

INQUIRY INTO YOUTH SUICIDE AND SELF HARM IN THE ACT

STANDING COMMITTEE ON HEALTH, AGEING, COMMUNITY AND
SOCIAL SERVICES

JUNE 2016

REPORT 8

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Mr Andrew Wall MLA	Deputy Chair
Ms Nicole Lawder MLA	Member
Mr Jayson Hinder MLA	Member
Dr Chris Bourke MLA	[to 21 January 2016]
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RESOLUTION OF APPOINTMENT

On 27 November 2012 the Legislative Assembly for the ACT agreed by resolution to establish legislative and general purpose standing committees to inquire into and report on matters referred by the Assembly or matters that are considered by the committee to be of concern to the community, including:

- c) a Standing Committee on Health, Ageing, Community and Social Services to examine matters related to hospitals, community, public and mental health, health promotion and disease prevention, disability matters, drug and substance misuse, targeted health programs and community services, including services for older persons and women, families, housing, poverty, and multicultural and indigenous affairs;

The Assembly agreed that each committee shall have power to consider and make use of the evidence and records of the relevant standing committee appointed during the previous Assembly.¹

TERMS OF REFERENCE

At its meeting on Thursday, 11 February 2016, the Assembly passed the following resolution:

“That this Assembly:

- (1) notes that, according to the ABS’ last recorded data from “Causes of Death” in 2013:
 - (a) a third of young people aged 15-25 who died in the ACT in 2013 died as a result of suicide;
 - (b) in 2013, suicide was the leading cause of death of children between 5 and 17 years of age;
 - (c) intentional self-harm is one of the top ten leading causes of death in males;
 - (d) 37 persons died due to suicide in the ACT in 2013, which is a 54% increase on the previous year;
 - (e) there was a 13% increase of persons aged 15-19 dying from suicide in Australia in 2013 compared to 2012;
 - (f) between 2011 and 2013, there were more deaths by suicide in the ACT than there were in transport accidents;
 - (g) intentional self-harm is the leading cause of death among Australian children and young people aged 15-24 years;

¹ Legislative Assembly for the ACT, *Minutes of Proceedings No. 2*, 27 November 2012, pp. 24-27, at http://www.parliament.act.gov.au/_data/assets/pdf_file/0005/393899/MoP_2.pdf

- (h) as at November 2014, one child under 18 years of age takes their own life every week, and 18 227 children and young people were hospitalised in Australia for intentional self-harm over the last five years;
 - (i) between 50 and 60 children every week are admitted to hospital for self-harming incidents in Australia; and
 - (j) there has been a 650% increase in deaths from self-harm, when comparing 12 and 13 year olds with 14 and 15 year olds from 2007 to 2012;
- (2) resolves to refer the issues related to youth suicide and self harm to the Standing Committee on Health, Ageing, Community and Social Services to examine the extent and impact of these in the ACT, having regard to:
- (a) ACT Government and Commonwealth Government roles and responsibilities in regard to youth mental health and suicide prevention, particularly in relation to the recently announced Commonwealth response to the National Mental Health Commission Report and the mental health and suicide commissioning role for the Primary Healthcare Networks as it affects the ACT;
 - (b) any gaps or duplicate roles and responsibilities;
 - (c) whether there are unique factors contributing to youth suicide in the ACT, taking into account the small number of young people who have died by suicide in the ACT in recent years, and the impact public investigation may have on families and close friends, that can be identified through submissions and expert witnesses; and
 - (d) ACT government-funded services, agencies and institutions, including schools, youth centres, and specialist housing service providers' role in promoting resilience and responding to mental health issues in children and young people; and

the Standing Committee on Health, Ageing, Community and Social Services will report back to the Legislative Assembly by the last sitting day of this Assembly".²

² Legislative Assembly for the ACT, *Minutes of Proceedings No. 126*, 11 February 2016, pp. 1438-1440, at http://www.parliament.act.gov.au/_data/assets/pdf_file/0012/820200/MoP126F.pdf

ASSISTANCE INFORMATION

IF YOU, OR SOMEONE YOU KNOW, NEED HELP OR ADVICE, THESE
SERVICES PROVIDE SUPPORT:

KIDS HELPLINE: 1800 55 1800

LIFELINE: 13 11 14

HEADSPACE: 1800 650 890 OR WWW.HEADSPACE.ORG.AU

SUICIDE CALL BACK SERVICE: 1300 659 467

SANE HELPLINE: 1800 18 7263

ACRONYMS AND ABBREVIATIONS

ACT	Australian Capital Territory
ABS	Australian Bureau of Statistics
AIHW	Australian Institute of Health and Welfare
ATSI	Aboriginal and Torres Strait Islander
ATSIEB	Aboriginal and Torres Strait Islander Elected Body
CAMHS	Child and Adolescent Mental Health Service
CHN	Capital Health Network
CSD	Community Services Directorate
CYPDRC	ACT Children and Young People Death Review Committee
NCIS	National Coroners Information System
NIMHR	National Institute for Mental Health Research
NMHC	National Mental Health Commission
NMHC Review	National Mental Health Commission Review; <i>Contributing Lives, Thriving Communities —Review of Mental Health Programmes and Services</i>
PHN	Public Health Network
RANZCP	Royal Australian and New Zealand College of Psychiatrists
ROGS	<i>Report on Government Services</i>
WHO	World Health Organization

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RECOMMENDATIONS

RECOMMENDATION 1

- 2.28** The Committee recommends that the ACT Government update the Legislative Assembly on both the development of the national database, and progress made in relation to improving the collection of ACT data, particularly in relation to receiving consistent data from community based organisations.

RECOMMENDATION 2

- 3.65** The Committee recommends that the ACT Government update this Committee in relation to Australian Government funding negotiations in relation to mental health funding, including the Capital Health Network.

RECOMMENDATION 3

- 5.63** The Committee recommends that the ACT Legislative Assembly consider re-examining this matter when funding and research outcomes are made public in order to determine the most appropriate way to further develop early intervention measures, education approaches and access to service for suicide prevention activities in the ACT.

1 INTRODUCTION

BACKGROUND

- 1.1 On 11 February 2016, the Legislative Assembly for the ACT referred issues related to youth suicide and self harm in the ACT to the Standing Committee on Health, Ageing, Community and Social Services for its consideration. The resolution required the Committee to pay particular attention to the following matters:

- (a) ACT Government and Commonwealth Government roles and responsibilities in regard to youth mental health and suicide prevention, particularly in relation to the recently announced Commonwealth response to the National Mental Health Commission Report and the mental health and suicide commissioning role for the Primary Healthcare Networks as it affects the ACT;
- (b) any gaps or duplicate roles and responsibilities;
- (c) whether there are unique factors contributing to youth suicide in the ACT, taking into account the small number of young people who have died by suicide in the ACT in recent years, and the impact public investigation may have on families and close friends, that can be identified through submissions and expert witnesses; and
- (d) ACT government-funded services, agencies and institutions, including schools, youth centres, and specialist housing service providers' role in promoting resilience and responding to mental health issues in children and young people.³

- 1.2 The Committee was required to report back to the Assembly by the end of August 2016.

CONDUCT OF THE INQUIRY

- 1.3 On 4 March 2016 the Committee called for submissions to its Inquiry into Youth Suicide and Self Harm in the ACT, including via direct invitation and advertisement on the Assembly website. On 6 April 2016, the Committee also advertised the Inquiry in the Canberra Times.
- 1.4 Submissions closed on 6 April 2016, although some additional submissions were accepted after this date.

³ Legislative Assembly for the ACT, *Minutes of Proceedings No. 126*, 11 February 2016, pp. 1438-1440, at http://www.parliament.act.gov.au/_data/assets/pdf_file/0012/820200/MoP126F.pdf

- 1.5 The Committee received 20 submissions from a diverse range of individuals and organisations. A list of the public submissions to the Inquiry, together with other information authorised for publication by the Committee, is provided at Appendix C.
- 1.6 The Committee held two public hearings on 24 March 2016 and 14 April 2016. Transcripts of the hearings are available on the Committee's webpage:
<http://www.hansard.act.gov.au/hansard/2013/comms/default.htm#health>. A list of witnesses who gave evidence at the public hearings is provided at Appendix D.

ACKNOWLEDGEMENTS

- 1.7 The Committee expresses its thanks to those individuals and organisations who made submissions and gave evidence at the public hearings.
- 1.8 The Committee also thanks staff from the Legislative Assembly library for their research assistance and support.

STRUCTURE OF THIS REPORT

- 1.9 Chapter 1 outlines the background to the Inquiry as well as defining the central issues to the Inquiry—suicide, self harm, and young people.
- 1.10 Chapter 2 of this report provides an overview of suicide and self harm statistics in the ACT and discusses risk factors for suicide and self harm.
- 1.11 Chapter 3 provides a summary of the ACT and Australian Government roles and responsibilities in regard to mental health and suicide prevention, with a particular focus on the National Mental Health Commission's *Report of the National Review of Mental Health Programmes and Services* (released in November 2014) and the Australian Government response to that report (released in November 2015). ACT Government youth and mental health policies and service provision are also considered in order to assess possible duplication in the roles and responsibilities between the ACT and Australian Government.
- 1.12 Chapter 4 details suicide prevention and self harm services and support funded by the ACT Government, Australian Government as well as privately provided services.
- 1.13 Chapter 5 analyses whether current services and responses to youth suicide and self harm are adequate, appropriate and responsive to the needs of the ACT community.

CONTEXT OF THE INQUIRY

- 1.14 When referring this Inquiry to the HACSS Committee, Members acknowledged that suicide has been the subject of debate in the Legislative Assembly on other occasions.⁴
- 1.15 In March 2012, Ms Amanda Bresnan, former MLA moved a motion relating to suicide in the ACT, including calling on the Minister for Health to set a target for the reduction of suicide in the ACT by the year 2020.⁵
- 1.16 Following debate, the Assembly passed an amended motion which called on the Minister for Health to:
- (a) consult the Ministerial Advisory Council on Mental Health and other relevant stakeholders about what ACT suicide reduction target is appropriate for 2020 and outline that target to the ACT Legislative Assembly by the end of 2012; and
 - (b) make a statement to the Assembly biannually until the end of 2020 on the ACT figures on suicide progress against the target, and information about available services and support.⁶
- 1.17 Ms Katy Gallagher MLA, then Minister for Health made a statement in the Assembly about suicide and presented the suicide statistics for the ACT at this time.⁷

KEY ISSUES

SUICIDE

- 1.18 A suicide occurs when a person dies as a result of a deliberate act intended to cause the end of his or her life. The World Health Organization (WHO) estimates that approximately 800,000 people around the world die due to suicide every year. The WHO reports that suicide is the second leading cause of death among 15-29 year olds.⁸

⁴ Legislative Assembly for the ACT, *Debates*, 11 February 2016, pp. 211-224, at: <http://www.hansard.act.gov.au/hansard/2016/pdfs/20160211a.pdf>.

⁵ Legislative Assembly for the ACT, *Debates*, 28 March 2012, pp. 1465-1476, at: <http://www.hansard.act.gov.au/hansard/2012/pdfs/20120328.pdf>.

⁶ Legislative Assembly for the ACT, *Minutes of Proceedings No. 143*, 28 March 2012, p. 1843, at: http://www.parliament.act.gov.au/_data/assets/pdf_file/0004/370615/12MoP143.pdf#1.

⁷ Legislative Assembly for the ACT, *Debates*, 12 August 2016, pp. 2322-2324, at: <http://www.hansard.act.gov.au/hansard/2014/pdfs/20140812.pdf>.

⁸ World Health Organization, *Suicide fact sheet*, online at: <http://www.who.int/mediacentre/factsheets/fs398/en/>, accessed 23 May 2016, See Submission 12, beyondblue, p. 5, Submission 14, Youth Coalition of the ACT, p. 11.

1.19 Evidence to the Inquiry noted that suicide is a complex issue which affects the whole community. When a person dies by suicide, there is a significant impact on the deceased's family, friends and broader support network. In this context, the Committee was encouraged to consider the issue of suicide in a broader context.

