assembly to hear the voices of young people in this process.

We know that there are approximately 78,000 12 to 25-year-olds in the ACT and we also know from many sources of data that one in four young people experience a mental health issue in any given year. That means nearly 20,000 young people potentially are going to experience mental health or mental ill health and could benefit from having support.

We also know it is unrealistic that we will have a clinical one-to-one response for 20,000 young people in any given year, and that is not necessarily what we would be calling for and it is not what young people tell us they want as well. One of the really important things for us around considering the issues of youth suicide and self-harm is that it is seen within the broader context of youth health and wellbeing, and particularly mental health, that we consider early intervention and prevention and that we hear from young people that they turn to family and friends and people whom they already have connections to and community first. So the role of teachers and the role of family and friends is really important in this issue.

We also consistently hear from young people that they are not necessarily confident that they can provide support to their friends or that their family know what to do. We certainly urge the committee to look into having a broad community development approach in increasing our skill as a whole community in addressing this issue.

I know that the committee are looking at government services, both federally and locally funded, as well as the community-based services that government invests in. We know that we have a service system that has pressures around capacity, so we tend to skew our responses towards that kind of tertiary, very extreme end of response. We urge the committee to consider early intervention and prevention. We know that there are bottlenecks within our service system as well. That is one of the key things that people talk to us about, too. It is really important that we consider what we know about help-seeking behaviour, what we know about our service system, what kind of wait lists there are and what kinds of services are available for people.

In 2012 the Youth Coalition undertook the rate Canberra survey, and we are in the process of doing that again at the moment. It is not quite closed, so I can only give you preliminary indications. Our 2012 survey reiterated that young people rate issues of stress, in particular in relation to schoolwork, body image and mental health, in their top issues of concern. Those three all rated in the top five issues. That is being duplicated in the data we are getting so far in the survey this year. We previously undertook some focus groups and further research because whenever we talk to young people as a group mental health issues come up in those top three to five issues of concern.

Through our submission as well, our strong message will be that we need to not see siloed, separate responses to this—a health response, an education response and a community services response—because the experience of young people, their families and communities who are going through ill health is that they do not fit neatly into any of those baskets. We are a small community. We have limited resources. We certainly believe that it is time to look at how we allocate and mobilise those resources in a much more coordinated way. That includes planning, and working with young people and their families around how those resources might best be spent. I will now hand over to Bec and Sophie.

Ms Cuzzillo: I want to expand on a couple of things that Emma touched on, particularly around what young people tell us, and the help-seeking behaviour of young people in mental health and when they are facing mental health issues.

Emma highlighted that friends and family are really important in this space, and young people consistently tell us that that is the first place they go. But there are some barriers that young people often experience when help-seeking. One thing we know is that young men are less likely to seek help for their mental health issues. We also know that stigma is a really big barrier. Young people tell us that there have been some improvements in awareness around mental health but that stigma does still remain an issue, particularly around actually seeking help for what they might be having issues with.

Another issue is the response time. We know that when young people seek help, if they do not receive help, they might not necessarily come back and try again. When we ask young people what kind of time frame would be reasonable, they talk about 48 hours; they are not talking about the six to eight-week waiting list that we see for some services in the ACT. So there is a need to respond quickly when young people seek help.

There is also a need to take young people seriously when they come forward with these issues. Yesterday there was some research released by Orygen, the National Centre of Excellence in Youth Mental Health, particularly around self-harm. They found that some young people report negative and damaging responses from front-line health professionals, including dismissiveness, trivialisation and scepticism. When we are talking particularly about self-harm, the attention-seeking aspect that some people come back to with that behaviour is really damaging, particularly if you are seeking help for it and someone comes back to you with that. You are not necessarily going to come back again.

The final thing I will say is that when we talk to young people about this, they do want to be involved in the solutions. We have done a lot of work with young people around mental health in particular. All of the research is showing that young people—and we have a contingent of them here today—are really keen to be part of this conversation. At the moment there are not necessarily ways that that can happen. So we want to see that.

Ms Hope: I would like to thank you for giving me this opportunity to be here. I want to touch on three things which have already been mentioned by Emma and Bec. The first one is that I feel it is really important—and we have had this discussion heaps of times—to look not just at improving the health services but at the people who come in contact with youth and at the places where there is a lot of negative discrimination and a lot of negative stigma against youth. We need to be looking at police, teachers, parents and other family members and educating them on mental health, making them literate in mental health. Obviously suicide and self-harm come along with that.

The second thing is in regard to services. In the ACT and in Australia as a whole, we have a spectrum but we only have services for extremely mild mental health issues and then we have the severe, which is the hospitals and the inpatient units. When you go to a hospital—and I know a lot of people who have been in this situation—if it is because of attempted suicide, you are usually not admitted. You get treated if you are bleeding out, if you have overdosed or if you have crashed your car on purpose. You will get treated for your physical wounds but you will not be treated for your psychological issues, and usually you are discharged pretty quickly.

At the other end there is education on self-care and the very beginning of prevention—"let's do meditation and let's take time for exercise and stuff". There is not much in between.

Leading on from that, with the services that do exist in between, in Canberra, for youth especially, that is pretty much only headspace, because young people often have financial struggles and are not able to access private psychological care. If they are going to find a free place, it is usually with headspace in Canberra. But the problem with headspace is that, because of their lack of funding, there are extremely long waiting lists. I have a friend, for instance, who contacted headspace and said that he had clinical depression et cetera. They empathised with that and then put him on their waiting list and said it would be a four to six-week wait for his appointment. In the meantime he committed suicide. It is really not okay, and the response time is just ridiculous.

If you are told to wait that long, often people will just leave. They have tried to seek help. It is a really big deal for young people to come forward and say, "I need help." You are then told, "That's great, but you have to wait six weeks." A lot of stuff happens in six weeks, especially if you are vulnerable. I will leave it there.

THE CHAIR: Thank you for that. I am really glad you brought the youth voice to this hearing. Looking at the terms of reference, the numbers are not the story. It does not matter if they are large numbers or small numbers; it is about the personal stories in this regard. On that notion about going to family and friends first or a known, comfortable contact, there are two questions. How do we improve their skills broadly; what do you think the answer is? There is then this notion of a response time. I agree with you; it does not matter what service you are seeking, once you have knocked on the door first, you have to get a response, because you may not come back and knock again. So how do you increase capacity to respond across the community, and what are some of the solutions if headspace cannot get to you? If there is a holding pattern or a gap in that service, what would be your suggestion on that?

Ms Robertson: I think there are multiple answers. I know that part of the terms of reference for this inquiry is looking at the role of teachers, youth services and so forth. Certainly, one of the things we hear consistently in the community sector from front-line workers is that they want more training around youth mental health first aid and accidental counselling. They recognise that they are often the ones that are there and that they are going to be the ones supporting people if they are on a wait list for another service as well.

That is certainly an issue for the sector, as is workforce development for teachers et cetera. We would advocate that we need to be implementing community development-style projects that support communities to grow their own literacy around this. I do not think the community is resistant to wanting to do better or know more about this issue—certainly amongst young people. We keep bumping into young people who have great ideas and are doing stuff actively in their community but feeling quite isolated, or they are doing that because they feel there is not something else on offer, so they are taking action. It is really about being able to support and resource those things to come to the surface and for people to develop their training.

I heard the directorate and Yvette Berry talking about funding, and commonwealth funding versus local funding. Headspace is an example of such a program. In the youth sector we get quite scared that if there is a change in commonwealth funding that would have a massive impact on us here in the ACT. That is one of the things we need to look at. We have seen a reduction in headspace's funding and that has led to an increase in the wait-list times.

I want to touch on the wait lists. The services and workers providing the services do not want those wait lists. I think it is a very debilitating and frustrating thing for the workforce to be working in that environment when they know they can have a better impact if—

THE CHAIR: They get that phone call and their only response is an appointment in

six weeks.

Ms Robertson: Absolutely. Somebody described to me the other day that it is sometimes like trying to empty a bath with a teaspoon with a big hole in it. You are constantly working and only touching the surface. I think we need to look at who does assessment and referral. What is the balance in referral points regarding people who can provide services and supports? Is it about referring people on or is it about equipping more youth workers, more people who are already operating in that environment?

Ms Hope: Especially with young men, it is a really big issue, and the statistics say that, obviously. As you say, statistics are not everything. I have been around a lot of suicide and self-harm in my life. Every case of attempted suicide of people close to me, apart from one, have all been men, and they have all been young men. I know that in Australia we have that Aussie bloke stereotype. That still exists and that is still really strong. Help-seeking behaviours and reduction in stigma are a lot more prevalent in young females than in young males. It is still really rigid in young males. That is something that needs to be looked at.

THE CHAIR: Andrew, do you have a question?

MR WALL: I am curious to get the Youth Coalition's perspective on what you see as, I guess, the first ports of call for young people when they do want to reach out and they make that often subtle cry for help. Who are normally the first people that they reach out to?

Ms Cuzzillo: I think it depends on the young person. One of the things that people will tell us is that they might look things up on the internet first to see whether there is any information there. There usually is. Sometimes it is not great, sometimes it is really good. And there are certainly a lot of services that are now emerging that are web based. Then it is the family and friends, particularly peer groups, parents or any adults that they might feel close to. Teachers is a big one. Depending what people are involved in, if they are involved in a church, it might be the church community, that kind of thing.

There is that aspect of it, but one of the other things that are important to know is that it is very individual how young people want help. When we talk to people about "Would you prefer to call someone on the phone to talk about this, like Lifeline service, or would you prefer to get help via the internet or see a psychologist one on one, or how would you like it?" People are really varied. The important thing is that we need a service system that caters to a whole range of ways that people want help and want support. But in terms of the first port of call, it is definitely friends and family.

Ms Robertson: Just on that also, people do talk about the importance of those people helping them get other help as well, for example, the idea that "the teacher I know and trust and have a relationship with might take me and introduce me to the school psychologist, whom I don't know at all".

MR WALL: On the topic of schools, which is a fairly structured environment where

pretty much all young people go through at some point or another, is there enough being done or is there enough capacity in schools to deal with students presenting with issues or, from your perspective, what more could be done in that space to, I guess, broaden the depth or the scope of assistance that is available?

Ms Hope: I do not think there is anywhere near enough done in schools. From what I understand—and I have had a lot of friends who have recently gone through teacher training for primary and secondary schools—they get very little to no mental health training. That does not seem right, for starters. Also in the schools themselves there is not guaranteed to be a counsellor, and when there is a counsellor they are not there the whole time. Some schools only have chaplains and they do not have to be qualified in counselling.