1.20 In their submission to the Inquiry, beyondblue explained suicide in the following way:

Suicide is best considered as part of a spectrum of suicidal behaviours that encompass self-harm, suicidal ideation, planning, suicide attempt and suicide.⁹

1.21 The National Institute for Mental Health Research submitted:

...youth suicide is the most common cause of death among young people and has an enormous burden on the population, particularly in terms of the emotional burden on the bereaved. In addition, suicidal ideation, self-harm behaviours and suicide attempts among young people have additional impact, including the emotional suffering of the young person and their family and friends, reduced functional ability of the young person, health costs of treatment, and long-term reductions in economic and academic productivity. Many of these impacts have life-long repercussions.¹⁰

1.22 Another submission described the effects of suicide:

The number of young people taking their lives is most alarming, yet those statistics reflect only the tip of the iceberg. No statistic can measure the insidious mess that is left behind when a young person takes their life. An insidious mess that engulfs two families. Along with close friends, class mates, teachers, team mates, coaches, neighbours... the list goes on.¹¹

SELF HARM

1.23 Submissions noted headspace's definition of self harm:¹²

Self harm refers to people deliberately hurting their bodies. Common types of self harm among young people include cutting (e.g. cutting the skin on arms, wrists or thighs), burning the skin, picking at wounds or scars, self hitting, or deliberately overdosing on medication, drugs or other substances that cause harm.¹³

⁹ Submission 12, beyondblue, p. 5.

¹⁰ Submission 1, National Institute for Mental Health Research, p. 1.

¹¹ Submission 10, Name withheld, p. 2.

¹² The Committee notes differing use of a hyphen in self harm. The term in the Report does not include a hyphen. Quotes from submissions that use self-harm have remained in their submitted form.

¹³ headspace, *Self harm fact sheet*, online at: <http://headspace.org.au/assets/Uploads/Resource-library/Young-people/Self-harm-web.pdf>, accessed on 23 May 2016.

- 1.24 In a report published in March 2016, Orygen, the National Centre of Excellence in Youth Mental Health, defines self harm as follows:

Self-harm refers to a range of behaviours (including self-poisoning and self-injury) through which an individual directly causes harm to her or himself, irrespective of the type of motive or the degree of suicidal intent.¹⁴

RELATIONSHIP BETWEEN SUICIDE AND SELF HARM

- 1.25 The White Wreath Association submitted that suicide and self harm ‘should be regarded as one in the same thing, i.e. suicidal behaviour’.¹⁵
- 1.26 The Committee notes the overlap between suicide and self harm but is aware that not everyone who self harms is suicidal. Officials from the Community Services Directorate advised the Committee:

I would like to point out that, as the committee would know, self-harming and youth suicide are not necessarily identical concepts. They can be related, but they may not be related. A large proportion of self-harming can be a strategy a young person uses to deal with internalised pain. It is for some young people an effective means of doing that, unfortunately, both biologically and socially.¹⁶

- 1.27 On their website, headspace note:

There is an overlap between self harm and thinking about suicide however not everyone who self harms is suicidal. Sometimes people do very risky things and accidentally die or seriously injure themselves as a result of their self harm.¹⁷

YOUNG PEOPLE IN THE ACT

- 1.28 The term ‘young people’ is generally used to categorise people in the community aged between 12 and 25 years of age however there is some variation. For example, Youth Coalition represent young people aged 12 – 25, whilst organisations such as the ABS and AIHW use an age bracket between 15-24 years of age when presenting statistics about young people.
- 1.29 The Committee notes that the ACT Young People’s Plan refers to young people between 12-25 years of age.¹⁸

¹⁴ Orygen, National Centre of Excellence in Youth Mental Health, *Looking the other way: Young people and self harm*, March 2016, p. 9.

¹⁵ Submission 2, White Wreath Association, p. 1.

¹⁶ Dr Mark Collis, *Transcript of Evidence*, 14 April 2016, p. 60.

¹⁷ headspace, *Self harm fact sheet*, online at: <http://headspace.org.au/assets/Uploads/Resource-library/Young-people/Self-harm-web.pdf>, (accessed on 23 May 2016).

- 1.30 The ACT Young People's Plan 2009-2014 Final Report included the following data about young people in the ACT.¹⁹

ACT Population	2009	2014	Percentage change
Young people aged 12 to 25 years (inclusive)	76,589 (22% of total ACT population)*	74,838 (19% of total ACT population)*	↓ 2.3% decrease
Male young people	39,354*	38,143*	↓ 3.1% decrease
Female young people	37,235*	36,695*	↓ 1.5% decrease
Aboriginal and Torres Strait Islander young people	1900 (2.5% of that age group)#	2145 (2.9% of that age group)#	↑ 12.9% increase
Aged 10 to 24 born overseas (using 2006 and 2011 census data only)	10,490 (2006 census)**	14,250 (2011 census)**	↑ 35.9% increase

Table sources: *ABS, Estimated Resident Population by Single Year of Age, Table 58, released 18 December 2014, cat. no. 3101.0. # ABS, Aboriginal and Torres Strait Islander Australians 2001 to 2026 by Single Year of Age, Table 8, released 30 April 2014, cat. no. 3238.0.

**ABS, Estimated Resident Population by Country of Birth, Age and Sex, 2006 & 2011, Tables 8.9 & 9.9, released 18 December 2013, cat. no. 34120DO009_201113. Note: The only available data for this measure as at May 2015 was for 2006 and 2011, and data was not available for the 12-25 years age group.

- 1.31 The Youth Coalition of the ACT (Youth Coalition) submitted:

Canberra has one of the youngest populations of any Australian State or Territory, with approximately 78,000 people aged between 10-24 years residing in the ACT, representing more than 20% of Canberra's population. With over one fifth of Canberra's population comprised of young people, it is important that the wellbeing of young people be regarded as an indicator of the ACT's future population health and development.²⁰

- 1.32 The majority of the evidence presented to the Committee for this Inquiry predominately related to young people aged between 12 and 25. Whilst the focus of the Inquiry has been on young people (i.e. 12-25 years old), the Committee is aware that incidents of suicide and self harm have been recorded by children younger than 12 years old. While the frequency of these

¹⁸ ACT Department of Disability, Housing and Community Services, Office for Children Youth and Family Support, December 2009, *The ACT Young People's Plan 2009-2014*, accessible at: http://ypaa.net/wp-content/uploads/2012/01/dhcs_vp_proof_3.pdf (accessed on 31 May 2016).

¹⁹ ACT Government, *ACT Young People's Plan 2009-2014, Final Report*, August 2015, p. 6, available at: http://www.communityservices.act.gov.au/_data/assets/pdf_file/0006/759741/ACT-Young-Peoples-Plan-Final-Report-August-2015.pdf

²⁰ Submission 14, Youth Coalition of the ACT, p. 4.

incidents is low in terms of absolute numbers, the manner in which they should be considered should not be understated.

NOTE ON STATISTICS IN THE REPORT

- 1.33 The Committee notes that available data does not exclusively fit neatly into the 12-25 year age range. When presenting data in this report, the Committee has endeavoured to maintain consistency and to ensure that data is presented clearly. When comparing data and tables, caution should be exercised to ensure accurate comparisons are made.

2 YOUTH SUICIDE AND SELF HARM

INTRODUCTION

- 2.1 The first section of this chapter will provide an overview of the following areas:
- statistics on youth suicide and self harm with a particular focus on the ACT;
 - identified challenges to collect data on suicide and self harm, including jurisdictional inconsistencies to identify, code and report suicide deaths; and
 - critical need for comprehensive suicide and self harm data to be collected to ensure support services can be appropriately developed and targeted.
- 2.2 The second section of the chapter will focus on suicide and self harm risk factors with a particular focus on population groups that are at an increased risk of suicide and self harm. The chapter will conclude with a discussion on whether there are unique factors contributing to youth suicide in the ACT (term of reference 2 (c)).

DATA ON SUICIDE AND SELF HARM

- 2.3 The Australian Bureau of Statistics (ABS) reports annually on all registered deaths where sufficient information exists for coding. The registration of deaths is the responsibility of the eight individual state and territory Registrars of Births, Deaths and Marriages. As part of the registration process, information about the cause of death is supplied by the medical practitioner certifying the death or by a coroner. Other information about the deceased is supplied by a relative or other person acquainted with the deceased, or by an official of the institution where the death occurred. The information is provided to the ABS by individual Registrars for coding and compilation into aggregate statistics. In addition, the ABS supplements this data with information from the National Coroners Information System (NCIS).²¹
- 2.4 The ABS publishes a *Causes of Death* report annually. This publication includes summary statistics on suicide deaths registered in Australia, where the underlying cause of death was determined as intentional self harm.

²¹ Australian Bureau of Statistics 3303.0 - *Causes of Death, Australia, 2014*, March 2016, pp. 28-29.

SUICIDE

- 2.5 The ABS *Causes of Death 2014* reports that in 2014, five young people between the ages of 15-24 years old died by suicide in the ACT. This represents an age specific death rate (number of deaths per 100,000 population) of 9.1 for 2014. This compares to a national age specific death rate of 11.5 for the same period.²²
- 2.6 Table 1 provides details about the number of ACT young people (15-24 years old) who died by suicide between 2009-2014 (ABS classification—intentional self harm). The table also includes the total number of deaths in that age category for all causes.

TABLE 1: UNDERLYING CAUSE OF DEATH—INTENTIONAL SELF HARM—ACT²³

Year	Number of young people—15-24 years old		Year	Number of young people—15-24 years old	
2014	5	Cause of death—suicide	2011	5	Cause of death—suicide
	15	Cause of Death—all causes		12	Cause of Death—all causes
2013	5	Cause of death—suicide	2010	3	Cause of death—suicide
	15	Cause of Death—all causes		15	Cause of Death—all causes
2012	(not published)	Cause of death—suicide	2009	3	Cause of death—suicide
	14	Cause of Death—all causes		18	Cause of Death—all causes

- 2.7 In relation to statistics in the ACT, Mr Simon Corbell MLA, Minister for Health provided the following evidence:

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

²² Australian Bureau of Statistics 3303.0 - *Causes of Death, Australia, 2014*, March 2016, (Table 1.3 and 9.3).

²³ This table uses data from the Australian Bureau of Statistics 3303.0 - *Causes of Death, Australia* publications between 2009 and 2014. Information is taken from Table 9.3— Underlying cause of death, Selected causes by age at death, numbers and rates, Australian Capital Territory for each year.

observing that the ACT does have the lowest overall rate of suicide in the country and is below the Australian average for youth suicide.²⁴

- 2.8 The ACT Children and Young People Death Review Committee (CYPDRC) noted that, across Australia, between 2005-2014, there have been over 24,000 deaths from intentional self harm, among which were 1,299 young people. Further to this, the CYDRC noted that each year the number of young people who die by suicide increase, on average, by six:²⁵

Year	Deaths	Change	CI	CI
	No.	Year on year	Lower	Upper
2005	101		80.25	121.75
2006	118	17	95.95	140.05
2007	128	10	104.71	151.29
2008	109	-19	87.42	130.58
2009	108	-1	87.34	128.66
2010	130	22	106.44	153.56
2011	133	3	108.90	157.10
2012	147	14	121.83	172.17
2013	174	27	146.34	201.66
2014	151	-23	125.04	176.96

Source: Submission 11, Children and Young People Death Review Committee, p. 2 (using data from ABS, 3303.0 Causes of Death, Australia, 2014)

- 2.9 In their submission CYPDRC stated that since 2004, 10 young people in the ACT have died by suicide. The majority of these young people were between the ages of 15 and 17 years old.²⁶ Data provided by the CYPDRC refers to young people aged up to 18 years old.

SELF HARM

- 2.10 Whilst statistics on the number of suicide deaths has been routinely collected for some time, the available evidence about the incidence of self harm is limited. Evidence provided to the Inquiry noted that it is difficult to accurately quantify incidents of self harm, particularly as young people are often reluctant to self report.