On top of that, I have actually heard a lot from my friends who have seen a school counsellor that it has been a negative experience. I do not know if that is because it was within the school environment or whether they were too much like a teacher. There were lots of different reasons. But I do not think that the teachers have the mental health literacy—I am generalising that—and I do not think that the schools have the facilities either. It is definitely like sending people to other places, yes.

Ms Robertson: There are some fantastic things happening in schools, and I am really pleased that you guys are going to hear from Menslink. They are doing some excellent work. Mental Illness Education ACT has a program we consistently hear great feedback about, and obviously headspace are doing work in the ACT. But all of those services, I think, are stretched. So it is not every school which has access to that. Certainly, when we talk to those services, they would like to be able to do more and deliver more as well.

Ms Cuzzillo: We know that teachers are already stretched enough in terms of what responsibility is on them to deliver to their students. Some of them might have mental health training, some of them might not. There are some really great teachers out there who are doing great work in this but we definitely do not necessarily see that that is consistent across the board. But, also, one of the things the Youth Coalition believe is that it would be great to see community services and schools working better together to support young people. Teachers are stretched enough to do their curriculum stuff and some of that other support. That is where the allied professionals like youth workers and community service professionals can come in and have that expertise and help young people with the other aspects of their lives like mental health.

MS LAWDER: I was reading your mental health perspectives from last year for young people aged 12 to 25. That talked about strong feedback from young people, that everyone needs to care about mental health as it is a community-wide issue that affects everyone, but they felt more people still needed to know about it. Do you still believe that is the case? We hear a lot about beyondblue, black dog, R U OK? Day and social media. Is it improving? Do more people understand about mental health now?

Ms Robertson: I feel like we could have quite a few different answers in the room. I guess I would say in some ways it is improving, but then when you hear stories about people being discriminated against in housing or discriminated against in employment

because people are fearful, actually on an individual level people are still affected by ignorance and people not understanding mental health issues.

MS LAWDER: So the knowledge has not led to a change in attitude or behaviour, is that—

Ms Robertson: Not across the board. Certainly in some key areas for people it can be really devastating, particularly if it is affecting those kinds of fundamental things like your access to employment, housing et cetera.

Ms Cuzzillo: And I think it is definitely an issue that is more out in the community and more spoken about. But when you actually talk to people about how confident they feel in responding to a friend, disclosing to them that they might be thinking about suicide, people just do not know what to do.

THE CHAIR: So we need to go from awareness now to some depth of understanding and have that then come back full circle?

Ms Robertson: Yes.

Ms Hope: I agree with that. And just on that, I think I have a slightly different opinion. I agree with what you just said. I am aware I am coming across as quite negative this whole time but I think that the younger generations have a pretty good literacy on it in general because there are all those organisations and we have been brought up with it to an extent. So it is really normalised to an extent in the younger community. But I think that the people we are trying to seek help from are not in our generation; they are in different generations who have not had that when they have been growing up and they have not been brought up with it. So I feel like the stigma, the denial and the suppression of it are actually coming from the people we are trying to get help from. And that is in the older generations, in my view.

MR HINDER: I do not know if you were here to hear my question about the fact that there is a mind-boggling array of services, groups and delivery vehicles for all sorts of services and the fact that there are so many doing so many different things, some of them very targeted, some of them not so targeted. That in itself is a maze for someone to negotiate to try to get the help they are after. We then had a discussion about a web-based tool that the ACT government seems to be pretty impressed with that came out of Queensland. Ms Sheehan talked about the fact that it was so good at directing because it answered the questions that were asked online by you guys, your generation being so tech savvy about those sorts of things. I think it probably removes the stigma and the confidentiality risk aspect of it too, because you can go in there any time you like and go through things. Are you aware of this tool and do you think it is as good or has the potential to be as good as Ms Sheehan seemed to think it did?

Ms Robertson: Which tool, specifically?

MR HINDER: I did not get the name of it, but the fact you are asking me that probably says no.

THE CHAIR: Minister Berry launched it, I think, in the back end of last year.

MR HINDER: Last year.

Ms Robertson: I would say the youth mental health sector has been leading the way in terms of modelling different ways of engaging with people online. And there is definitely some real potential in that but I do not think that we should view young people as tech savvy, therefore, they do not want to make real human connections in person with people, because that is certainly not what they tell us.

Ms Hope: However, on that, I think that, personally and those close to me, we love using online tools better, sometimes especially if you are suffering from social anxiety. And that is one of the issues. You do not want to face someone face to face or make a phone call. That is terrifying. But then going online and being able to have that online conversation, I think, is extremely helpful.

I do not know about that specific tool but I do know that headspace has eheadspace. It was launched not that long ago, and it is a national online web counselling service. But it is only open limited hours and on top of that they have a really long waiting list. I am on the national headspace group, and the eheadspace team was telling us that they do not really like to advertise that it actually exists because they know that their numbers would go through the roof and they cannot deal with that demand. I think there is definitely a need for it. I think it needs to be developed, yes.

THE CHAIR: A final question, going back to your earlier comment about a colleague of yours that had a six-week wait, is there then a service system? There will never be enough service system responses. Is it smart to look at some of those e-based and internet-based services to come in while people are waiting for that face-to-face, human contact?

Ms Hope: I think it would be useful so long as there was somebody checking up on the person instead of it just being like, "Hey, there's this web-based counselling service. Go use it." That is great, but then I think there needs to be follow-up, "Are you using it? How are you finding it? How are you travelling?"—just having somebody check up on you.

Ms Robertson: I would suspect many people would start with the web-based service before they get to trying to refer to a face-to-face service as well. But I think they are also important in recognising that young people self-harming and attempting suicide affects whole communities as well. Actually what we see is that it is really devastating for a school community if somebody attempts or is successful with suicide. So we need to think about it in terms of that community development space. I think that those tools are a great option in being able to offer something to all of the other young people who are then affected by what is going on as well.

THE CHAIR: Any very quick final questions before we close?

MR HINDER: Just one. It is probably for you, Emma. If you had the option to take some money out of something being funded in mental health and put it into something else, what would it be? Wish list No 1?

Ms Robertson: That is a really tricky question. I will take up the right to take it on notice and come back to you. But I guess what I would say is that I would not view it as taking money out of one area and putting it in another. I think we need all the areas to be doing that planning together, because there are some good things happening in schools, there are some good things happening in community services, there are some good things happening in health. But the experience of people navigating our service system is that those are separate entities rather than a coordinated response.

I think we have got some things happening in the ACT through the better services work that is being done and so forth where we are looking at different ways that we can do planning and arranging our services. So we are certainly hopeful that we might be able to do that particularly in looking at mobilising the resources that we have for the social, emotional wellbeing for young people.

THE CHAIR: Thank you for that. We are aware that you are putting a submission in. Thank you for that. If there are questions we will put them to you in a timely manner and you may want to include that in your submission, if the time aligns for you. Thank you for coming in. Thank you for coming and sharing that. Well done.

Ms Robertson: Thank you very much for having us.

FISK, MR MARTIN, Chief Executive Officer, Menslink

THE CHAIR: Thank you for coming to the public hearing of the Standing Committee on Health, Ageing, Community and Social Services and its inquiry into youth suicide and self-harm. In front of you is a privilege card. Do you understand and accept that?

Mr Fisk: Yes.

THE CHAIR: Thank you. Before we go to questions, do you want to make an opening statement?

Mr Fisk: Yes, thank you, Ms Burch.

Menslink is a charity in Canberra that supports young men aged 12 to 25 through the region to get through the turbulent years of adolescence and youth with the least amount of harm to themselves or those around them—harm through suicide, self-harm or violence against others. It is important to note that we are a community organisation, not a health organisation, and that will go to the heart of my opening statement.

We are very active in the suicide prevention and intervention space through our three main programs. The first one, our silence is deadly campaign, is directly aimed at reducing stigma and encouraging help-seeking behaviour amongst young men with a view to reducing suicide and harmful behaviours. It is now in its fourth year, and every year we reach about 7,000 secondary school students across the region.

Secondly, our counselling service provides face-to-face therapeutic support from professional qualified counsellors to over 200 young men each year in our offices, in around eight high schools and colleges, and in the Alexander Maconochie Centre. It is an important service because it is independent. One of the things we are able to provide is a crossover through those critical transition periods in young men's lives—from high school to college, from a school environment to a school holiday environment, or leaving school or leaving jail, all of which are high risk points for suicide. Around five per cent of our counselling clients present with suicidal thoughts and/or behaviours.

Finally, our volunteer mentoring service provides positive, non-parental adult male relationship and role modelling support to around 50 young men in any given year.

Our client base is exclusively young men and their families, but that covers every economic circumstance, every majority and minority group and every suburb in Canberra and across the region. The ACT government provides approximately 50 per cent of Menslink's funding via the Community Services Directorate, and it is directed to our counselling and mentoring services. The remaining 50 per cent, and 100 per cent of our silence is deadly campaign funding, is provided through our own sponsorships and donations. We receive no federal government funding.

My statement today will be drawn from observations made while working at

Menslink, supported, where possible, by national research from the Australian Institute for Suicide Research and Prevention, the National Health and Medical Research Council Centre of Research Excellence in Suicide Prevention and the Men's Health Information and Resource Centre at Western Sydney University. The statements are going to be drawn from experience and research around young men, but I believe many of them may also be applicable to young women at risk of suicide and self-harm.

I want to talk briefly about causal factors in youth suicide. Much attention has been given in recent years to mental health and clinical health conditions as the primary factor in youth suicide. However, a recent study by the Australian Institute for Suicide Research and Prevention into completed suicides by children and youths aged 10 to 19 showed that of completed suicides in Queensland, around 50 per cent had experienced a recent stressful life event while only 22 per cent had a diagnosis of any mental disorder. Stressful life events, such as a parental or romantic relationship breakdown, outnumbered diagnosable mental disorders by a factor of almost two to one.

Further research highlights the following general risk indicators for suicidal young men and young women. They are generally impulsive and have poor emotional control, especially when subjected to stressful events. They have poor problem-solving techniques to develop strategies for managing and overcoming life's hurdles or challenging circumstances. They are socially isolated, often through circumstance such as disability or discrimination, through a dysfunctional family or school peer network or through those transition periods of leaving school or leaving a detention facility. Particularly for young men, they have a belief that they need to solve their problems themselves, and are therefore reluctant to seek help, often due to stigma, as I said, particularly for young men.

These indicators, when compounded together, and particularly when combined with a recent relationship breakdown, form the perfect storm for young men, with the institute finding:

> Men appear to be most vulnerable to suicidal behaviours when changes in their employment and marital statuses occur …

Their study of child and youth suicides concur with that finding: that the most stressful life events present were familial conflict in the age group of 10 to 14 and romantic relationship problems in the 15 to 19 age group.

A brief review of Menslink's own case notes in Canberra showed that, of the young men who have disclosed suicidal thoughts to us, only 30 per cent had a diagnosable mental illness where either we referred a young man for further clinical support or he was already receiving treatment. Fifty per cent of suicidal young men, however, reported stressful life events as the primary influence on their suicidal thoughts, including relationship breakdowns, family violence, unemployment or bullying. Of these 50 per cent, fewer than half also had compounding mental health issues. These figures correlate very well to the Queensland findings I mentioned earlier.

I would add that in our experience early life or ongoing trauma is a key indicator for

suicidal behaviours in young men and young women, whether that is exposure to domestic violence, bullying in school or in the family environment or being in prison or a detention facility.

A case in point is a young man who presented to Menslink for counselling with suicidal thoughts. He had recently had a car accident while under the influence of alcohol, resulting in criminal charges, loss of his job, loss of his car and a seemingly insurmountable debt. We were able to provide him, in a non-medical setting, with some coping strategies and tools for rebuilding his fragile self-esteem. We still keep in touch with that young man, and I am glad to say that some four years later he has never needed additional support. In fact, he has gone on to provide support to our organisation.

I also wish to draw the committee's attention to a particular group of young people who I believe are particularly susceptible to self-harm and suicide—a group that to my knowledge has never been identified in any suicide research in Australia, a group that to my knowledge receive no specific targeted support in this regard yet are at high risk of suicide and self-harming behaviour. I refer to the group of young adults on the autism spectrum.

Again, a brief review of our case notes reveals that over half of all young men presenting to Menslink with suicidal ideation and/or a history of suicide attempts or self-harm are on the autism spectrum. When looking at the contributing factors I spoke of in the research earlier, young autistic men, and women, meet all three criteria: they have poor emotional or impulse control, poor problem-solving skills and social isolation. For these young men and women, life stresses and social isolation are magnified more than for any other sector of our population.

Highly functioning autistic people—those who would in common parlance be referred to as having Asperger's syndrome—when faced with a major life stressor, are perhaps more likely to obtain the means of suicide and are less likely to be supervised to prevent suicidal attempts. These young men and women are not necessarily mentally ill, and therefore traditional suicide treatments are (a) not appropriate to them and (b) not available.

Again, I will give a case study of a young man who had harmed himself so severely that he was taken by ambulance to Canberra Hospital and admitted to the surgical ward for a significant amount of repair work. We tried to get him some additional support through the mental health team at Canberra Hospital. I remember clearly the psychiatrist on duty explaining to me, with regret, that the young man actually did not have a mental illness—which he did not—and therefore admitting him to a ward was actually going to be counterproductive for the young man's recovery. At the end of the day, the young man had to go straight back into the environment from which he came, with all of the stressors and causes that resulted in him being in hospital in the first place.

I would like now to talk about issues in current treatment options, reflecting on those causal factors that I spoke about. I believe there is currently too much emphasis on medical treatments and interventions that, firstly, may increase stigma for some people who do not identify with a mental illness, reducing the likelihood of them

seeking help in the first place; secondly, do not necessarily help those who are suicidal but do not have a diagnosable or, in fact, treatable mental condition; and finally, by placing emphasis on medical treatment, put unsustainable stress on very limited clinical resources such as psychiatrists, psychologists, headspace, CAMHS, CAT teams and the emergency and mental health wards in our hospital system. We have already heard other testimony around waiting lists and the impact that that can have on young people.

Our belief is that alternative, non-clinical and community-based interventions designed to build emotional resilience, build problem-solving capability and reduce social isolation, particularly for those most at risk, may address these issues and go some way to reducing the suicide rate. Our view is that the government needs to invest more in supplementary preventative support options to reduce the stress and waiting times associated with our current clinical treatment options. These options could include the following, and I quote again from the Australian institute for suicide research:

> … Improved exposure to mental health promotion campaigns in school settings from an early age. Male students, especially, should learn healthy coping strategies and problem-solving skills.

Secondly, we would recommend greater access to counsellors who can provide clients with coping strategies and support specifically targeted at resolving those stressful life events present in over 50 per cent of the suicide cases identified by Menslink and the institute in Queensland.

Finally, we believe that the government should conduct or identify research into the prevalence of autism in young people presenting with suicidal or self-harming behaviours. Specific treatment options through targeting learning or behaviour modification programs for young adults on the autism spectrum, I believe, are critical, not only in reducing the incidence of suicide and self-harm, but also in assisting these young people to develop their potential to become healthy contributing adults and members of our community.

Thank you very much. I am sorry if that went over time.

THE CHAIR: No; thank you for that. You seem to talk around stressors. Whilst we have heard a lot around mental health, what you are putting to us is that the bulk of what you see is around life experiences, those stress points where they are at transition points. In many ways, they are normal events that happen in one's life, but these young folk just have limited capacity to deal with them. Where do you think that early intervention, that emotional resilience, plays out? Is that through a community organisation, is it within the school or is it just generally getting the whole community to be better aware of how you build your emotional resilience?

Mr Fisk: School is obviously the area the bulk of young people will be moving through. That is an area where already Menslink is doing it for young men. There are organisations like MIEACT, but we need more specific targeted teaching. I think that teachers already have enough in their curriculum jobs, but there is a role for community organisations to come in; demonstrate and teach resilience; and, in

particular, get young men and young women—and I am talking as young as 10—to be able to recognise signs in each other that somebody is going through a hard time and get them some adult assistance. As our counselling program manager says, if this is the first time you have had a relationship breakdown, your parents have split up or you have experienced violence, you do not know that you can get through this. You actually need somebody who has been there and done that—that is, an older person; maybe even an older student, through a buddy program—who can teach you and show you in a positive, supporting way that you can get through this. I believe they are skills we can teach people as young as 10.

THE CHAIR: The other point of that is that within the school we often hear the debate about whether we need counsellors, youth workers or a multidisciplinary team. Do you have a view about that? It is more of a skill set rather than the name of a profession that is embedded within the schools to help the students and the other teaching staff?

Mr Fisk: I think it needs to be a multidisciplinary team, particularly with counselling. It is a recognised fact that around 30 per cent of the benefit of a trained counsellor is actually just in the relationship. That could be provided by anybody. We recommend young men to go and see a coach, a teacher, a chaplain, a pastor or a youth worker. It does not matter. Where somebody is struggling in particular areas, you need some specialist expertise, whether that is a qualified counsellor; at the pointy end, a psychologist; or somebody perhaps with training in Asperger's and autism, because we are seeing increased rates of people with autism spectrum in our community. I think one of the worst things we could do is have very limited resources, such as psychologists, performing some of those roles which could and should be performed by people who have not got a three or four-year degree and perhaps postgraduate qualifications behind them.

THE CHAIR: Before I go to Mr Wall, can I say that you have reinforced that referral to familiar faces first and foremost, and this notion of accidental counselling that happens along the way.

Mr Fisk: Very important.

MR WALL: Mr Fisk, I would like you to talk a little to the committee about the silence is deadly program which Menslink runs. I put on the record that I have had the opportunity to come and witness how that program operates, and I want to get your perspective as the head of the charity that runs it as to why you think it has been so effective and successful in breaking down some of that stigma.

Mr Fisk: The silence is deadly program is where Menslink staff or volunteers will go out to schools and present to groups as small as 10 and as large as 400 or 500 students at a time together with male role models such as Canberra Raiders football players. They go out and they do not teach lessons to the young men; they talk about their own stories. They talk about being bullied or being a bully. They talk about mental health issues. They talk about struggling at work. They talk about relationship problems. They talk about being scared before a football game. Then, importantly, they give a message about how important talking with their friends and their football coaches, bosses at work, schoolteachers when they were younger, is in alleviating those

stresses.

Finally, we give every young man in the group a card. It is a card that they can fit in their wallet. They do not have to the show their girlfriend, they do not have to show their parent. It contains tips on "how I can get advice and help myself" and finally "how I can help a friend". On the back we have options for phone and face-to-face counselling from Menslink, Lifeline, headspace. We provide online chat facilities and finally apps that they can download on their phone to help themselves or to help a friend.

We have had clients approach Menslink after three years and say, "We came to a silence is deadly session some years ago. Never thought we needed anything but kept the card in the wallet. Now XYZ's happened in my life. I need help. Can you help me?" I think it is reducing that stigma, because you have front-row footballers saying, "Yep, I've been to see a counsellor. I've been lonely and upset and couldn't cope. And the counsellor helped me through. Now I face a front-row pack every weekend." Those stories are incredibly important for young men.

MS LAWDER: You talked a little earlier about people who have experienced early or ongoing trauma and who may be more prone to suicidal thoughts or self-harm. How does your organisation help those people? Is it a referral service? Is it partly through your mentoring? Can you explain a little more?

Mr Fisk: The two greatest areas of trauma that the young men coming to us have are bullying at school and family breakdown and particularly family violence. We have a number of young men who have been witness to family violence, been victims, are perpetrators of family violence or sometimes they have been all three.

We provide them often with an adult male role model who is just a volunteer, and the benefit of that is to provide the young man with some stability in his life. Some of the young men in our mentoring program may not have experienced a man who was not violent. They may not have experienced a man who did not talk down to women, who addressed the young man not as an equal but as somebody to be respected. And that is incredibly traumatic for young men. So just having that person who is interested in them, who does not go away for two years or longer, is incredibly important.

The other thing we provide is trained counsellors. We have two trained counsellors who are diploma qualified. They have post-graduate qualifications and they receive extensive hours of ongoing training and supervision throughout their life at Menslink, and they provide trauma-informed counselling to give the young man strategies on how to deal with that trauma without overly internalising it or externalising it in the schoolyard or back at home.

MS LAWDER: Do you feel you have had good success with that approach in terms of eliminating further violence, or can you—

Mr Fisk: Very much so.

MS LAWDER: Do you have an evidence-based kind of—

Mr Fisk: We find it difficult to get statistical data because often what we find is that the young man, once he has left our programs, is going on and doing other things. But anecdotal feedback from schools, parents and sometimes the young men themselves is very supportive. We are working on a program at the moment to hopefully roll out later this year which we hope will give us some quantitative data, but it is very difficult to obtain, for the reasons I just mentioned.

MS LAWDER: Are there instances where you refer young men on to other professionals?

Mr Fisk: Yes. We have referred young men on to the male sexual assault part of the Canberra Rape Crisis Centre. We have referred young men on to Directions ACT where they need specific drug and alcohol counselling. We have referred young men on to headspace or to private psychologists where we feel they have a mental health condition that is perhaps beyond the role of a counsellor, and that might be a referral onwards or it might be a referral and we would continue to see the young man and work together with those other services.