- 2.11 Carers ACT provided detail from a 2010 community survey:

In 2010 a community survey on self-injury was undertaken with 12, 006 Australians from randomly selected households. This study found that 4% of females aged 15-19 years had self-harmed in the 4-weeks prior to the interview. For males the rate of self-injury was 2.3% for those aged 10-14 years and 2.2% for those aged 15-19. Only 14.3%

²⁴ Mr Simon Corbell MLA, *Transcript of Evidence*, 24 March 2016, p. 38.

²⁵ Submission 11, ACT Children and Young People Death Review Committee, p. 2.

²⁶ Submission 11, ACT Children and Young People Death Review Committee, p. 3.

of those who had self-injured in the 4 weeks prior to the interview had sought and received medical treatment.²⁷

- 2.12 Officials from ACT Health noted that measuring and recording incidents of self harm is problematic:

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.²⁸

- 2.13 Furthermore, officials from ACT Health acknowledged that it can be difficult when someone presents at hospital with injuries that may be the result of self harm but the patient does not self report in that way:

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.²⁹

ENHANCED DATA COLLECTION

- 2.14 Submitters and witnesses highlighted a number of issues relating to data collection and reporting including:

- the need for comprehensive and accurate suicide and self harm data to ensure support services can be appropriately developed and targeted;
- jurisdictional inconsistencies in the identification, coding and reporting of suicide deaths;
- difficulties in classifying deaths as suicide and the subsequent underreporting; and
- importance of accurate and comprehensive ACT specific data.

INCONSISTENT AND INCOMPLETE DATA COLLECTION

- 2.15 beyondblue submitted:

²⁷ Submission 18, Carers ACT, pp. 4-5.

²⁸ Mr Ian Thompson, *Transcript of Evidence*, 24 March 2016, p. 39.

²⁹ Mr Ian Thompson, *Transcript of Evidence*, 24 March 2016, p. 40.

Understanding incidence and risk and protective factors profiles for self-harming behaviour and suicide is imperative to developing meaningful prevention and intervention strategies.

Accurate statistics through improved surveillance and data collection are therefore required to support suicide prevention strategies, including their development, implementation, evaluation, and accountability for achieving outcomes. The National Committee for Standardised Reporting on Suicide has identified priorities and plans for achieving standardised and accurate reporting of suicide...

A national database, that provides standardised information across all states and territories, will improve the usefulness and impact of data on self-harm and other suicidal behaviours and deaths by suicide.³⁰

2.16 The Royal Australian and New Zealand College of Psychiatrists (RANZCP) submitted:

The development of a cross sector suicide reporting system that is easy to use and allows accurate data reporting will be an essential step in establishing effective prevention and early intervention mechanisms. The [Public Health Networks] PHNs offer an effective platform for coordinating and implementing this, and the RANZCP welcomes early indications that the Government is looking to take this approach.

Accurate statistics provide the foundation for appropriately targeted programs and strategies. Reliable data also enables more accurate monitoring and evaluation of approaches, contributing to a clearer picture of the efficacy of the various approaches.³¹

2.17 On the matter of a national database, the ACT Government advised:

Work is underway at a national level to develop a national child death and injury database. When established, this initiative will benefit the ACT government and professional agencies by enabling the ACT to compare and contrast the success of other jurisdictions' initiatives (by assessing their impact on trends and rates of child and youth death or injury) and to further improve CSD's policies and practices.³²

2.18 Carers ACT drew particular attention to the lack of available data about the rate of self harm:

The prevalence of self-harm is also not clear. As self-harm does not always lead to medical treatment, there are potentially many cases that are not picked up in standard data collection devices.³³

³⁰ Submission 12, beyondblue, p. 17.

³¹ Submission 20, Royal Australian and New Zealand College of Psychiatrists, p. 3.

³² Submission 19, ACT Government, p. 5.

³³ Submission 18, Carers ACT, p. 4.

JURISDICTIONAL LEVEL DATA

- 2.19 The importance of accurate and comprehensive ACT specific data was identified throughout the Inquiry. The Minister for Health advised the Committee:

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.³⁴

- 2.20 Officials from the Health Directorate explained that there are two broad way that data is collected: in relation to the services people come in contact with as well as population health survey data.³⁵

- 2.21 Further to this, the Committee heard:

For the ACT government, the data that we collect inevitably in that circumstance [services people come in contact with] 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.³⁶

- 2.22 In their submission, the Youth Coalition noted:

Consultation with community based service providers for this Submission also identified a gap in the sector's understanding of the specific factors that drive self-harm and suicidal ideation among young people in the ACT. Workers believe that more data is needed to support better-informed decision-making and service delivery, and called for ACT Government to fund research initiatives that aim to better understand these issues in the ACT.³⁷

- 2.23 On this issue, Youth Coalition recommends that research be conducted 'to better understand self-harm and suicidal ideation amongst young people in the ACT, and the gaps in service system responses'.³⁸

³⁴ Mr Simon Corbell MLA, *Transcript of Evidence*, 24 March 2016, p. 38.

³⁵ Mr Ian Thompson, *Transcript of Evidence*, 24 March 2016, p. 39.

³⁶ Mr Ian Thompson, *Transcript of Evidence*, 24 March 2016, p. 39.

³⁷ Submission 14, Youth Coalition of the ACT, p. 15.

³⁸ Submission 14, Youth Coalition of the ACT, p. 6.

CAUTION WHEN COMPARING DATA ACROSS JURISDICTIONS

- 2.24 The ACT Government advised that CSD provides information to the Productivity Commission for the *Report on Government Services* (ROGS) in relation to the rates and incidents of self harm and suicide attempts of children and young people in custody annually.

Furthermore:

Accurate and consistent reporting of this information across jurisdictions requires regular review by the Juvenile Justice Research and Information Group to ensure consistent interpretation and application of relevant counting roles. Despite undertaking these measures, current data in ROGS is not comparable across jurisdictions due to variations in the defining, recording and measuring of self-harm and suicide incidents. Jurisdictions are working to address these issues.³⁹

COMMITTEE COMMENT

- 2.25 The Committee notes that currently data collection relating to youth suicide and self harm is problematic and often incomplete. This is particularly relevant to services not provided directly by the ACT Government. It is recognised that in the absence of consistent definitions and good data there is a lack of certainty around the scope of the problem.
- 2.26 Further to this, the Committee notes that in a small jurisdiction such as the ACT, data collection and publication needs to be considered sensitively and respectfully.
- 2.27 The Committee supports the view that more accurate and comprehensive data is required to facilitate a greater understanding of suicide and self harm and to enable suicide prevention services to be better targeted.

Recommendation 1

- 2.28 The Committee recommends that the ACT Government update the Legislative Assembly on both the development of the national database, and progress made in relation to improving the collection of ACT data, particularly in relation to receiving consistent data from community based organisations.**

³⁹ Submission 19, ACT Government, p. 5.

SUICIDE AND SELF HARM RISK FACTORS

2.29 The draft *ACT Mental Health and Wellbeing Framework 2015-2025* identifies a number of population groups who are at increased risk of harm from suicide and self harm:⁴⁰

-
- | | | |
|-------------------------------------------------|------------------------------------------------------------------|------------------------------|
| ▪ Aboriginal and Torres Strait Islander people; | ▪ people from culturally and linguistically diverse communities, | ▪ men; |
| ▪ people who abuse alcohol or other drugs; | ▪ people with an intellectual disability; | ▪ people with mental illness |
| ▪ asylum seekers and refugees; | ▪ lesbian, gay, bisexual, transgender and intersex people; | ▪ prisoners; |
| ▪ carers; | | ▪ problem gamblers; |
| ▪ children in care; | | ▪ women; and |
| ▪ people with chronic illness or disability; | | ▪ young people |
-

2.30 Submitters and witnesses provided evidence about the experiences of a number of the population groups identified in the draft Framework.⁴¹

2.31 The Minister for Children and Young People advised the Committee:

Children and young people with severe or profound disability or who have learning disabilities have a higher risk of self-harming behaviour or attempting suicide. Research suggests that children and young people with an intellectual disability are at a higher risk of intentional self-harm, suicidal behaviours and death by suicide with rates as high as 42 per cent.⁴²

2.32 In relation to lesbian, gay, bisexual, transgender, intersex and queer young people, the Minister for Multicultural and Youth Affairs told the Committee:

⁴⁰ ACT Health, DRAFT *The ACT Mental Health and Wellbeing Framework 2015-2025*. Canberra, Australia, 2015, pp. 8-9, available at: <http://www.timetotalk.act.gov.au/storage/2-Consultation%20Draft%20MH%20Framework%202015-2025.pdf>. The Draft is discussed further in Chapter 3 of this report.

⁴¹ See for example, Submission 18, Carers ACT, pp. 7-8.

⁴² Dr Chris Bourke MLA, *Transcript of Evidence*, 14 April 2016, p. 58.

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.⁴³

2.33 In relation to gender diverse young people, A Gender Agenda told the Committee:

We know a lot of the mental health and wellbeing issues that these gender diverse young people face come as a result of having to come out to communities that are perhaps not as supportive as they could be. We know that 81 per cent of these young people have experienced some kind of abuse, whether that be verbal, physical or emotional. Of that 81 per cent, 80 per cent had thought about self-harm and 70 per cent had self-harmed, and 81 per cent had thought about suicide and 37 per cent had attempted suicide. So these are very high statistics. We know that 90 per cent of those who had experienced physical abuse in particular had thought about suicide because of the abuse they had been subjected to. So there is a direct link there.⁴⁴

2.34 With respect to the experiences of Aboriginal and Torres Strait Islander people, the Minister for Aboriginal and Torres Strait Islander Affairs advised the Committee:

Every year at least five per cent of all deaths of Aboriginal and Torres Strait Islander peoples across Australia are due to suicide. For those aged 15 to 34, suicide is the leading cause of death, accounting for a third of all loss of life. One-third of all Aboriginal and Torres Strait Islander people in our country aged between 15 and 34 take their own life. Unfortunately, young Aboriginal and Torres Strait Islanders are suiciding and self-harming at alarming rates.⁴⁵

2.35 The Aboriginal and Torres Strait Islander Elected Body (ATSIEB) submitted:

ATSIEB notes that, according to the ABS 2014 Causes of Death data, national suicide statistics are indicating an upward trend that is at the highest rate in ten years and that suicide remains a leading cause of death in people aged 15-34. Most alarmingly, the suicide rate for the Aboriginal and Torres Strait Islander community is double that of non-Indigenous people.⁴⁶

2.36 The Committee also received evidence from Families and Friends for Drug Law Reform that illicit drug dependence is a powerful driver of suicide.⁴⁷

⁴³ Ms Yvette Berry MLA, *Transcript of Evidence*, 24 March 2016, p. 1.

⁴⁴ Ms Mirja (Majka) McLean-Engstrom, *Transcript of Evidence*, 14 April 2016, p. 72.

⁴⁵ Dr Chris Bourke MLA, *Transcript of Evidence*, 14 April 2016, p. 59.

⁴⁶ Submission 16, Aboriginal and Torres Strait Islander Elected Body, p. 2.

⁴⁷ Submission 15, Families and Friends for Drug Law Reform, pp. 2-3.

YOUNG PEOPLE

- 2.37 As highlighted throughout the Inquiry, young people are at increased risk of suicide and self harm.
- 2.38 National ABS data shows that in absolute terms, the biggest increase in deaths from suicide over the period 1921-1925 to 1996-1998 has been in the 15-24 years age group (6 per 100,000 persons in 1921-1925 to 17 in 1996-1998). As a proportion of all causes of deaths male suicides in the 15-24 years age group have increased from 3.3% to 27% in the period from 1921-1925 to 1996-1998. Female suicides aged 15-24 years also increased substantially as a proportion of all causes of death during the same period from 1.3% to 16%. The increase in suicides as a proportion of all deaths in this age group partly reflects declining death rates due to other causes such as motor vehicle accidents and malignant neoplasms.⁴⁸
- 2.39 beyondblue highlighted that suicidal behaviours vary by age:
- In the child and adolescent mental health survey females aged 16-17 years had the highest rates of self-harm – around 17 per cent had harmed themselves in the previous 12 months and almost 23 per cent had self-harmed in their lifetime. The prevalence among 12-15 year-old females was lower, with just under 10 per cent of females aged 12-15 years having self-harmed in the previous 12 months and 11 per cent having ever self-harmed. 12 month and lifetime self-harm rates were lower for males but followed a similar age pattern with 16-17 year old males reporting higher rates than 12-15 year old males. The adult survey in 2007 found that for females, suicidality was highest in those aged 16-24 years (5.1%) while for males it was higher among 25-34 year olds and 35-44 year olds (2.5%).⁴⁹
- 2.40 Drawing on information contained in national research reports and publications, the Minister for Health noted that suicide, self harm and mental illness are increasing in young people.⁵⁰
- 2.41 Menslink advised the Committee about research that highlights a number of general risk indicators for suicidal young men and 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.