MR HINDER: I would like to disclose that I have been a volunteer with Menslink for three or four years and—

THE CHAIR: Well done.

MR HINDER: I was instrumental in having the community bank support them and also in having the ACT vets rugby union become a major sponsor. I am a massive fan of this group and I congratulate Martin on all the work he has done. Please keep doing it.

You identified the stressors for particular young men and the fact that discussing that early in their schooling probably would be, you would think, a massive advantage to discuss the fact that these things are likely to happen to you somewhere in the not-too-distant future and just bring that out as a discussion. What do you see as the value of that in terms of getting them ready for that likely eventuality?

Mr Fisk: One of our school principals, albeit of a secondary independent school, talks to his young men about the need to have what he calls real conversations before trouble starts. So it is about, in particular for young men, building relationship skills. Study after study after study has shown that if there is a gender difference—and I think there is a gender difference in suicide, there is a gender difference in violence; most violent acts, most suicidal acts are perpetrated by men—it is due to the lack of relationship skills. Thomas Joiner, who is one of the world's leading experts in suicide, talks about young men sacrificing relationships.

Our view is that talking about stressors and the need to have relationships around you so that you can have those conversations is incredibly important. We need to remember that by the time young men and young women reach 18 one in four of them will have had their parents split up. One in four of them will then be living with a single mother. So 25 per cent of them, with everything else going equal in their lives, are going to have a massive life stressor, and the age of that is starting to creep earlier and earlier. When we talk to year 7s, it is the biggest topic—mum and dad are

breaking up, fighting or have broken up. It is above any other discussion. We thought bullying would be the highest topic, but it is that family breakdown. So they are going through those life stresses.

There is not actually a mechanism right now that I can see to bring people together and say, "You know what? It's okay. You can get through this, young man." I look at the results through the Queensland University study that parental breakdown and familial conflict and domestic violence is the number one key indicator of suicide in that age gap between 10 and 14.

THE CHAIR: I am not quite sure if I was right—I do not want to verbal you either—but the mention of a medical model was almost a barrier to seeking help, if it was categorised as mental health with the stigma attached to that. Just parking that then, if you have reference to the young man with autism, is that considered a medical model so that you just fixed him up and sent him home rather than wrapping around that emotional resilience and some other support strategies that clearly that family and that young man needed? And how do we break that out within a hospital that is purely a medical model or acute mental health? We have heard from Youth Coalition there is either this end or this end and nothing in the middle.

Mr Fisk: That is exactly right. I think that particular young man needed physical, medical intervention to fix his wounds. However, from a mental capacity, (a) they were not able to help him, and (b) also a clinical hospital environment with gowns and disinfectant smells and things like that is not ideal to bring somebody from a high level of stress down to a more peaceful, more manageable way. If you look, there was a woman by the name of Susan Beaton who did a Churchill Fellowship study around the world. And one of the things that she found in Canada and again in the UK with Mayfield House is that they are now providing non-clinical community houses and support services for in-crisis, suicidal people who do not need to go to hospital.

At the moment I think we have within the ACT—and it is the same, I believe, around Australia—community organisations providing a level of support, then we have a very overworked set of psychologists, whether they are at headspace or in private practice, and then an even more limited capacity hospital environment. I believe we need to invest more in the community work to prevent people needing to access the hospital environment or trying to access the hospital environment and either being turned away or it is inappropriate for their needs.

THE CHAIR: The terms of reference go to ABS data. It shows 50 to 60 children every week are admitted to hospital for self-harm. You have made the comment that you think there are a high number of people on the autism spectrum within that. Do you know if there is any data on that or, indeed, is that why you commented about it being an area we should be looking at?

Mr Fisk: There is. I know personally a young man whose first response to a life stressor is probably self-harm, and being a highly functioning Asperger's young man, he does have access to weapons, he is unsupervised. Something goes wrong, and it is not the last response; it is his first response. That is a really difficult situation to deal with. I note we have no specialist Asperger's or autism spectrum disorder services here in the ACT available to young adults.

MR WALL: You talked about the in-school counselling program that you operate and that it is independent of the school. How is it different to, I guess, the traditional model where it is an employee of the school on site most days?

Mr Fisk: The two main differences we have found are (a) the young men know we are not part of the school system. So they have an expectation and a belief, which is fully justified, that we will be more confidential than somebody in the school. You heard from the Youth Coalition that often young people want to talk to somebody who is anonymous. Our counsellors come in for only a morning a week. A young person who might have disclosed that he is gay or he is getting bullied or he is getting bullied by a teacher is able to come and see us and know that he is not going to bump into the school counsellor and see him go into the staff room, for example. So they are more likely to come and see us than sometimes a school counsellor. There is also the issue of variety.

The second thing we are able to provide is continuity. If you have a young man who is in a stable but perhaps challenging environment at school, all those supports stop during school holidays, particularly Christmas school holidays, which is eight weeks, where the education directorate is unable to help them in any way, shape or form. Our counsellors, subject to normal holidays that everyone takes, are still there over that period.

More importantly, what we have found is that one of the high stressors is transition and loneliness. They happen very much so when a young person leaves school. When a young person leaves school they can continue to see our counsellor. They might be seeing the counsellor in Kingsford Smith or Melba Copland College or Calwell high. When they leave that environment, they can continue to see our counsellors, whether they are unemployed, employed or in further education and training. So there is that continuity of support which I believe is absolutely critical.

MR WALL: What is the demand for those sorts of services? What numbers are you providing services to, and is there an unmet demand?

Mr Fisk: There is a very significant unmet demand. From our own funding sources we are about to employ a third counsellor. Were we to have the money, I believe that we could employ four counsellors and still not meet the demand in schools and outside in society.

MS LAWDER: I was interested to hear you talk earlier about your volunteers. How do you support your volunteers? They must hear some traumatic stories at times. What sort of assistance do you provide to your volunteers for their own mental health?

Mr Fisk: We have two near-full-time employees who case manage the volunteers and have a face-to-face meeting with every volunteer once a month in their first year and once every two months in their second year, unless there is a need. We also provide counselling services to the volunteers and/or their young men if there are those difficult circumstances.

We also provide a monthly catch-up where the volunteers get to mingle with other young men, so they are not feeling 100 per cent responsible for this one young man, and they get to mingle amongst themselves and share stories and become that sort of community and self-supporting network, which is actually the model we are trying to promote across the community: people helping each other.

We are taking 20 volunteers down to Jindabyne next weekend. Somebody has donated some facilities for us and we are taking them away on a retreat just to, again, provide that out of care support for our volunteers in addition to the case management and additional counselling.

MS LAWDER: Do you have a good retention rate of your volunteers?

Mr Fisk: Yes, we do.

MS LAWDER: Longer term?

Mr Fisk: We have some volunteers who have been with us for 10 years or more. We have some volunteers who have managed three or more young men's relationships over a two-year period. So we are very pleased with the number of volunteers. Could we do with more? Yes. In actual fact we are looking next year to potentially expanding our program to provide mentoring for younger men, down to age 10.

THE CHAIR: Is that because the earlier you get in around emotional resilience, the better the outcomes?

Mr Fisk: Yes. Also, anecdotally from school principals and the police, the problems that used to be seen in year 7 are now starting to appear in year 5. I believe the earlier we can build up that resilience, the adult positive supporting relationships, the better off we will all be.

MR HINDER: I was interested to hear your comments about autism and Asperger's. I do not know whether you know this, but I was on the board of Autism Asperger ACT. The Bendigo Bank has supported them for the past nine years. I am wondering how much interaction you have had with Gay Von Ess or Peter Brady from that organisation, since you have come to this realisation of what you say is a pretty well undocumented existence of demand and need.

Mr Fisk: I also used to be on the board of Autism Asperger ACT, so I know the organisation very well. We receive a number of referrals from that organisation and work with them reasonably closely. Across our programs approximately 20 per cent of our clients are on the autism spectrum. There is increasing demand, but we are not a specialist provider, and that organisation also is very limited in their capacity.

THE CHAIR: I have a final question. Is Menslink putting in a written submission, or are you just appearing? We value your appearance—I should not have said "just".

Mr Fisk: No—

THE CHAIR: I will go to the last question. One part of the terms of reference is

about whether there are unique factors contributing to youth suicide in the ACT. It is a very big question. You have made comment around maybe having better supporting data on young folk with autism. Would there be anything else that we would benefit from being aware of?

Mr Fisk: I think there is a degree of transience in our adult population which then affects younger people as well. I know the Defence Community Organisation has defence mentors to help people transition into schools. We do have a number—and I cannot tell you what that number is—of young people who have been in the ACT for two years or less and who may be in the ACT and leaving the ACT. That makes it difficult for adults to form meaningful relationships, so I cannot imagine what that would be like for young people as well. Beyond that, I do not see that there is any unique factor in the ACT that is different from any other state.

THE CHAIR: If there is nothing else, thank you for coming in. The committee recognises the great work that Menslink do. Continue being a champion for young men in the ACT, and well done. If we have any further questions, we will send them to you in a timely manner.

Mr Fisk: Thanks.

THE CHAIR: We will break for 15 minutes for afternoon tea.

Sitting suspended from 3.14 to 3.30 pm.

CORBELL, MR SIMON, Deputy Chief Minister, Attorney-General, Minister for Capital Metro, Minister for Health, Minister for Police and Emergency Services and Minister for the Environment and Climate Change
THOMPSON, MR IAN, Deputy Director-General, Canberra Hospital and Health Services, ACT Health
BRACHER, MS KATRINA, Executive Director, Mental Health, Justice Health and Alcohol and Drug Services, ACT Health
O'DONOUGHUE, MR ROSS, Executive Director, Policy and Government Relations, ACT Health

THE CHAIR: Good afternoon, minister and officials. Thank you for coming to this public hearing of the Standing Committee on Health, Ageing, Community and Social Services and its inquiry into youth suicide and self-harm.

Can you please confirm that you have read the privilege card, and that you understand and accept all of that.

Mr Corbell: Yes, thank you.

THE CHAIR: Thank you. Do you want to make a statement before we go to questions?

Mr Corbell: Thank you to you and the committee for the opportunity to appear before you this afternoon. I do have a brief opening statement and then I and my officials will be happy to try to answer your questions.

Can I start by saying that the mental health and wellbeing of young Canberrans are a key priority for the government. I am pleased to say that the government invests heavily in the area of mental health and wellbeing. In this year the government has invested $1.5 billion across the health sector, including $133 million in mental health services, which is an increase from the previous year's budget of $6 million.

ACT Health provides a comprehensive suite of public mental health services, including the child and adolescent mental health service. The child and adolescent mental health service assists children, young people and their families and/or their carers by providing specialist assessments, therapeutic interventions and clinical case management as well as specialist services such as the cottage day program, eating disorders program, early intervention psychosis service and dialectical behavioural therapy program.

The government also funds a wide variety of community-based organisations that work with young people to support their mental health and wellbeing and to help try to prevent suicide and self-harm. I would like to give a few examples. We provide funding in the non-government sector space to Mental Illness Education ACT so that they can provide information and education about mental illness and the maintenance of mental health targeted to students of secondary schools and colleges and through youth groups and organisations; for the implementation of the kids matter and mind matters national programs for primary and secondary schools to enable individual schools to develop their own mental health strategies to help kids and young people to

improve their mental health and wellbeing; to the Gugan Gulwan Youth Aboriginal Corporation, providing an early intervention youth outreach program supporting and advising vulnerable Aboriginal and Torres Strait Islander young people who are experiencing mental illness or emotional wellbeing concerns; and to the trauma recovery centre, Melaleuca Place, which provides trauma-informed therapeutic services for children aged zero to 12 years who present with issues including emotion dysregulation, severe impulsivity, impaired relationship functioning and high levels of aggression and suicidality. The centre works with children in the context of their care and provides support networks using trauma and attachment-informed interventions.

These are important investments in supporting the health and wellbeing of our young people. But, regrettably, we know that serious problems remain both in Australia as a whole and in our own community. In March this year the ABS released its latest causes of death data that includes data on deaths by suicide. These figures are sobering. It shows us that suicide increased across the nation in 2014. In Australia as a whole, the rate of death by suicide per 100,000 of population has increased to 12, up from 10.9 in 2013. In the five years to 2014, youth suicide also increased, to 2.2 per 100,000 of population, up from 2.1 in the five years previous. Nationally, 2,864 people committed suicide, more than twice the number lost on our roads each year.

In the ACT we have also seen an increase in the rate of suicide. Because of our relatively small population, the ACT uses the five-year age standardised death rate by suicide to report suicide rates. For 2014 the rate increased to 9.2, up from 9.1 in 2013. In terms of youth suicide in the ACT, the rate increased to 2.1 per 100,000 of population, up from 1.8 in the previous year. Despite these increases, it is worth observing that the ACT does have the lowest overall rate of suicide in the country and is below the Australian average for youth suicide.

It is the government's view that one of the most significant issues in this area is the lack of research into suicide and self-harm. While we know the official rate of suicide, we have much less information about mental health and self-harm at a jurisdictional level and less again in respect of the mental health and self-harming behaviour of young people. While the data on youth mental health and self-harming behaviour at a jurisdictional level is lacking, there has been a series of national reports that have helped us to improve our level of knowledge and understanding.

The National Children's Commissioner's children's rights report from 2014 contains the findings of an examination conducted by the commissioner into the protection of children from intentional self-harm with or without suicidal intent. The AIHW report *Suicide and hospitalised self-harm in Australia: trends and analysis*, which was released at the end of 2014, provides information about trends in hospitalised self-harm over the period 1999 to 2000 and for suicide for a much longer period. *The mental health of children and adolescents: report on the second Australian child and adolescent survey of mental health and wellbeing*, released last year, provides information and analysis on child and youth mental health, including self-harm and suicidal behaviour. Finally, the report of Orygen, the National Centre of Excellence in Youth Mental Health, released in March this year summarises the available data on youth self-harm in Australia and current government responses and suggests a series of actions to take a joined up, systemic response to the problem.

We know from these reports as well as from the regular ABS reports that suicide, self-harm and mental illness are increasing in young people. We also know that there is significant stigma which presents as a barrier to seeking help for people in these circumstances and that health promotion, education of both the community and health professionals, better coordination of services and improvements in early intervention may very well be the way to combat the issues presented by this problem.

For all these reasons, the government remains committed to increasing the effort and the resources, wherever possible, that we are able to put in to ensure that all ACT residents, and especially young people, are able to tackle these challenges and enjoy good and healthy productive lives with good mental health and wellbeing.

I would like to thank the committee for the opportunity to make a statement. I am happy to try to answer your questions.

THE CHAIR: Thank you. I think the report that is just out highlights what we have heard through witnesses today: education, coordination and early intervention around early trauma seem to be the theme for me today. You have mentioned research into mental health and self-harm data. Can you explain a bit how you capture that data and how much you think you are not capturing. While people may present with physical injuries, how do you identify whether it is self-harm or a suicide attempt? And today a witness spoke about a feeling that with self-harm and suicide, only 50 per cent have actually got a diagnosis of mental health: that they are responding to stressors; they just do not have the emotional resilience and they act out in self-harm. So one is about data and the second is how you would capture the data that is not within mental health.

Mr Thompson: In relation to the data, there are two broad ways we collect data. The first is in relation to the services that people come in contact with; the second is through population health survey type data. The sorts of data that the minister was talking about earlier tend to focus more on the population health side of things, but there is a degree to which they are also looking at the service contact data.

In relation to understanding self-harm, it relies on the clinical interaction to be recorded in relation to the services that people are encountering. For example, if it is in the emergency department, someone can come in with a range of injuries that may or may not be self-harm; within that, what we will have is whether or not, through the clinical interaction, someone is prepared to disclose the nature of the injury and seek help accordingly. Similarly, within the specialised mental health services and other service providers, there is a means, through that clinical engagement, to elicit some of the information.

For the ACT government, the data that we collect inevitably in that circumstance is limited to the services we provide directly. Where people are seeking help from non-government organisations and through primary care, there are limits to how much of that we are aware of and are able to access. That is definitely an area in data that is worth developing.

THE CHAIR: Do you get a sense of what that is? If a young man comes into A&E and they have been in a car accident, fallen off the first floor balcony or some such

thing, they are not going to necessarily open up and say, "I self-harmed."

Mr Thompson: Not necessarily, yes. And that is the issue here.

THE CHAIR: Do you get a sense of what sort of leakage there is in that—

Mr Thompson: It is very difficult to estimate that, unfortunately. But that is where we try to complement the service delivery data with the survey data to see what the differences are and whether or not there are patterns that we can elicit through that.

Mr Corbell: I might ask Ms Bracher if she wants to add to that.

THE CHAIR: When she responds, perhaps she could go to the proposition that not everyone who self-harms has a mental health problem and how you would nuance that.

Ms Bracher: With regard to the data, we just reinforce what Mr Thompson said about reporting output indicators to the Assembly around our child and adolescent and adult community-based services. But that is a fairly blunt suite of data with regard to suicide and self-harm. The coroner's data is really the absolute data with regard to suicide numbers in the ACT.

With regard to our qualitative measures within our public mental health services, we do look at our clinicians' clinical practice with regard to suicide risk assessment and vulnerability assessment, and we do measure that and monitor those data on a monthly basis.

So we do have those data. That does not tell us, though, other than doing a clinical record review, how many people have been assessed as positive at a given point in time. The clinicians are also very particular in stating that a suicide vulnerability assessment at a point in time is not necessarily a very good predictor of long-term outcome. But it is part of the assessment process that clinicians do.

With regard to the second question that you posed, around people self-harming not necessarily having a mental illness, that is certainly what the clinicians experience, both in the emergency department and in the inpatient areas.

THE CHAIR: And that is where that community resilience and education come to bear. I have one last question before I move to Mr Wall. With people with autism, particularly young men on the autism spectrum, they have a diagnosis that is not mental health. They may not respond as readily to other intervention programs. Is there anything afoot in Health about the management of that or being aware of it?

Ms Bracher: Certainly child and adolescent psychiatrists are very well aware of the interface between autism, mental illness—and, in fact, intellectual disability and acquired brain injury—and the interactions between all of those experiences that people—young men, young women and older people—might have. So, absolutely. Our public mental health clinicians work very closely with staff in education and in the Community Services Directorate that are also involved in those other areas, for example, the autism team that works in the Community Services Directorate.

MR WALL: Minister, we heard from a couple of witnesses this afternoon, and particularly the Youth Coalition, the feeling that there is a gap in services available for young people in particular; that there is a good offering for a low level of need or severity of suicidal tendency, and then the extreme end is also well served. With the intermediate area there is a slightly more moderate need than low level but it is certainly not a case of requiring severe intervention or the mental health ward. Can you enlighten the committee on what services are available in that moderate, intermediate space, particularly for young people where cost would be a determinant as to whether or not they are accessible, and then maybe allude to what some of the wait times might be for access to those services as well?

Ms Bracher: I can talk about the on-the-ground services. When we talk about young people, it is different depending on how young the person is. For children, if we go to that end of the spectrum, there are services predominantly through paediatrics, and our child and adolescent psychiatrists and mental health workers are a secondary consultation.

MR WALL: Up to what age does paediatrics cover?

Ms Bracher: There comes an overlap in early adolescence. Certainly, for a primary school age child the referral pathway from a GP is predominantly to a paediatrician, and the paediatrician would then do a secondary consult or tertiary consult to our child and adolescent psychiatrists. We have a number of clinics where both paediatricians and psychiatrists see the child and family together. Once we start to get into older adolescents and youth—and youth is defined as being up to 25—the services available are predominantly in the community sector—primary care and the community sector. The administration of funding to those community sector organisations is part of Ross O'Donoughue's area.

Mr O'Donoughue: While listening to the question, I was reflecting that the National Mental Health Commission report that was released recently by the commonwealth highlighted some of the problems of duplication and siloed implementation of mental health services for children and called upon greater coordination between Australian government-funded services and state and territory services, including those in the primary care sector. In that light the commonwealth has in fact bundled up some of its previously funded programs and offered them to the primary health networks—and our one is the Capital Health Network in the ACT—for future commissioning of new services.

I am pleased to report that the ACT health service and Capital Health Network have formed a coalition around that process. We agree that there is scope for better coordination of services and that some of the previous commonwealth services did duplicate services that were funded in the territory. So we are looking forward to a collaborative arrangement once the guidelines for the commonwealth funding are clearer, whereby we hope we will be able to provide better coordinated services in the primary mental health space.

As Ms Bracher alluded to, there is a long list of youth-related community organisations that are funded in the territory. In fact the territory has the largest

proportion of community-based mental health services in the country, which we are very proud of. We have a list of approximately $5,550,000 of recurrently funded services that are based in non-government organisations. I would be happy to provide the list and the detail of the funding subsequently.

THE CHAIR: That would be good.

Mr O'Donoughue: Perhaps it would be better, if you do not mind, if I do that rather than run down the whole list of organisations.

THE CHAIR: Yes.

MR WALL: Of the services that are funded, what does the department look for in providing that grant funding? Does there need to be an evidence-based proposal put forward? What are you looking for when the grants are issued and what assessment and measuring are done of the efficiency and effectiveness of those programs?