⁴⁸ Australian Bureau of Statistics, *3309.0 - Suicides, Australia, 1921-1998*, March 2000, p. 7

⁴⁹ Submission 12, beyondblue, p. 6.

⁵⁰ Mr Simon Corbell MLA, *Transcript of Evidence*, 24 March 2016, pp. 38-39.

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.⁵¹

PEOPLE WITH A MENTAL ILLNESS

2.42 The majority of submissions to the Inquiry identified that mental illness is serious and impacting the lives of many young people.⁵²

2.43 beyondblue submitted:

Mental health conditions are a significant contributing factor to suicidal behaviours. Mental health conditions are common and can occur at any age, but are particularly common among young people. Self-harm may occur in the context of borderline personality disorder and depression is a major risk factor for all suicidal behaviours.⁵³

2.44 The CYPDRC noted that diagnosed mental health issues were present in over half of the 10 youth suicide deaths in the ACT since 2004, including diagnoses of depression, bipolar disorder and anxiety.⁵⁴

2.45 On a related matter, the Youth Coalition highlighted the impact that mental illness can have on young people who are experiencing disadvantage in other areas:

Mental health issues can also affect different groups of young people disproportionately. Youth services report that young people experiencing homelessness, alcohol and other drug issues, young carers, multicultural young people, Aboriginal and Torres Strait Islander young people and young people who identify as gay, lesbian, bisexual, transgender or intersex are often affected in higher proportion. It is important to note the cyclic impact these co-occurring issues can have upon young people.⁵⁵

⁵¹ Mr Martin Fisk, *Transcript of Evidence*, 24 March 2016, p. 27.

⁵² See for example, Submission 4, Mind Blank.

⁵³ Submission 12, beyondblue, p. 7.

⁵⁴ Submission 11, ACT Child and Young People Death Review Committee, p. 3.

⁵⁵ Submission 14, Youth Coalition of the ACT, p. 10.

AUTISM SPECTRUM DISORDER

- 2.46 The Committee heard evidence from Menslink that young adults on the autism spectrum are at high risk of suicide and self harming behaviour:

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.⁵⁶

- 2.47 Further to this, Menslink provided the following case study:

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.⁵⁷

- 2.48 With reference to this experience, Menslink argued for alternative interventions for people at risk and less emphasis on medical treatments and interventions:

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.⁵⁸

⁵⁶ Mr Martin Fisk, *Transcript of Evidence*, 24 March 2016, p. 28.

⁵⁷ Mr Martin Fisk, *Transcript of Evidence*, 24 March 2016, p. 28.

⁵⁸ Mr Martin Fisk, *Transcript of Evidence*, 24 March 2016, p. 29.

- 2.49 On the issue of assistance and support for people with autism, officials from ACT Health told the Committee:

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.⁵⁹

- 2.50 Following the public hearing, Menslink provided a United Kingdom (UK) journal article which reported research findings that adults with Asperger's syndrome were significantly more likely to report lifetime experience of suicidal ideation than were individuals from a general UK population sample or people with psychotic illness. Compared with people diagnosed with Asperger's syndrome without depression, people with Asperger's syndrome and depression were more likely to report suicidal ideation and suicide plans or attempts.⁶⁰

LIFE EVENTS AS A RISK FACTOR

- 2.51 A number of submitters and witnesses highlighted that young people may be at increased risk of suicide and self harm during periods of transition or when responding to a significant event in their life.

TRANSITION PERIODS

- 2.52 Evidence to the Inquiry highlighted that transition periods are particularly challenging for young people—transitioning from: primary school to high school, high school to college, from a school environment to a school holiday environment, leaving school and/or moving into higher education or the workplace, and leaving a correctional facility.

⁵⁹ Ms Katrina Bracher, *Transcript of Evidence*, 24 March 2016, p. 40.

⁶⁰ Exhibit 1, Menslink.

Officials from CSD told the Committee:

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.⁶¹

2.53 Menslink highlighted that transition and loneliness are high stressors for young people, particularly when a young person leaves school. Menslink argued that continuity of support for young people during these periods of transition is particularly critical.⁶²

2.54 The Minister for Children and Young People also highlighted the difficulties experienced by young people as they transition into adulthood. The Minister advised the Committee that, in recognition of the difficult transition periods:

...Child and Protection Services continue to provide supports for young people on a voluntary basis until the age of 25 to ensure their successful transition to adulthood.⁶³

SIGNIFICANT EVENTS

2.55 Menslink told the Committee:

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.⁶⁴

2.56 Menslink also noted that the research from the Institute found:

... 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.⁶⁵

⁶¹ Mr David Matthews, *Transcript of Evidence*, 24 March 2016, pp. 15-16.

⁶² Mr Martin Fisk, *Transcript of Evidence*, 24 March 2016, p. 34.

⁶³ Dr Chris Bourke MLA, *Transcript of Evidence*, 14 April 2016, p. 58.

⁶⁴ Mr Martin Fisk, *Transcript of Evidence*, 24 March 2016, p. 27.

⁶⁵ Mr Martin Fisk, *Transcript of Evidence*, 24 March 2016, p. 27.

2.57 Further to this, Menslink explained:

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.⁶⁶

2.58 CSD officials also acknowledged the impact of critical life events:

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.⁶⁷

ARE THERE UNIQUE FACTORS IN THE ACT?

2.59 In relation to whether there are unique factors contributing to youth suicide in the ACT, submissions to the Inquiry that referred to this term of reference highlighted the following matters:

- there are inconsistencies and gaps in the available data directly about the experience in the ACT;
- the ACT suicide and self harm statistics that are available largely reflect national rates and trends; and
- there are some factors that may be unique to the ACT.

2.60 SupportLink Australia submitted:

The current restructure of Mental Health and Suicide Prevention funds, from a National to local level focus reflects the importance of localised support developed with an understanding of the unique needs of a particular community. For example, in the ACT, we have an often-transient population and a large number of school and university students who may spend only a short time in the ACT. Therefore, support structures

⁶⁶ Mr Martin Fisk, *Transcript of Evidence*, 24 March 2016, p. 27.

⁶⁷ Mr David Matthews, *Transcript of Evidence*, 24 March 2016, p. 15.

need to be clear and accessible as well as accounting for the unique challenges facing those who may live away from their support networks.⁶⁸

2.61 Families and Friends for Drug Law Reform submitted:

The recent alarming spike in child suicide needs to be put into the context of the overall trends in suicide in the territory. The rate of suicide in the territory measured in terms of deaths per 100,000 of the population is 9.8...

This rate was in 2014 the lowest in the country, slightly lower than that of New South Wales... within which the ACT lies. Furthermore, the overall suicide rate here has remained fairly stable at least since 2006...

By comparison then, the ACT is doing reasonably well but 38 self-inflicted deaths in a year is 38 too many. What the ACT is doing maybe better than other jurisdictions but it is still not good enough, particularly in the light of the surge in suicides of children.⁶⁹

2.62 Carers ACT submitted:

A unique factor for youth suicide is its proportion of young people compared with other Australian states and territories. While the ACT has the third highest proportion of its population aged 0-19 years (behind the Northern Territory and Queensland) it also has the highest proportion of young people in Australia in the age cohorts 15-29 years. This is attributed to young people relocating to Canberra for higher education or employment opportunities.

Our submission addresses concern about the effect of relocation upon mental health as well as the difficulties facing young carers entering tertiary education or seeking a career path.

Relocation can cause a sense of anticipation and achievement, but it can also contribute to mental health risk factors – a sense of isolation because of reduced contact with and support from close family and social networks; and additional living costs, such as accommodation and transport that can contribute to increased anxiety and financial and housing stress.⁷⁰

⁶⁸ Submission 13, SupportLink Australia, p. 2.

⁶⁹ Submission 15, Families and Friends for Drug Law Reform, p. 5.

⁷⁰ Submission 18, Carers ACT, pp. 9-10.

2.63 Similarly, Menslink observed that there is a degree of transience in the ACT's adult population which then affects young people as well, potentially having an impact on their ability to form meaningful relationships. Whilst acknowledging the transient ACT population, Menslink noted that:

...I do not see that there is any unique factor in the ACT that is different from any other state.⁷¹

2.64 The Youth Coalition noted that 'there are a number of challenges unique to the ACT in looking at young people's experience of education, housing, employment, access to services, and participation in community life'.⁷²

2.65 Further to this, Youth Coalition highlighted:

...intergenerational poverty and disadvantage in the ACT is more dispersed throughout the community and can be more hidden as a result. This provides a challenge in looking at place based interventions and funding, particularly with the limited resources of a small jurisdiction.⁷³

2.66 Youth Coalition noted that there are limited youth specific services namely:

- one youth specific community health service;
- one youth specific early intervention to moderate mental health service; and
- one youth specific alcohol and other drug treatment service.

2.67 Youth Coalition also noted that there are other generalist services in the ACT that address social support needs which 'may not be accessible to or meet the needs of young people. This results in gaps in our service system responses for young people'.⁷⁴

COMMITTEE COMMENT

2.68 The Committee notes and agrees with submissions highlighting that there are a number of specific at-risk groups for youth suicide, which may include Aboriginal and Torres Strait Islander young people, lesbian, gay, bisexual, transgender, intersex and queer young people and young people with a mental illness. The Committee also notes that evidence shows young people who fall outside identified categories can experience great stress as a result of challenging life events, or times of transition, resulting in an increased risk of self harm or suicide.

⁷¹ Mr Martin Fisk, *Transcript of Evidence*, 24 March 2016, p. 36

⁷² Submission 14, Youth Coalition of the ACT, p. 14.

⁷³ Submission 14, Youth Coalition of the ACT, p. 14.

⁷⁴ Submission 14, Youth Coalition of the ACT, p. 14.

- 2.69 The Committee notes the differing views received regarding the unique factors that young people in the ACT experience that could potentially contribute to the rate of suicide. In the absence of clear evidence the Committee is unable to determine whether the factors identified are unique to the ACT or if they are experienced by young people across Australia. The Committee appreciates that organisations working with young people have identified what they see through their work, and acknowledge that gaps in data collection may be responsible for the lack of qualitative data in this respect.
- 2.70 The Committee notes that while the ACT rate of suicide is not disproportionate to other Australian jurisdictions, any occasion of suicide is one too many. The Committee encourages the ACT Government to continue focussing suicide prevention activities to at-risk groups and cohorts likely to be experiencing high levels of stress and transition, such as senior high school students.

3 ACT AND AUSTRALIAN GOVERNMENT ROLES AND RESPONSIBILITIES

- 3.1 In accordance with Term of Reference (a) the Committee was asked to examine the following:

ACT Government and Commonwealth Government roles and responsibilities in regard to youth mental health and suicide prevention, particularly in relation to the recently announced Commonwealth response to the National Mental Health Commission Report and the mental health and suicide commissioning role for the Primary Healthcare Networks as it affects the ACT.

- 3.2 This will be examined along with Term of Reference (b) which requires the Committee to report on any gaps or duplicate roles and responsibilities. This chapter only considers term of reference (b) in relation to policy and funding considerations.

- 3.3 This section of the report will consider the findings of the National Mental Health Commission Review (the NMHC review) in relation to funding and service provision relevant to the ACT, and general findings in relation to suicide prevention; review the status of the Primary Healthcare Network as it affects the ACT; and consider ACT specific mental health policies as they relate to youth mental health and suicide prevention activities.