Mr O'Donoughue: Thank you for the question. There is a longstanding relationship with the non-government sector in respect of mental health services in the territory. In addition to their participation in planning things like the mental health services plan, we have invested in their capacity and we have asked them as part of that process to move towards accreditation standards and to comply with standards like the national mental health standards. Depending on the type of service, because there is a varied range of services provided, broadly speaking they are all asked to meet minimum qualification requirements and to assess themselves against standards like the disability standards or the national mental health standards. They are the broad things. For each service funding agreement there are specific performance criteria that they report against on a six-monthly basis, as well as their audited financial reporting that they are required to comply with.

MS LAWDER: Minister, what is the overarching framework, strategy or plan for mental health that we are currently working to in the ACT mental health system?

Mr O'Donoughue: Thank you for the question. There are a couple of things. The government is very close to finalising *The ACT mental health and wellbeing framework 2015-2025*. The government decided some time ago that the two previous strategy documents—*A framework for promoting mental health and wellbeing in* the *ACT* and *Managing the risk of suicide: a suicide prevention strategy for the ACT*—in their next iteration should be combined into a whole-of-government framework. That document has been agreed by cabinet and will be released very shortly. It lifts up, in a sense, the responsibility for resilience and mental health wellbeing across all government directorates and accords particular responsibilities for government directorates in that space.

It comprises a suite of documents. There is the framework itself, which is a brief overview document, there is an evidence base which sets out the research background that it is based on, and there is a snapshot document that contains a selection of indicators of mental health and wellbeing in the ACT and brief details of flagship programs across the directorates. It is the intention that that snapshot document will form the basis of a high level report that will be tabled in subsequent years to reflect

the framework.

In addition to that local document, which is pretty groundbreaking, we think, in the ACT, we participate in the national planning frameworks. There is currently a fifth national mental health plan in preparation. The COAG mental health council will be considering progress on that at its forthcoming meeting. That is something that all jurisdictions, including the commonwealth, contribute to for national direction in mental health.

MS LAWDER: You mentioned we previously had *Managing the risk of suicide: a suicide prevention for the ACT* and *Building a strong foundation*, which are being combined into a framework.

Mr O'Donoughue: I am sorry; I confused you. I garbled the title. *Building a strong foundation* is in fact *A framework for promoting mental health and wellbeing in the ACT*. We used to have a suicide prevention strategy and effectively an early intervention and prevention strategy, and it is those two documents that have now been combined to form this new framework document.

MS LAWDER: Will it be renamed for 2016, because—

Mr O'Donoughue: *Building a strong foundation* was the earlier name of one of those documents. The new name is *The ACT mental health and wellbeing framework*.

MS LAWDER: I think you said 2015-25. Will it actually be renamed 2016, given we have already passed 2015?

Mr O'Donoughue: That is a good point. That is something that should be considered.

MS LAWDER: In the meantime are we still using the old documents as the overarching plan?

Mr Corbell: Those are the extant policy documents at the moment, but they are at the end of their applicable life. The new policy work has superseded that, and that will be promulgated shortly.

MS LAWDER: Without asking you to announce policy, in one of the submissions I have seen so far, from the National Institute for Mental Health Research, one of the things they talk about is enhancing available data on suicide in the territory by establishing a suicide surveillance system or registry. Is that likely to be part of the new framework?

Mr Corbell: There will be a range of actions that sit under the framework but will not be explicit in it. The framework is about responsibilities for different types of activities and interventions and sitting within each directorate there will be specific programs and activities that those directorates will determine. Certainly, the idea of a registry is one that would fall within the public health areas of ACT Health, and indeed the policy areas around mental health. Those would be matters that the Health Directorate would give consideration to.

THE CHAIR: That would help in some ways with the data. That information around research could be a mechanism for that.

Mr Corbell: The difficulty—and Ms Bracher alluded to this—is that at the end of the day, with unexpected deaths, the legal mechanism is through the Coroners Act and relevant procedural arrangements. Matters that are referred to the coroner because they are an unexpected death are the way that we determine suicide in the territory, because that is the legal framework by which we attach that nomenclature to a particular event, not through other mechanisms.

MS LAWDER: We heard some groups say that potentially a coroner's findings might say "misadventure for other reasons", for the ease of the family or insurance purposes, rather than suicide. Is that the case?

Ms Bracher: I could not possibly make a comment about a coroner's findings. However, across the nation there is anecdotal discussion that the incidence is higher than what is reported by the coroner because the coroner is limited to evidence which categorically says that it is a suicide. There may be other cases where the level of evidence is not sufficient to make that finding.

Mr Corbell: What is often alluded to is single motor vehicle accidents, for example, where, as Ms Bracher says, there is no evidence such as a note or some other indication left after the event of the person's intent. In any event it would be difficult to obtain definitive data. You could speculate on what it was, but you could not be definitive. Even with a broader reporting or surveillance arrangement, it would still not be definitive because unless we know what the person's intent was, it is not definitive.

MR HINDER: I have a question about the coordination of different agencies in relation to addressing the issue. I am reminding myself that we are talking about youth suicide as opposed to the broader issue of suicide itself and a whole-of-government policy and response. There is a table in the documentation that gives a whole range of options and responses but we heard fairly persuasive evidence, in my view, about the fact that quite often suicide is not a health issue; it is a response to a stressful life event. I think the numbers that Ms Burch referred to showed that 22 per cent of people in the Queensland study that self-harmed or attempted suicide were diagnosed with a mental health issue, whereas 50 per cent of them were about stressful life events. Family breakdown, family violence, bullying, employment loss were the sorts of indicators for those.

Given that Family Court justices are referring to five and eight-year marriages as long marriages these days, it is logical, then, in my mind, that children going into high school—one in four of them seems to be the number—will be subject to one of those stressful life events in the breakdown of family. How do you see the coordination of these non health-related things that result in health-related outcomes, I suppose, being improved as time goes on? It is probably a policy issue.

Mr Corbell: I think fundamentally it requires us to continue to strengthen what we do, which is support programs and activities particularly in the school setting, and make sure that there is outreach into the school setting, that there is capability building

within the school community itself to work with children in that context in particular. I think, importantly in the school setting, the school can be the gateway to other services and to further support. Rather than having the family or, indeed, the child themselves trying to work out where to go, the school can provide the gateway, the referral and the connection through to more intensive levels of support if that is what is required.

Again, in the government submission we outline the broad range of programs that are funded to provide support particularly to school-age children and how many of those are delivered by the NGO sector. That, I think, is something that we are going to need to continue to strengthen and to build over time. In particular, I think building capability amongst school communities themselves is very important.

Ms Bracher: Minister, would you mind if I added something to that?

Mr Corbell: Go ahead.

Ms Bracher: In operations land in comparison with policy land, we talk about a stepped model of care. I find that is a very useful way of understanding the steps that somebody might escalate through as their needs either deteriorate or improve. The population base, the school-based models are that first step of identifying concerns and addressing concerns. Primary care is the next step where a referral to a GP is the appropriate next step. Then the specialist, community-based mental health services is the next step, and then the next step would be an inpatient facility to be cared for. So they are the steps.

Our public mental health service, our CAMHS service, actually does in-reach into all of those steps that are down that tree, if you like. We work with GPs very closely. We work with the police in primary care. We have a specific CAMHS clinician who goes out with the police over and above what our crisis team does with police—somebody focused on children and adolescents—and those clinicians support police in cases where it is the first time that a child or adolescent has got to that point of such significant emotional distress that the police have been called by family or schools. We also do early intervention and mental health promotion in the school setting with the teachers.

On the question of integration, we are trying very hard to work across those sectors, recognising that our role is in the specialist secondary and tertiary level care as the public mental health service so that we do not not provide that function, because that is our role, but that we are very aware of our connections with general practice, our connections with school and our connections with other emergency services like the police and the ambulance services who can be the first point of contact for a family and a young person that is really in distress.

MR HINDER: The events that lead up to each one of these are completely different to each other, and I do not try and suggest there is some formula for it but is there any attempt at all to come up with some sort of matrix of indicators, whether that be breakdown of marriage and those things, where young people tick boxes for social workers or people in schools? I think schools are probably the first place for these things as well. But where you get a level of Defcon increase or something like that,

that allows for the focus of any services that are available? You only get one go at this sometimes.

Ms Bracher: I spoke earlier about our indicators within our mental health services that we use for assessing. There are suicide vulnerability assessments and self-harm assessments that we do. They are very clinically oriented. They require a health professional to do them—psychologist, nurses and the doctors as well. I am not aware of what screening assessments that either teachers or school counsellors might do. I am not aware of that; so I cannot speak to that on behalf of education.

We have through ACT Health and through one of the previous budgets—I think it was last budget, for 2015-16—there was some funding that went to the ANU Medical School, to the School of Behavioural Sciences. Professor Raphael is leading a piece of research into suicide within the ACT. That is not necessarily only looking at coronial findings but also doing some qualitative research with the Mental Health Consumer Network, Carers ACT, the Mental Health Community Coalition and Winnunga and Gugan, the two Aboriginal health services, to try and qualitatively document for the ACT a point in time around suicide, self-harm and suicide attempts, and completed suicide as well.

That piece of research is underway at the moment, and the report into that is expected towards the end of this year. That will be a qualitative piece of information that we will be able to use in the ACT along with the information that comes from the coroners or from the population health data that we extrapolate from national data into the ACT.

THE CHAIR: Is it the end of this calendar year that you are expecting that report?

Ms Bracher: Yes.

Mr O'Donoughue: If I may, just for the record, the research is being conducted through the academic unit of psychiatry and addiction medicine based at the ANU Medical School under Professor Raphael's supervision. It is the period 2010 to 2015, and the report is expected by the end of 2016.

THE CHAIR: You mentioned the Orygen report and others. We have heard today from other witnesses around education across the community so that people are aware of, as I have heard today, counselling where people go to someone who is familiar. How do you build a skill level up across the community, whether they are teachers, nurses or others? We also heard about the importance of early intervention. Again, without releasing the framework, what focus is Health putting on that early intervention, community education?

Mr O'Donoughue: One of the themes in the Orygen report is about destigmatising self-harm and suicide ideation and encouraging people to have sensible conversations about it. And each year in conjunction with Suicide Prevention Week and Suicide Prevention Day, which is 10 September each year, we have been running the let's talk campaign, which is a locally developed, social marketing awareness raising campaign developed here in the territory. We think that is gradually building in terms of community awareness. There are community events. We get good support from

community service announcements in the media. We run community events. And quite a number of the programs that I mentioned we fund in the non-government sector are in particular settings, like the OzHelp Foundation works in the building and construction industries among apprentices, raising awareness. So I think there are some quite tailored approaches.