NATIONAL POLICIES AND PROGRAMS

- 3.4 There are a number of Australian Government policies and funded programs that relate to mental health and suicide prevention activities.⁷⁵ Due to the finalisation of the NMHC review, and the Australian Government's response to the review which states that significant changes will be made to existing practice, it is expected that existing resources and oversight documents will also change. As such this Inquiry has chosen to consider the NMHC review and the Australian Government response instead of existing policy documents in order to address the likely roles and responsibilities for youth mental health and suicide prevention matters in relation to the ACT.

⁷⁵ See Australian Government, Department of Health, *Mental health*, <http://www.health.gov.au/internet/main/publishing.nsf/Content/Mental+Health+and+Wellbeing-1>. (accessed on 17 May 2016)

NATIONAL MENTAL HEALTH COMMISSION REVIEW

- 3.5 In February 2014, The Hon Peter Dutton MP, former Minister for Health, announced the Terms of Reference for the review of mental health services and programs to be conducted by the National Mental Health Commission (NMHC). The focus of the review was on assessing the efficiency and effectiveness of programmes and services in supporting individuals experiencing mental ill-health and their families and other support people to lead a contributing life and to engage productively in the community.
- 3.6 The final report from the NMHC, *Contributing Lives, Thriving Communities —Review of Mental Health Programmes and Services* (the NMHC review) was provided to the Australian Government on 1 December 2014. The NMHC noted that:
- The ultimate goal of this Review was to make a set of recommendations for Government to consider, that will create a system to support the mental health and wellbeing of individuals, families and communities in ways that enables people to live contributing lives and participate as fully as possible as members of thriving communities.⁷⁶
- 3.7 In conducting their review, the NMHC's primary areas of focus was the efficiency and effectiveness of Australian Government services and programs and overall investment and spending patterns. Specific clinical treatments and state and territory funded programs, services and systems were not evaluated.⁷⁷ However, it was noted that 'gaining a comprehensive picture of what is funded and delivered at the state and territory level proved difficult'.⁷⁸
- 3.8 Despite the acknowledged challenges, the NMHC review provided a snapshot of what mental health services are provided in the ACT, the nature of that service and the cost per capita of that service.

⁷⁶ National Mental Health Commission, *Contributing Lives, Thriving Communities - Review of Mental Health Programmes and Services*, <http://www.mentalhealthcommission.gov.au/our-reports/contributing-lives,-thriving-communities-review-of-mental-health-programmes-and-services.aspx> (accessed 29 March 2016)

⁷⁷ National Mental Health Commission, *Contributing lives, thriving communities —Report of the National Review of Mental Health Programmes and Services, Volume 1*, November 2014, p. 13.

⁷⁸ National Mental Health Commission, *Contributing lives, thriving communities —Report of the National Review of Mental Health Programmes and Services, Volume 4, Paper 3*, November 2014, p. 1.

ACT EXPENDITURE ON MENTAL HEALTH SERVICES

- 3.9 The NMHC review found that in 2012 -2013 the ACT had the highest rate of community mental health care service contacts provided per capita of all Australian jurisdictions and one of the lowest rates of residential mental health care service.⁷⁹
- 3.10 In relation to the proportion of expenditure, by service type for specialised mental health services in 2011–12, the ACT spent 44.7% of total mental health funding on community mental health services, 24.5% on public hospital services, 13.3% on grants to the community sector and 17.4% on other services.⁸⁰
- 3.11 Per capita expenditure for specialised mental health services in the ACT in 2009-2010 was \$203.55 per person. In 2010-2011 it was \$205.11 per person and in 2011-2012 it was \$213.51.⁸¹
- 3.12 In relation to expenditure on Medicare Benefits Schedule-subsidised mental health services, per capita, by practitioner type, in 2012–13 the ACT Government spent \$6.89 for psychiatrist services, \$6.35 for general practitioner services, \$9.88 for clinical psychologist services, \$6.73 for other psychologist services and \$0.55 for other allied health services.⁸²

FINDINGS IN RELATION TO SUICIDE

- 3.13 In relation to suicide prevention the Review made a number of findings:
- A complex interaction of variables which may or may not include mental illness can lay behind a person's suicide or suicide attempt. Suicide prevention is not the same thing as prevention and treatment of mental illness.
 - People who attempt suicide are not all receiving sufficient support and follow-up to help prevent further attempts, especially in the high-risk period following discharge after a suicide attempt. This is a missed opportunity to reduce suicide rates and save lives.
 - Many people who had attempted suicide perceived there was no 'middle ground' between inpatient hospital care on the one hand and no support on the other hand.
 - Many people with suicidal thoughts felt strongly that they were not taken seriously by health professionals, particularly those in Emergency Departments, when seeking help for

⁷⁹ National Mental Health Commission, *Contributing lives, thriving communities –Report of the National Review of Mental Health Programmes and Services, Volume 4, Paper 3*, November 2014, pp. 5-6.

⁸⁰ National Mental Health Commission, *Contributing lives, thriving communities –Report of the National Review of Mental Health Programmes and Services, Volume 4, Paper 3*, November 2014, p. 8.

⁸¹ National Mental Health Commission, *Contributing lives, thriving communities –Report of the National Review of Mental Health Programmes and Services, Volume 4, Paper 3*, November 2014, p. 8.

⁸² National Mental Health Commission, *Contributing lives, thriving communities –Report of the National Review of Mental Health Programmes and Services, Volume 4, Paper 3*, November 2014, p. 11.

suicidal thinking or self-injury, and reported being sent home with no follow-up despite explicit plans for suicide.

- A previous suicide attempt is the most reliable predictor of a subsequent death by suicide. How the system responds to people who think about suicide or make an attempt therefore must be a central plank of suicide prevention efforts.⁸³

3.14 These NMHC findings largely reflect evidence heard by the Committee throughout this Inquiry.

3.15 A Fact Sheet accompanying the Review also identifies a number of key responses that the NMHC believes should be undertaken by the Australian Government to reduce suicide rates in Australia. They include:

- Establishing 12 regions across Australia and initiating systemic, multi-level and multi-sectoral prevention models with key stakeholders in each of those communities.
- Working with state and territory governments, people with lived experience and other key stakeholders in the development of a National Suicide Prevention Framework which is based on Australian and international evidence of what works.
- Using Commonwealth funding as incentive funds to leverage local contributions.
- Implementing a ‘no wrong door’ approach, ensuring that no one who expresses suicidal ideas or who has attempted to take their own life is ‘turned away’ from any service at which they seek help.
- Providing access to adequate services, ensuring that therapeutic interventions are tailored to the complexity and severity of individual need.
- Ensuring first responders and health professionals who are likely to encounter suicidal people are appropriately trained in communication and “soft skills”.
- Aiming to close the gap in rates of suicide between Aboriginal and Torres Strait Islander peoples and other Australians with culturally appropriate, evidence based services; and by implementing the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy 2013.⁸⁴

NMHC REVIEW RECOMMENDATIONS

3.16 In relation to overall mental health and funding the Review identified nine strategic directions to guide reform and proposed 25 recommendations (Appendix A). The Committee notes key recommendations will have a significant effect on the operation of mental health services in the ACT.

⁸³ National Mental Health Commission, *Contributing lives, thriving communities –Report of the National Review of Mental Health Programmes and Services, Fact Sheet 4*, November 2014, p. 1.

⁸⁴ National Mental Health Commission, *Contributing lives, thriving communities –Report of the National Review of Mental Health Programmes and Services, Fact Sheet 4*, November 2014, pp. 1-2.

- 3.17 Strategic Direction 1 recommends that a National Mental Health and Suicide Prevention Plan is developed in conjunction with the States and Territories which clearly defines roles and responsibilities.
- 3.18 In regards to the funding, Strategic Direction 3 provides that the Australian Government shift funding priorities from hospitals and income support to community and primary health care services. Accompanying recommendations suggest that the Australian Government should extend the scope of Primary Health Networks (renamed Primary and Mental Health Networks) as the key regional architecture for equitable planning and purchasing of mental health programmes, services and integrated care pathways.

AUSTRALIAN GOVERNMENT RESPONSE TO THE NATIONAL MENTAL HEALTH COMMISSION REVIEW

- 3.19 On 26 November 2015, the Australian Government released its response to the NMHC's review and stated that:

The Australian Government response to the Review aims to transform Commonwealth mental health funding and leadership over the next three years to achieve a more efficient integrated and sustainable mental health system and to improve mental health service delivery for Australians.⁸⁵

- 3.20 In response to recommendations relating to early intervention, the Response states:

The Commonwealth supports in-principle the need for a long term shift towards intervening early and away from providing reactive services late in the trajectory of mental illness, averting where possible the need for hospitalisation.⁸⁶

- 3.21 No timeline or detail relating to action in this regard is provided in the Australian Government response.

- 3.22 In relation to mental health services for young people the Response states:

The Commonwealth will work across portfolios to join up child and youth mental health programmes to establish a new networked system of reducing the impact of mental illness on children, commencing with the early years and going through to adolescence. This will include:

- a single integrated end-to-end school based mental health programme;

⁸⁵ Australian Government, Department of Health, *Australian Government Response to Contributing Lives, Thriving Communities - Review of Mental Health Programmes and Services*, <http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-review-response> (accessed 29 March 2016).

⁸⁶ Australian Government, Department of Health, *Australian Government Response to Contributing Lives, Thriving Communities- Summary of actions within the Australian Government response to recommendations of the Review of Mental Health Programmes and Services* <http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-review-actions> (accessed 17 May 2016).

- easy access to telephone and web-based services through the new digital mental health gateway; and
- a national workforce initiative assisting clinical and non-clinical professionals and services who work with children to identify, support and refer children at risk and to promote resilience building.⁸⁷

3.23 The Response states that people at risk of suicide will be better supported in their local community through a new evidence based approach to suicide prevention, including a systematic and planned, integrated and regional approach, replacing the current piecemeal approach. Negotiations with states and territories will seek to ensure that people who have self-harmed or attempted suicide will receive critical follow-up support, and efforts to reduce suicide among Aboriginal and Torres Strait Islander people will be refocused.⁸⁸

3.24 In relation to suicide prevention activities the Australian Government Response states that a new national suicide prevention strategy will be implemented immediately, with four critical components:

- national leadership and infrastructure, including whole of population activity and crisis support services;
- a systematic and planned regional approach to community based suicide prevention. PHNs will commission regionally appropriate activities, in partnership with LHNs and other local organisations;
- efforts to prevent Aboriginal and Torres Strait Islander suicide will be refocused; and
- working with states and territories, including in the context of the Fifth National Mental Health Plan, to ensure people who have self-harmed or attempted suicide are given effective follow-up after discharge⁸⁹

PRIMARY HEALTH NETWORKS

3.25 On 1 July 2015, 31 PHNs were established to increase the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and to improve coordination of care to ensure patients receive the right care in the right place at the right time.

⁸⁷ Australian Government, Department of Health, *Australian Government Response to Contributing Lives, Thriving Communities- Summary of actions within the Australian Government response to recommendations of the Review of Mental Health Programmes and Services* <http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-review-actions> (accessed 17 May 2016).

⁸⁸ Australian Government, Department of Health, *Australian Government Response to Contributing Lives, Thriving Communities - Review of Mental Health Programmes and Services, Fact Sheet* <http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-review-response> (accessed 4 May 2016).

⁸⁹ Australian Government, Department of Health, *Australian Government Response to Contributing Lives, Thriving Communities - Review of Mental Health Programmes and Services, Fact Sheet* <http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-review-response> (accessed 4 May 2016).

Previously the network was known as Medicare Locals.⁹⁰ The Australian Government agreed to six key priorities for targeted work by PHNs including mental health, Aboriginal and Torres Strait Islander health, population health, health workforce, eHealth and aged care.⁹¹

3.26 The NMHC review noted that:

The current development of 30 Primary Health Networks across Australia provides the ideal opportunity to build on that infrastructure and better target mental health resources to meet population needs on a regional basis. These new entities will be the meso-level organisations responsible for planning and purchasing services on a regional basis.

Regional entities could work in partnership and apply targeted, value-for-money interventions across the whole continuum of mental wellbeing and ill-health to meet the needs of their communities.⁹²

3.27 The Australian Government response noted the NMHC recommendation and announced that from 2016 Commonwealth mental health programme funding will be transitioned to PHNs to form a newly created mental health flexible funding pool⁹³

3.28 Suicide prevention was identified as a priority for PHNs with ‘a regional approach to suicide prevention, including community based activities and integrated post discharge care for people at high risk of suicide’ approach supported.⁹⁴

3.29 The Australian Government Response is clear that the name of PHNs will not be changed to accommodate the recommendation that they be called Primary and Mental health networks stating:

Transition will commence from 1 July 2016 with the aim of all regionally delivered mental health grants programmes being delivered through PHNs by 2019. At this point in time Government is not considering a name change to Primary Health Networks.⁹⁵

⁹⁰ <http://www.medicarelocals.gov.au/internet/medicarelocals/publishing.nsf#.Vzqb1HI01Co>.

⁹¹ Australian Government, Department of Health, *Primary Health Networks*, <http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Home> (accessed 29 March 2016).

⁹² National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services, Volume 1*, November 2014, p. 48.

⁹³ Australian Government, Department of Health, *Australian Government Response to Contributing Lives, Thriving Communities - Review of Mental Health Programmes and Services*, p. 4.

⁹⁴ Australian Government, Department of Health, *Australian Government Response to Contributing Lives, Thriving Communities - Review of Mental Health Programmes and Services, Fact Sheet* <http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-review-response> (accessed 4 May 2016).

⁹⁵ Australian Government, Department of Health, *Australian Government Response to Contributing Lives, Thriving Communities- Summary of actions within the Australian Government response to recommendations of the Review of Mental Health Programmes and Services* <http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-review-actions> (accessed 17 May 2016).

- 3.30 During the public hearings for this Inquiry, an ACT Health Directorate official confirmed that work is progressing on the development of the PHN for the ACT. They stated ‘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 commission of new services’.⁹⁶

EVIDENCE IN SUBMISSIONS ABOUT THE NMHC REVIEW AND AUSTRALIAN GOVERNMENT RESPONSE

- 3.31 A number of submissions considered the findings of the NMHC review and Australian Government response.

- 3.32 beyondblue submitted:

The recently announced Commonwealth Government mental health reforms and the development of the 5th National Mental Health and Suicide Prevention Plan provide a perfect opportunity to clarify the roles and responsibilities of various levels of government as well as the roles and responsibilities of individuals, groups and communities.⁹⁷

- 3.33 beyondblue submitted that while reforms outlined in the NMHC Report relate to the spectrum of conditions and age groups, several reforms are clearly relevant to the issue of self-harm and suicide among young people including:

- the proposed reforms relating to child mental health which emphasise the importance of working across portfolios to join up child mental health programs to reduce the impact of mental health conditions on children, commencing with the early years and going through to adolescence.
- the youth mental health reforms which propose better integration between existing Commonwealth funded youth mental health services, state and territory child and adolescent services and broader primary care or social support services (such as education and employment supports).
- a new approach to suicide prevention using a multi-pronged approach which emphasises national leadership combined with regionally based approaches to suicide prevention, that include refocused efforts to prevent Indigenous suicide and initiatives to ensure effective post-discharge follow-up for people who have self-harmed or attempted suicide.⁹⁸

⁹⁶ Mr Ross O’Donoghue, *Transcript of Evidence*, 24 March 2016, p. 41.

⁹⁷ Submission 12, beyondblue, p. 15.

⁹⁸ Submission 12, beyondblue, p. 15.

3.34 Evidence and submissions presented to the Committee highlighted the need for alignment between ACT suicide prevention initiatives and the reforms outlined by the NMHC to ensure clear responsibilities for each level of government.

3.35 For example, beyondblue submitted that when examining their own suicide prevention initiatives, the ACT Government should include a governance framework that sets out:

- clear responsibilities for all individuals and organisations involved, with mechanisms in place to track accountability
- decision-making processes, particularly focusing on allocating, controlling and using resources and defining project objectives, outcomes and priorities
- structures, resources and processes which ensure that all individuals and organisations can be represented and ‘have a say’.⁹⁹

3.36 Submissions to the Inquiry highlighted that there is uncertainty about the role of PHNs following the recommendations included in the NMHC Report (see Appendix A).

3.37 The Youth Coalition submitted particular concerns about the impact that changes to PHNs will have on headspace:

The national mental health reforms mean headspace contracts and compliance will transfer to Primary Health Networks from July 2016. The Youth Coalition understands that it is likely headspace centre budgets will remain as is for the next 2 years. headspace National Office will remain, but it is unclear in what capacity. Additionally we understand:

- headspace centres will be funded at current level with no growth for the next 2 years;
- e-headspace will continue for 12 months, there is uncertainty how this need will be met beyond that; and,
- headspace School Support will extend until December 2016, there is uncertainty how this need will be met beyond that.¹⁰⁰

3.38 The Youth Coalition noted that funding for both headspace Canberra and Queanbeyan will be across two PHNs and ‘it is unclear how cross border service access will be impacted by the devolving of funding allocation decisions to the PHNs.’¹⁰¹

⁹⁹ Submission 12, beyondblue, p. 16.

¹⁰⁰ Submission 14, Youth Coalition of the ACT, p. 22.

¹⁰¹ Submission 14, Youth Coalition of the ACT, p. 22.

3.39 The ACT Government submitted:

Following the release of the Response, the ACT Primary Health Network, Capital Health Network (CHN) has taken on new responsibility for implementing the Australian Government's mental health and suicide prevention agenda. ACT Health have had a series of preliminary meetings with CHN to discuss the process for working together to develop a mental health and suicide prevention system to meet the needs of the whole community. Given the early stage of discussions it is not yet clear how the future system will eventually be configured.¹⁰²

3.40 Similarly, RANZCP noted:

More information is required regarding how the PHNs will interact with ACT-funded child and adolescent mental health services. In particular, clarity is required regarding whether acute service system responses will primarily be through the PHNs or not, and how this will be managed.¹⁰³

3.41 The RANZCP welcomes the early indications from the PHNs that their policies and procedures will include a system for follow up following a suicide attempt and/or discharge from an inpatient unit. RANZCP noted that for this to be implemented successfully, 'the system needs to be easy to use, accurate and enabling of cross-sector communication'.¹⁰⁴

3.42 Further to this, RANZCP submitted:

While the PHNs' responsiveness to suicide risk is promising, more information is required as to how the PHNs' stepped-care model will be operationalised with regards to deliberate self-harm, and how the approach of the PHNs will fit alongside that of ACT-funded services.

...

The RANZCP emphasises that, for the potential of the PHNs to be realised, there needs to be a coordinated, transparent and consultative development and implementation process. Currently there is a uncertainty in the mental health sector with regards to how the PHNs will impact on and interact with services. Localised mental health plans will need to be drafted in close consultation with local services and groups, so that they accurately represent the needs of the population. PHNs will need to carefully establish roles with regards to their interactions with ACT-funded child and adolescent mental health services.¹⁰⁵

¹⁰² Submission 19, ACT Government, p. 4.

¹⁰³ Submission 20, Royal Australian and New Zealand College of Psychiatrists, p. 4.

¹⁰⁴ Submission 20, Royal Australian and New Zealand College of Psychiatrists, p. 3.

¹⁰⁵ Submission 20, Royal Australian and New Zealand College of Psychiatrists, p. 3.

- 3.43 On a related matter, the RANZCP expressed concern that the PHN's focus on youth mental health risks missing an opportunity for identifying children with significant suicide risk factors, noting that this vulnerable population tends to be overlooked in service design and delivery.¹⁰⁶

ACT POLICIES AND APPROACH

- 3.44 The ACT has a number of policies in place that relate to mental health, young people and suicide prevention. They include the following:
1. ACT Mental Health Services Plan 2009-2014.¹⁰⁷ A strategic level document giving broad direction for the future development of public mental health services in the ACT. The guiding vision is that by 2020 the mental health needs of the community will be met by a comprehensive network of complementary and integrated mental health services. The ACT Health Annual Report 2014-15 noted that the Mental Health Services Plan was scheduled to be reviewed in the 2015-16 year.
 2. Managing the Risk of Suicide: A Suicide Prevention Strategy for the ACT 2009-2014.¹⁰⁸ This strategy provides a service development framework to guide an integrated, whole-of-community approach to suicide prevention across the lifespan. A research paper evaluating the implementation of the strategy was published in 2014.¹⁰⁹
 3. Building a Strong Foundation: A Framework for Promoting Mental Health and Wellbeing in the ACT 2009-2014.¹¹⁰ A sub-plan of the Mental Health Services Plan and is a companion document to Managing the Risk of Suicide which sets out the ACT Government's commitment to promoting mental health and wellbeing, preventing mental illness and early intervention.
 4. Child and Adolescent Mental Health Service Model of Care¹¹¹ (May 2013) outlines the model of care to be implemented and delivered by the Child and Adolescent Mental Health Service.
 5. The ACT Children and Young People's Commitment 2015–2025¹¹² identifies six priority areas. The areas for action under each key priority provide guidance to the Canberra community on how we can best support children and young people to reach their potential and how we can work together to promote and protect their rights.

¹⁰⁶ Submission 20, Royal Australian and New Zealand College of Psychiatrists, p. 3.

¹⁰⁷ <http://www.atoda.org.au/wp-content/uploads/MentalHealthServicesPlan2009-2014.pdf>

¹⁰⁸ http://www.health.act.gov.au/sites/default/files/Policy_and_Plan/Suicide%20Prevention%20-%20Managing%20the%20Risk%20of%20Suicide%20in%20the%20ACT%202009-2014.pdf

¹⁰⁹ <http://econtent.hogrefe.com/doi/pdf/10.1027/0227-5910/a000295>

¹¹⁰ <http://www.atoda.org.au/wp-content/uploads/Building-1.pdf>

¹¹¹ [http://www.health.act.gov.au/sites/default/files/Child%20and%20Adolescent%20Mental%20Health%20Service%20Model%20of%20Care%20\(May%202013\).pdf](http://www.health.act.gov.au/sites/default/files/Child%20and%20Adolescent%20Mental%20Health%20Service%20Model%20of%20Care%20(May%202013).pdf)

¹¹² http://www.communityservices.act.gov.au/_data/assets/pdf_file/0008/798785/CSD_CYPC_A4_web.pdf.

3.45 Appendix B highlights the complex relationship between these policies.

3.46 The ACT Health website states that:

In 2009 the ACT Government launched the *Building a Strong Foundation: A Mental Health Promotion, Prevention and Early Intervention Framework for the ACT 2009-2014* and *Managing the Risk of Suicide: A Suicide Prevention Strategy for the ACT 2009-2014*. As these plans are about to expire there is a need for the ACT Government to develop a replacement for these plans.

The ACT Government has directed that the plans are to be combined into a single high-level strategic framework. The Framework will provide direction and coordination for mental health and suicide prevention activities in Canberra for the next decade.

The Suicide Prevention and Promotion, Prevention and Early Intervention Implementation and Evaluation Working Groups and an Inter-Directorate Committee with representation from all of the directorates of the ACT Government are engaged in the development of the Framework.¹¹³

3.47 The ACT Government released the draft for community consultation in December 2014.¹¹⁴

3.48 The draft Framework identifies 3 goals, one being to 'make a sustained reduction in the rate of mental illness, suicide and self-harm in the ACT over time'.¹¹⁵ The draft also states that the Framework 'aligns with both Commonwealth and other Territory policies on mental health and suicide prevention'.¹¹⁶

3.49 The draft cites research indicating that the total cost of suicidal behaviour (both directly and indirectly) to the Australian economy has been assessed as being \$17.5 billion per year, and that investing in promotion, prevention and early intervention makes economic sense with the return on investment for every \$1 expended was between \$0.30 and \$83.70 with an average return of \$17.70.¹¹⁷

¹¹³ ACT Health Website, <http://www.timetotalk.act.gov.au/consultations/?engagement=act-mental-health-and-wellbeing-framework-2015-2025> (Accessed on 4 May 2016).