But I think there is gradually building the notion that it is actually okay to ask people if they are okay, it is okay to talk about what self-harming might be about, that it is not a taboo subject, that it is not going to place people at greater risk by raising the issue or having a sensible conversation about it. That is one of the key focuses that we have.

THE CHAIR: You made mention of, I think it was, $1.5 billion in health—$130 million in mental health and $5 million in community health. Given what everyone is saying—that early intervention, education and awareness pay dividends—is $5 million enough in that area?

Mr O'Donoughue: The $5 million is the ACT Health community organisation-funded component. We have not costed there the activity that goes on in education or in Community Services Directorate or other parts of government.

THE CHAIR: The final question before I go to Mr Wall is: is there much commonwealth investment in mental health across our community and is that maintained or is that steady and reliable and are there matters of duplication as well? How do you both keep an eye on that?

Mr Corbell: This issue was identified through the commonwealth's reform program led by Ian Hickey, I think, who was involved in the report into mental health—no, it was Allan Fels's report into delivery of mental health services across the federation. His report identified significant overlap. That is right, the National Mental Health Commission report. It identified significant overlap of funding and service delivery between the states and the territories and recommended a broad range of reforms designed to provide for integration of service delivery, reduction of duplication overlap and gaps in service delivery between the two funding models.

As I understand it, the Australian government provided a response but they did so without talking to the states and territories about the response to that report. This was disappointing because we are also service deliverers and we were not engaged in that process. If the whole issue is about reducing duplication overlap, we need to talk with each other about it.

THE CHAIR: Is that in the public record, the response?

Mr Corbell: Yes, it is. Minister Ley released that last year. The commonwealth has changed its funding arrangements for primary mental health services, particularly funding to the community sector, and has moved away from a direct funding model where it provides grants directly to a whole range of service providers and instead is providing funding to the primary health networks which are the replacement bodies for Medicare Locals and PHNs. Here in the ACT the Capital Health Network will be given a bucket of money to contract a range of service providers or do it itself for

certain primary mental health services in the community.

THE CHAIR: And one would assume that Health and the network would coordinate so that we do not get a repeat set of overlaps.

Mr Corbell: One of the criticisms of the decision around the funding through the PHNs is that obviously in larger jurisdictions you will have multiple PHNs and they will each be potentially contracting different providers. We are fortunate here in the ACT that we have one PHN and we have a very constructive, collaborative relationship with Capital Health Network. So we are working closely with them on those issues.

MR WALL: Minister, you or some of your officials might be able to walk the committee through the experience of someone that presents at the hospital after a serious incident of self-harm or attempting to take their own life beyond, I guess, the physical treatment for the injuries they may have incurred in that act, the mental health and the psychiatric support that might come in.

Ms Bracher: Thank you for the question. I think the point that you make about what happens before is really important. We have got great emergency services that bring people in very quickly to the emergency department. That is very important. Addressing the physical issues—that might be a substance that a person has ingested, it might be a surgical need—is very important, and those two things take priority before anything else does. I make that point. The physicians in the emergency department and their clinical teams do that very effectively.

At the point of triage, though, in the emergency department, our mental health service is notified of a person who has come in and might have self-harmed. We are put on notice, if you like, on standby, for an assessment at a point in time when the physicians have assessed the person to be stable. Our mental health nurses will do an assessment in the emergency department and provide advice to the psychiatrists and then a decision will be taken at that point. Sometimes it is very clear that the person does not need any further physical medical care. Then there is a decision about what mental health care the person might need.

If the person is at such high risk that they meet the threshold of the Mental Health Act, our clinicians will detain the person and provide involuntary care. That might be in the emergency department and that might be in our inpatient unit. That is one pathway.

If the person does not meet that threshold, there is a conversation that goes along the lines, "We are worried about you. We think that you would benefit from being admitted and we would like to do that." But if they have not met the threshold of the Mental Health Act we are obliged to put in place a safety plan with them and try and support them with their chosen path, if you like.

We very actively include the crisis team in that case and we actively include our community-based mental health teams or CAMHS, the Child and Adolescent Mental Health Service, if that is the age of the young person. And then we try to provide community-based care, which we can do seven days a week until 10 o'clock at night. We can do that.

Mr Thompson: The other thing I would quickly add is that at the beginning of this calendar year we opened a new assessment area and short-stay unit within the emergency department to provide a more therapeutic environment both for the assessment as well as potential for a short stay afterwards for people who have come in for a range of mental health issues, including self-harm. That is providing a more effective means within the emergency department to go through the steps that Ms Bracher was talking about.

Ms Bracher: Sometimes the mental health assessment actually takes longer than other times. Sometimes it is very obvious for the clinicians who are experienced, and sometimes it takes a little longer. We just like to take our time to establish whether the person would be safe to go home with their family and with supports in the community or whether the safest place for them is in the inpatient area. And that short-stay unit is a great addition for us to be able to do that in. We do not necessarily admit the people to the adult mental health unit or to the paediatric wards; we can keep people in that area for a day, overnight till the next morning, when we can have a conversation with the family about what supports can happen in the community. That is a great alternative to either admitting or not admitting.

MR WALL: And if they do not get admitted as an inpatient, the supports that can be provided in community, how long do they occur for—the following couple of weeks or even the first month or two? What might those supports look like, I guess, in a practical sense? I am just trying to get a picture of what the journey of someone in this space might be.

Ms Bracher: With the caveat that everybody is assessed individually and will have an individual care plan, we have seven-day-a-week care—if I keep it to the child and adolescent space, given the committee's considerations.

MR WALL: Yes.

Ms Bracher: Child and Adolescent Mental Health Service provides seven-day-a-week care. After hours that care is provided by our crisis team. It is based on an individual assessment, if somebody needs support, whether that is in-home visiting or whether that is in-clinic visits, bringing the child and family into a clinic, or whether that is phone contact. Sometimes the in-between days are by phone contact. Sometimes there is a transfer back to general practice and if the family have already got a psychologist engaged and they have a good relationship with that psychologist there will be a transfer back to that psychologist. We always do a safety plan with the child, adolescent and their family. Sometimes as the adolescents become older and into that youth age group, we have to work carefully with the individual and their family to do that in a way that meets everybody's needs, because the young person and their family obviously can have different perspectives around that. So there is a safety plan put in place and contact details for where to go if you are concerned after hours and how to make contact with the service.

MS LAWDER: I have a supplementary. Mrs Jones, when we spoke about this motion in the Assembly, referred to an instance in the emergency department of a mother with a daughter who was threatening self-harm or suicide, and who said to Mrs Jones

that she had been waiting in two different hospital EDs for 20 hours, I think. Would that be typical or would that have been because you were observing the daughter? Can you explain that?

Ms Bracher: People can stay in the emergency department, and in our mental health assessment unit prior to transitioning into this new model of care. People can have been in the physical building of the emergency department. You asked whether that was because we were observing how the child was doing. That may well have been the case. I cannot speak about individual cases. Sometimes the emergency services do take people to Calvary, there is an initial assessment there and then a transfer over to the Canberra Hospital, if that is considered to be the most appropriate place, and that takes time. But we do try and keep people in a safe place for long enough to assess what their needs are and whether the level of risk is acceptable to both our clinicians and to the family for discharge back into the community.

MS LAWDER: Mrs Jones said:

> … the mother was actually getting to the point where she was considering taking her daughter home because she herself could not cope mentally with waiting any longer and she was melting down quite severely in the emergency area. I think we all have to ask ourselves the question: even though there are services in Canberra, how can that be happening?

That is, they had waited for 20 or 21 hours.

Mr Corbell: It is not clear from that whether it was a case of waiting without having being seen or whether it was waiting in the context of an ongoing assessment. Without being privy to the particulars of that case, it is difficult to answer that, but it is important to stress that we have deliberately built capacity inside the ED for short stay. Rather than people needing to be admitted as an inpatient, they are able to be observed for what would be a longer period—as Ms Bracher says, it could be up to 24 hours potentially—but they are in an environment which is suitable, modern, clean, light, airy, and purpose built for the purposes of observing and making sure people are safe before they are discharged. If it is clear that they are not going to be safe, they are able to be admitted involuntarily if needed or with their agreement.

MR WALL: Minister, what is the extent of the difference between the levels of care that can be provided at the two main hospital campuses in Canberra between Calvary and TCH?

Mr Corbell: Any significant acute episode would need ultimately to attend TCH. That is where our primary care arrangements are.

MR WALL: I was not sure what level of support was able to be provided at Calvary.

Mr Corbell: Obviously, there is a level of support that is available at presentation at ED and doctors at the ED at Calvary and the other professionals there have the capability to deal with that presentation initially, but if it is a longer term proposition, that requires—

MR WALL: And bearing in mind that physical injuries and damage are the primary

focus and then—

Ms Bracher: Yes, that is treated. That is managed in both emergency departments by the emergency physicians. Our psychiatrists who work as the consultant liaison team at Calvary hospital will do assessments into Calvary emergency department. The distinction between the two emergency departments in the two campuses is that if somebody needs involuntary care, which is giving an indication of their level of severity, they need to be transferred to the Canberra Hospital. Calvary do admit directly from their emergency department into ward 2N, or older persons mental health, but there is an assessment around whether that is an involuntary admission or not. If it is involuntary, it needs to be on the Canberra Hospital campus.

MS LAWDER: I refer again to a submission the committee has received from the National Institute for Mental Health Research, which I understand you might not have seen. It refers to nine categories of interventions that could be implemented, and it lists the nine categories and says that all of these approaches except one have been previously shown to reduce suicide attempts or deaths in Australia or overseas. One of them is responsible media reporting of suicide. I am sure we are all aware of what that means. However, I have heard some family members of people who have committed suicide say that they feel suicide needs to be talked about more broadly. How do you weigh up those issues?

Mr Corbell: I think both can be achieved. Obviously, in the immediate aftermath of a suicide there are a range of sensitivities that have to be had regard to and also the shock and trauma associated with that death that are felt and experienced by family, friends and workmates. That has to be dealt with sensitively, and I think privately, because it is a difficult enough thing, I would imagine, to deal with without having to deal with public reportage as well.

Of course, there is also the issue and concern around copycat behaviour, particularly if the event is quite public, has a particular profile or the nature of it has drawn attention that has to be had regard to as well. I think it is sensible to continue to adopt that approach, but that does not mean there are not other ways of talking about suicide. Rather than doing it in the immediate aftermath where there is trauma, pain and loss, and it is a very raw moment, there is still the capacity to talk about it in the context of the lived experience of family and friends who have lost someone to suicide at a time when they are ready to talk about it, warning signs, understanding of the triggers and what the lived experience is.