¹¹⁴ <http://www.timetotalk.act.gov.au/consultations/?engagement=act-mental-health-and-wellbeing-framework-2015-2025>.

¹¹⁵ ACT Health, DRAFT *The ACT Mental Health and Wellbeing Framework 2015-2025*. Canberra, Australia, 2015, p. 4, accessible at: <http://www.timetotalk.act.gov.au/storage/2-Consultation%20Draft%20MH%20Framework%202015-2025.pdf>.

¹¹⁶ ACT Health, DRAFT *The ACT Mental Health and Wellbeing Framework 2015-2025*. Canberra, Australia, 2015, p. 6.

¹¹⁷ ACT Health, DRAFT *The ACT Mental Health and Wellbeing Framework 2015-2025*. Canberra, Australia, 2015, p. 7.

- 3.50 During the hearings the Framework was discussed. A Health official informed the Committee that:

The government is very close to finalising *The ACT mental health and wellbeing framework 2015-2025*... 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.¹¹⁸

- 3.51 The Minister for Health elaborated that ‘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’.¹¹⁹

DUPLICATION

- 3.52 The ACT Government submission provided the following detail about ACT Government and Australian Government roles and responsibilities for youth mental health and suicide prevention:

In relation to mental health services, broadly state and territory governments are responsible for tertiary health services—that is hospital and hospital related services. The Australian Government is responsible for primary health services—mainly provided by GPs and to a lesser extent some services provided by allied health professionals such as psychologists, social workers and mental health nurses. Both state and territory governments and the Australian Government provide and fund health promotion education and services. Both state and territory governments and the Australian Government fund community sector services that work across the spectrum of interventions from health promotion and education to services that interface with hospital systems.

In relation to suicide prevention services, both state and territory governments and the Australian Government fund and provide suicide prevention services.¹²⁰

- 3.53 Further to this, the ACT Government submitted:

Please note that mental health services are also suicide prevention services, either through directly working with people displaying suicidal behaviour or by preventing or treating mental illness which is a significant contributing factor to suicide risk.¹²¹

¹¹⁸ Mr Ross O'Donoghue, *Transcript of Evidence*, 24 March 2016, p. 42.

¹¹⁹ Mr Simon Corbell MLA, *Transcript of Evidence*, 24 March 2016, p. 43.

¹²⁰ Submission 19, ACT Government, p. 2.

¹²¹ Submission 19, ACT Government, p. 2.

3.54 The Committee heard two different views in relation to the level of duplication in the hearings. The CSD stated 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’.¹²²

3.55 Health Directorate officials had a different perspective:

We agree that there is scope for better coordination for 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 prove better coordinated services in the primary mental health space.¹²³

3.56 The Minister for Health also commented on duplication stating:

[The NMHC Review] 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.¹²⁴

COMMITTEE COMMENT

3.57 The Committee notes the significant amount of flux in relation to current funding and administrative arrangements. The roles, responsibilities and funding arrangements in relation to youth mental health services and suicide prevention activities between the Australian Government and the ACT Government are unclear due to the Australian Government undertaking to make changes based on the NMHC review but not yet implementing the preferred approach as identified in the response to the NMHC review.

¹²² Ms Maureen Sheehan, *Transcript of Evidence*, 24 March 2016, p. 16.

¹²³ Mr Ross O'Donoghue, *Transcript of Evidence*, 24 March 2016, p. 41.

¹²⁴ Mr Simon Corbell MLA, *Transcript of Evidence*, 24 March 2016, p. 47.

- 3.58 The Committee notes that the ACT Government has only recently commenced negotiations in relation to the Capital Health Network which will, as highlighted by the submissions to this Inquiry, have significant ramifications to mental health service provision to young people in the ACT. This has the effect of limiting the Committee's ability to comment on funding arrangements and service provision or potential duplication at this time.
- 3.59 The Committee also notes that this uncertainty is present in relation to ACT priorities with only a draft Mental Health and Wellbeing Framework available for consideration. Whilst the Committee appreciates that there is potential benefit in waiting to finalise negotiations with the Australian Government prior to finalising the ACT Framework, the Committee is not able to comment on the appropriateness of the Framework and its relationship with Australian Government policy.
- 3.60 This in conjunction with the absence of updated Australian Government policy (following the Response to the NMHC review) has resulted in the Committee considering it inappropriate to make findings in relation to the future relationship between the Australian Government and ACT Government in relation to funding or roles and responsibilities.
- 3.61 The Committee notes that uncertainty of funding can place pressure on community sector organisations working in the field. The Committee encourages the ACT Government to work with the sector and provide information as readily as it is available in order for organisations to appropriately respond and ensure consistent service provision in the ACT.
- 3.62 The Committee acknowledges that the existing materials available show that there is significant duplication in relation to roles and responsibilities between the Australian Government and the ACT Government currently.
- 3.63 The Committee also finds that there is little clarity or material available to explain how funds are allocated and spent between the Australian Government and ACT Government on youth mental health and suicide prevention activities.
- 3.64 Looking forward, the Committee notes that there is significant overlap between the objectives of the draft ACT Mental Health and Wellbeing Framework and the recommendations of the NMHC Review. The Committee acknowledges the submissions made highlighting the need for clear delineation of roles and responsibilities and encourages the ACT Government to take the opportunity presented by the NMHC review and the PHNs to ensure that ACT policy works in conjunction with national policy and aims to support national measures, not duplicate existing service provision. In this respect the Committee acknowledges that the ACT Government has existing practice models which aim to reduce the impact of multiple service interaction for families such as the Strengthening Families Program. Lessons from these programs could also be applied.

Recommendation 2

- 3.65 The Committee recommends that the ACT Government update this Committee in relation to Australian Government funding negotiations in relation to mental health funding, including the Capital Health Network.**

4 YOUTH SPECIFIC MENTAL HEALTH AND SUICIDE PREVENTION SERVICES IN THE ACT

- 4.1 In accordance with Term of Reference (d) the Committee was asked to examine the following:

ACT government-funded services, agencies and institutions, including schools, youth centres, and specialist housing service providers' role in promoting resilience and responding to mental health issues in children and young people.

- 4.2 This will be examined along with Term of Reference (b) which requires the Committee to report on any gaps or duplicate roles and responsibilities. This chapter only considers term of reference (b) in relation to service provision.
- 4.3 This section of the report will consider youth mental health and suicide prevention service provision in relation to both ACT and Australian Government funded services operating in the ACT. The Committee has undertaken this examination in order to assess the range and accessibility of services. Private and online services will also be considered to ascertain the full range of service available to young people in the ACT.

ACT GOVERNMENT FUNDED SERVICES

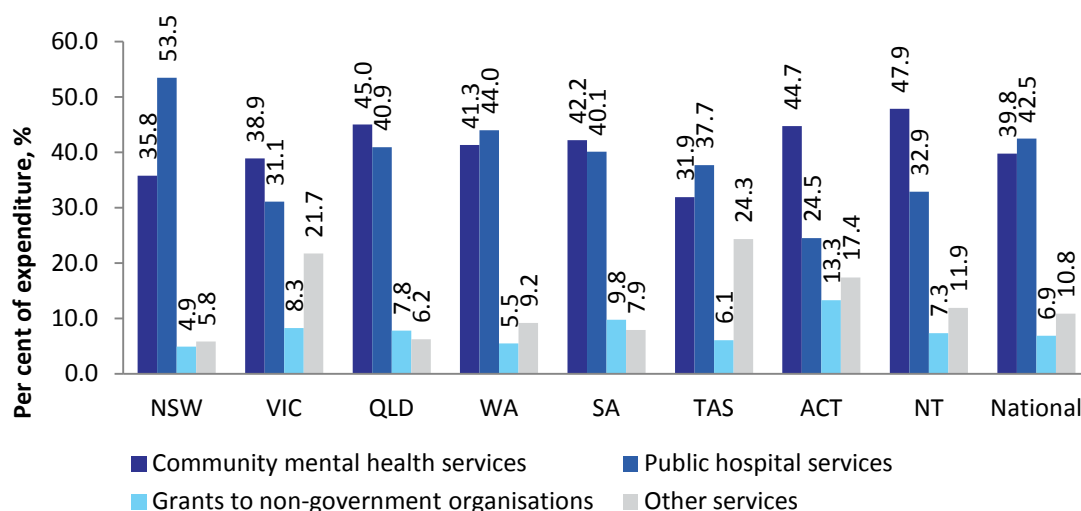
- 4.4 A suite of mental health services are supported by the ACT Government through the Health Directorate. The Territory both funds and operates some services, and contracts community organisations to provide complementary services. Services are offered in a variety of models (from general parenting programs to targeted psychiatric treatments) and across the service spectrum (early intervention activities to intensive residential facilities). There are a limited number of services targeting young people with mental health concerns or young people at risk of suicide.
- 4.5 The Community Services Directorate clarified that although they fund the child, youth and family support programs between \$11 and \$12 million per year to assist a young person in the context of their family and their general circumstances,¹²⁵ the Directorate does not fund any programs specifically to address youth suicide or to stop youth suicide.¹²⁶
- 4.6 As mentioned previously in this Report, the NMHC Review identified ACT government spending on mental health. Figure A shows that in 2011- 2012 the ACT spent 44.7% of its total

¹²⁵ Ms Maureen Sheehan, *Transcript of Evidence*, 24 March 2016, p. 3.

¹²⁶ Ms Maureen Sheehan, *Transcript of Evidence*, 24 March 2016, p. 14.

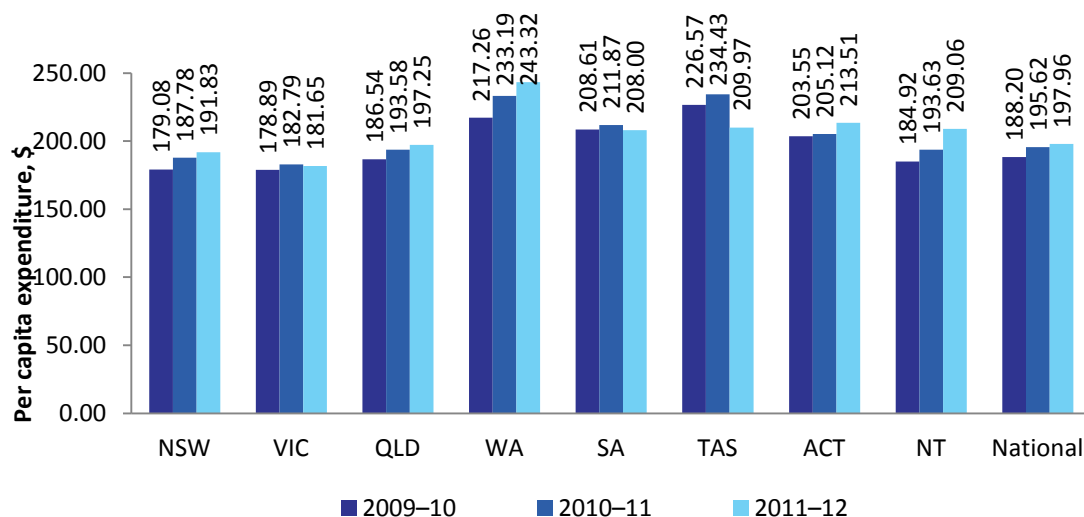
mental health funding on community mental health services, 24.5% on public hospital services, 13.3% on grants to the community sector and 17.4% on other services.¹²⁷

FIGURE A – PERCENTAGE OF EXPENDITURE ON MENTAL HEALTH SERVICES BY STATE 2011-2012



4.7 Figure B shows recurrent spending for specialised mental health services between 2009–10 and 2011–12.¹²⁸

FIGURE B – PER CAPITA RECURRENT EXPENDITURE ON MENTAL HEALTH SERVICES BY STATE



¹²⁷ National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services, Volume 4, Paper 3*, November 2014, p. 8.