There is no reason why that cannot be and should not be talked about much more openly than it is. There is stigma and shame associated with someone taking their own life, and that is cultural in our community. But it is like any other form of mental illness, in a way, and the consequences of that mental illness; we benefit from the conversation being had in the right setting and in the right context. So it is not an either/or proposition; it is about context.

MR HINDER: My question is probably for Ms Bracher. It is in relation to suicide and self-harming in the context of Indigenous young people and the unique challenges that first Australians have. Winnunga, the health centre at Narrabundah, has a saying that they do not do body part health. That clearly relates to the need for that holistic

kind of approach to the delivery of primary health care for Indigenous people. Do you have any statistical anomalies or differences in outcomes and status for Indigenous young people or differing strategies to deal with the unique challenges?

Ms Bracher: The data related to Aboriginal and Torres Strait Islander mental health and suicide rates is in the AIHW domain. The 2014 data was recently reported. I cannot recall the exact numbers other than to say it is very much higher for Aboriginal and Torres Strait Islander people than for the general population in Australia. The numbers in the ACT are very small, so I would not like to make a comment about that.

Mr Corbell: I think there are limitations on reporting the ACT numbers because they are so small.

THE CHAIR: We have heard about different multicultural communities—those that are coming here. Refugees and asylum seekers who have come out of refugee camps are traumatised. Again the data does not allow us to look at whether they are a fragile, vulnerable group.

Ms Bracher: Yes, I would agree with that.

Mr Thompson: The issue in the ACT, at the whole-of-population level, is that we aggregate over a five-year period to get a statistically meaningful indication of what is happening. With drilling down into individual small populations, it is incredibly difficult to get reliable information.

MR HINDER: The second part was about whether there were any additional resources, strategies or differences in strategies about dealing with those particular circumstances, and that applies to refugees as much as it does to whether there is any tailoring of programs to—

Ms Bracher: Thank you for that question. In my earlier response about a step model of care and our service trying to in-reach into other services, we have psychiatrists, a psychiatry registrar and a senior mental health nurse funded through our service and work in Winnunga with the health workers and the other medical staff there. We do acknowledge that it is a unique area. With the culturally sensitive approach to care—I think Winnunga are very clear about the cultural sensitivity around care. So we support their model of care and what they ask for to the best of our ability. On occasions, when we believe there is a need, we do try to support the Aboriginal people to use mainstream services, if they need inpatient care. We have Aboriginal and Torres Strait Islander liaison officers in our service—one in mental health and one in our alcohol and drug service. They are very embedded in our service and when somebody who identifies as Aboriginal or Torres Strait Islander is admitted, those workers see them on the ward.

We are also doing some work in our workforce space around how we could utilise an Aboriginal health worker—people who have a cert IV qualification as an Aboriginal health worker, and how we could utilise that group of health workers in our spectrum of workforce, from people with cert IV training through to degree training and right through to our specialist psychiatry training. That is an acknowledgement of the particular additional needs that Aboriginal people may have when they make contact

with mainstream services.

THE CHAIR: Going back to questions around the journey of someone who presents to A&E, it goes to there being a good service over here and a good service over there, and what is in between. Again it was a personal story that they shared about a young person threatening self-harm who made contact with a community-based organisation that had a six-week wait list. He never made it to that clinical service. If he were to have presented or if someone took him to hospital, the journey could have been different because they could have gone into this other service. How do we get the message out that you do not have to sit and wait for six weeks before you can get into a community-based mental health service? It is quite confronting when you hear that through one of these inquiries.

Ms Bracher: I am sorry to hear that story. We try very hard in our communication with the community to say that if anybody is worried, 000 is the number you call. And that is right at that point in time. If you are worried and it is not a 000 response, come to the emergency department, come into the health centre, come to wherever. That is the message all through the health promotion and communication literature and strategies that we have. If people are worried, seek help. One too many times is better than not enough. That is our advice. The Ambulance Service and the police service are very responsive in those situations. We have nothing but positive experiences with those two services.

THE CHAIR: Where is the space for these organisations? And you will have more with the HPN contracting what could be a new suite of providers coming in. How do you herd that set of cats and harness all of that to have better coordination so that the information, messaging and the journey for people is consistent?

Mr Corbell: I think it is a consistent education message. You would not talk to an early intervention service, a health promotion service or a primary healthcare service that did not have that message. I think the challenge is with broadening out and building the understanding around what the right response is. We have this same challenge when it comes to purely physiological problems that people experience—heart attacks, telling people what the appropriate response is if you have chest pain, which is to call an ambulance, no matter what. We still have people who do not heed that message, either. It is very much an educative campaign. It is more complex and more difficult in this space because if someone is suffering an episode of depression, they are not processing well the information they need to process around what to do to help themselves because they are in that space where it is really hard to do that.

The message has to be for those around them, and the networks and the connections around them, around what is the right response, what is the right pathway to go down. This is not about blame or putting the problem back on those individuals; far from it. It is a recognition that we have to continue to strengthen awareness and education around where the pathways are.

THE CHAIR: That consistent message, yes. The other comment—then I will go to Mr Wall—is that the younger generation have grown up within that head space, and hearing that one in four young people will have mental health problems, but it is the generation before them that are probably still caught up in that stigma around mental

health and that need an extra bit of attention.

Mr Corbell: I think that stigma still exists everywhere. It is still widespread. I think it is much better than it was, but it is still very widespread across all generations for a broad range of reasons.

MR WALL: I asked Ms Berry this question, but I believe it is much more relevant to be asked of you, minister. The numbers of young people with a diagnosis of depression, mental illness, anxiety and the like seem to be increasing. Is it a case of us diagnosing these issues better or is it a symptom of modern society? Is it trending in a direction? What sort of evidence or research has begun, what is available on that and what can be done to try to address it?

Ms Bracher: That is an epidemiological question, which I probably cannot answer in a way that is sufficient for the committee. The chief health officer's report will give data across years in that space. Anecdotally, I hear the same thing—that anxiety and depression are more common; and that question about whether it is diagnosis or help-seeking behaviour is more common. I do not think there is an answer out there in the literature.

MR WALL: Minister, is there perhaps something you would be able to provide to us on notice in that space?

Mr Corbell: Certainly—

MR WALL: If there is something that exists, it would certainly be of interest.

Mr Corbell: As Ms Bracher says, it is very much an epidemiological question, and I am sure our public health experts would at least be able to give you some references as to where this question has been looked at.

Ms Bracher: I could certainly ask the chief psychiatrist as well.

MR WALL: Thank you; that would be appreciated.

MS LAWDER: In the mental health area, we hear a bit of talk about step-up, step-down models. Is that applicable to young people or is it more for adults?

Ms Bracher: We have a child and a youth step-up, step-down service in the ACT already. So, yes, it is very applicable. We get very positive feedback from families and from young people.

MS LAWDER: Can you talk a bit more about what it involves, the step-up, step-down model?

Ms Bracher: It is a link between home-based community care and inpatient care. It is usually around six weeks to three months, so it is a place for the child or the young person to go, a safe place and a wraparound service for people to go to, and to stabilise. The language "step up" means potentially on the way to hospital, but it is an intervention to prevent hospitalisation. "Step down" is the discharge out of hospital.

We use both of those services in that way, so a young person might come into the emergency department, have a short inpatient stay but then go to the step-down facility. That is where the language comes from.

In the ACT the contracts are coordinated through Mr O'Donoughue's area. A community organisation provides the care and support in that facility. With our clinical team, we have embedded clinicians in that service, so we have very senior mental health nurses that operate in both the child and in the youth step up, step down. The child or young person is also connected with other clinical services that they need. So we might in-reach. But it is supposed to be encouraging independence, so we do try to have the child or the young person come and access services and learn how to access services in GP space, in primary care space or in the community health centres.

Mr O'Donoughue: We are very proud of the facilities. They are in a home-like environment. They are good neighbours in ordinary communities and we think they are really cutting-edge services.

MS LAWDER: Ms Burch mentioned earlier that one of the earlier witnesses mentioned they felt a certain number of suicide attempts and self-harms were due to adverse events in the young person's life as opposed to a diagnosed or diagnosable mental illness. Do you keep those kinds of statistics?

Ms Bracher: No.

MS LAWDER: Or have a feel for that?

Ms Bracher: The short answer is no, we do not keep those sorts of statistics in the public mental health service.

MS LAWDER: Because you are dealing with people who are in the mental health area; is that why?

Ms Bracher: Sometimes we come in contact with people who have an acute response to an incident in their life, like the ones you have described. They might come into the emergency department and they are assessed as not having a mental illness. But we stay involved with that person until they are stable and are stepped down, if you like, through that step model of care into primary care or into other supportive social networks. So there is that group, but there is also the group who might have a suicide or self-harm attempt that do have a diagnosed mental illness, and they are part of our child and adolescent mental health service.

MS LAWDER: For those young people who may have attempted self-harm or suicide and who come to the mental health system, do you have statistics about how long you remain engaged with that young person?

Ms Bracher: We would, through our electronic clinical record.

MS LAWDER: Are you able to provide any summary data to the committee about that?

Ms Bracher: I can provide a commitment to have a look at whether we can pull it out.

Mr Corbell: We can see if we can provide it, yes.

Mr Thompson: The range will be from very short to lifetime contact. We will need to think about the best way that we can look at the data in terms of providing a meaningful response.

MR HINDER: The evidence we have had, both written and oral, has had some consistency around some of the barriers to accessing mental health services around thoughts of self-harm and suicide. They include things like stigma and confidentiality issues, response times, waiting times and access to things like transport for young people. They also identified that online services were one of the first points of access that young people went to. Is there anything going on in your world that is focused on promoting that online service gateway, if you like, about accessing what is a very large group of services available from a very large group of providers? Minister Berry talked about one such Queensland tool that she announced late last year. I cannot tell you what it was called.

Ms Bracher: Both our crisis service and our child and adolescent service—because we are focusing on a population that are very IT savvy, being children and young people, that is why we focused there—in their therapy sessions teach and work through online apps that can help the child or the young person at a point when they are distressed to de-escalate themselves. That is a supportive and protective mechanism for 3 o'clock in the morning when our crisis team is not readily available, and there is access to national online services. eheadspace—electronic head space—is one of the other ones that is readily available for young people, and I think accessed very positively and actively.

THE CHAIR: There being no further questions, thank you for that. A copy of the *Hansard* draft will be provided. If we have other questions, they will be sent through to you. The government's submission is finding its way to us. This is out of normal synch, but otherwise we will run out of time to get things done.

Mr Corbell: It will be with you shortly.

THE CHAIR: Thank you, minister and officials, for that.

The committee adjourned at 4.51 pm.