¹²⁸ National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services, Volume 4, Paper 3*, November 2014, p. 8.

ACT GOVERNMENT OPERATED SERVICES

- 4.8 The Child and Adolescent Mental Health Service (CAMHS) is a tertiary mental health service that responds to children and young people who present with moderate to severe mental health issues by providing specialist assessment, therapeutic interventions and clinical case management.¹²⁹ It is the primary referral point for ACT Government funded youth mental health service provision in the ACT. Approximately \$6,452,000 was allocated to CAMHS in the last ACT budget.¹³⁰
- 4.9 Services available through CAMHS include a Perinatal Mental Health Consultation Liaison Service, an Eating Disorders Program, STEPS (a residential facility that is an alternative to hospital for young people (aged 14 -18 years) for up to a period of 12 weeks who are experiencing moderate to severe mental health issues), an Early Intervention Team, the Cottage Adolescent Day Programme, and Community Teams which provide assessment and treatment for children and young people under 18 years of age who are experiencing moderate to severe mental health difficulties.¹³¹
- 4.10 The ACT has the highest number of community based mental health contacts of any jurisdiction in Australia per capita¹³² (see figure C). Local data shows that CAMHS made 19,126 community service contacts between July to September (2015-16) which represents a 13 per cent increase in the number of contacts on the previous year.¹³³

FIGURE C RATE PER 100,000 POPULATION COMMUNITY BASED MENTAL HEALTH CONTACTS PER STATE



¹²⁹ ACT Government, Response to question taken on notice no. 1. Available at http://www.parliament.act.gov.au/in-committees/standing_committees/Health,-Ageing,-Community-and-Social-Services/inquiry-into-youth-suicide-and-self-harm-in-the-act/responses-to-questions?inquiry=822269.

¹³⁰ <http://health.act.gov.au/our-services/mental-health/specialty-services> (accessed on 10 May 2016).

¹³¹ <http://health.act.gov.au/our-services/mental-health/specialty-services> (accessed on 10 May 2016).

¹³² National Mental Health Commission, *Contributing lives, thriving communities –Report of the National Review of Mental Health Programmes and Services, Volume 4, Paper 3*, November 2014, p. 5.

¹³³ ACT Health, *ACT Public Health Services Quarterly Performance Report* December 2015, <http://health.act.gov.au/sites/default/files//Quarterly%20Report%20September%202015%20Final.pdf>

4.11 The Health Directorate also supports an Aboriginal Liaison Officer who provides consultation and liaison services to mental health teams to assist in the delivery of services that are sensitive to the social and cultural beliefs, values and practices of Aboriginal and Torres Strait Islander people.¹³⁴

4.12 The Committee heard that the range of service offered by CAMHS is appropriate although resources are stretched and waiting lists are common.¹³⁵

4.13 In respect to how limited resources affect operational needs one submission noted:

It is generally noted that CAMHS is under resourced to meet the increasing demands and responses to young people with serious mental health issues. It is often difficult to acquire a CAMHS immediate response or to access facilities in the face of a crisis. Lack of resourcing can lead to tension between mental health workers who are over stretched and cannot provide a response and those seeking guidance.¹³⁶

HOSPITAL BASED SERVICES

4.14 Both of Canberra's public hospitals have specialised mental health facilities. The Adult Mental Health Unit at the Canberra Hospital has 35 beds, and ward 2n at Calvary Hospital is a 20 bed unit that provides acute and sub-acute care services for people with a mental illness. Calvary also has the Older Persons Mental Health Inpatient Unit which has 20 beds. There is no specific hospital facility for young people with mental health needs.

4.15 The NMHC review identified the number of mental health-related emergency department occasions in public hospitals during 2011–12 across Australia per capita according to jurisdiction.¹³⁷ See Figure D for ACT figures.

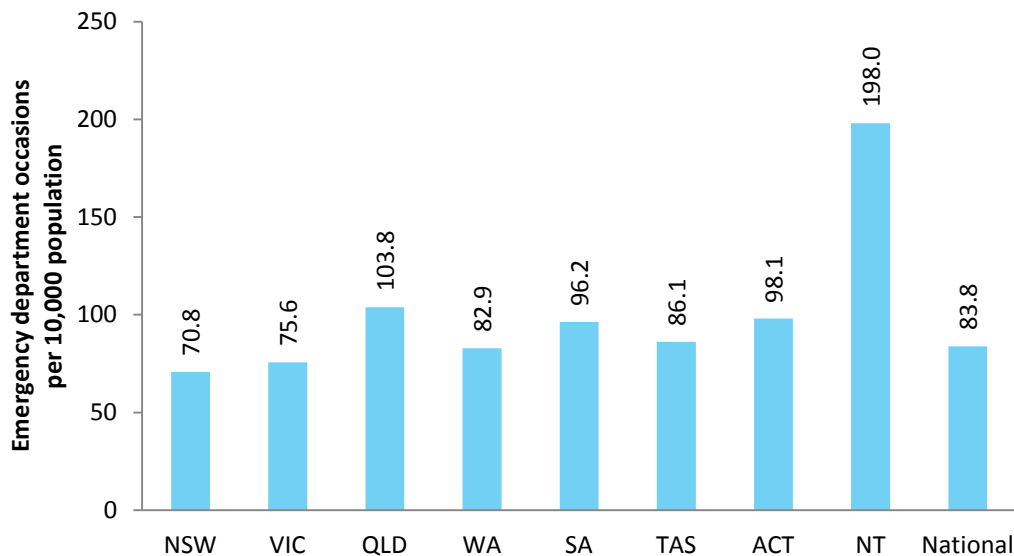
¹³⁴ ACT Government, ACT Health, *Specialist Services*, <http://health.act.gov.au/our-services/mental-health/specialty-services> (accessed on 10 May 2016).

¹³⁵ Submission 6, Institute for Professional Standards and Safeguarding, Archdiocese of Canberra and Goulbourn, p. 4.

¹³⁶ Submission 6, Institute for Professional Standards and Safeguarding, Archdiocese of Canberra and Goulbourn, p. 3.

¹³⁷ National Mental Health Commission, *Contributing lives, thriving communities –Report of the National Review of Mental Health Programmes and Services, Volume 4, Paper 3*, November 2014, p. 4.

FIGURE D - MENTAL HEALTH-RELATED EMERGENCY DEPARTMENT OCCASIONS PER STATE IN 2011-2012



- 4.16 In raw numbers, Australian Institute of Health and Welfare data shows that in 2013-14 the ACT had 1,367 admitted patient mental health-related separations in a public hospital. This equates to 3.6 separations per 1,000 population, which is slightly lower than the national average of 4.1. Total patient days came to 24,491, with psychiatric care days representing 22,972 of those days. This means that there were a total of 1,519 days where patients were admitted but did not receive psychiatric care. The average length of stay in hospital was 17.9 days. This is slightly higher than the national average which is 16.3 days.¹³⁸ This represents total admissions, and is not limited to young people.
- 4.17 The Health Directorate explained to the Committee what process should be followed when a young person presents to an emergency room with a mental illness.

Firstly, any physical issues are addressed, and that takes priority before anything else. At the point of triage the mental health service is notified of a person who has come in and might have self-harmed. A mental health nurse will do an assessment in the emergency department and provide advice to the psychiatrists and then a decision will be taken at that point. 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.

¹³⁸ Australian Institute of Health and Welfare, *Mental health services in Australia, Admitted patient mental health related care*, (Table AD.3), <https://mhsa.aihw.gov.au/services/admitted-patient/>

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. We very actively include the crisis team in that case and we actively include our community-based mental health teams or CAMHS.¹³⁹

4.18 The Committee also heard that a new assessment area and short-stay unit within the emergency department at Canberra Hospital has opened to provide a more therapeutic environment both for the mental health 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.¹⁴⁰

4.19 The Committee enquired into what supports are provided to young people if they are not admitted. A Health Directorate official stated:

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.¹⁴¹

4.20 beyondblue highlighted how important post admission support can be.

A previous suicide attempt is the most significant risk factor for suicide. The first few months post-attempt is a particularly high risk period. Given the strong association between suicide attempts and subsequent suicide, it is important to ensure that people who have attempted suicide receive evidence-based care and appropriate follow-up during the post-attempt period.

¹³⁹ Summarised extract, Ms Katrina Bracher, *Transcript of Evidence*, 24 March 2016, p. 48.

¹⁴⁰ Mr Ian Thompson, *Transcript of Evidence*, 24 March 2016, p. 49.

¹⁴¹ Ms Katrina Bracher, *Transcript of Evidence*, 24 March 2016, p. 49.

At present, many young people who present to health care providers following self-harm or suicide attempt receive poor care and report being treated in a stigmatising way. In addition, follow-up may be absent, poorly communicated, poorly coordinated or poorly timed. As a result, many young people either do not attend appointments or attend only briefly and are lost to follow-up. Increasing the use of safety planning and improving emergency department care and after care therefore needs to be prioritised.¹⁴²

- 4.21 Health officials informed the Committee that there is a distinction between the two emergency departments (The Canberra Hospital and Calvary Hospital). If somebody needs involuntary care they are transferred to the Canberra Hospital. Calvary do admit directly from their emergency department into ward 2n.¹⁴³
- 4.22 The Committee notes that Youth Coalition had a different perspective on how hospitals respond to the mental health needs of young people.

When you go to a hospital ... 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.¹⁴⁴

- 4.23 The Committee notes that hospitals play an important role in responding to acute self harm incidents. It is important that adequate resources are in place to enable quality responses at Emergency Departments and community follow up.

COMMUNITY BASED SERVICES

- 4.24 The ACT Government supports a significant number of community based services that work directly with young people and their families at different stages of life and crisis.¹⁴⁵ In response to a question taken on notice at the hearing, the ACT Government submitted that 14 community based organisations are funded to provide a range of mental health services to young people. Approximately \$5,539,900 was contracted to provide these services.¹⁴⁶
- 4.25 The Committee notes that the services identified by the ACT government range from specialised mental health and suicide prevention services such as Youth in ACTION for Suicide

¹⁴² Submission 12, beyondblue, p. 12.

¹⁴³ Ms Katrina Bracher, *Transcript of Evidence*, 24 March 2016, p. 51.

¹⁴⁴ Ms Sophie Hope, *Transcript of Evidence*, 24 March 2016, p. 19.

¹⁴⁵ Submission 19, ACT Government.

¹⁴⁶ ACT Government, Response to question taken on notice no. 1. Available at http://www.parliament.act.gov.au/in-committees/standing_committees/Health,-Ageing,-Community-and-Social-Services/inquiry-into-youth-suicide-and-self-harm-in-the-act/responses-to-questions?inquiry=822269.

Prevention and beyondblue to more general services such as the Brindabella Women's group which is a self help support group.¹⁴⁷ A number of services are designed to work with families, or strengthen parenting skills as an early intervention measure. The range of funding received by organisations varied significantly.

- 4.26 The Committee notes the operation of the Step Up Step Down Service which offers accommodation, 24-hour support staff and an alternative to hospitalisation for up to three months for young people aged 12-18 years who have, or are experiencing mental distress.¹⁴⁸ The program is funded by the ACT Government Health Directorate and is delivered in partnership with CAMHS and CatholicCare Canberra & Goulburn and is a rare example of a service targeted at youth with mental health concerns and provides accommodation.

SCHOOL BASED SERVICES

- 4.27 The ACT and Australian Government contribute to mental health services provided in schools through the provision of social workers, psychologists and other allied health services. The community sector also work with individual schools and offer a wide range of services that ranges from counselling or mentoring to a group presentation for particular cohorts within schools.
- 4.28 The Inquiry heard different views in relation to the role of teachers and the mental health of students. A number of submissions identified teachers as the first contact point for identifying mental health issues and suggested that they be provided with training to assist them engage with young people and their mental health needs.
- 4.29 The AEU submission states:

School based programs are important in the area of early intervention and prevention. Schools are uniquely positioned due to their access to large groups of students and are well placed to provide early intervention and prevention services in relation to suicide and self-harm.¹⁴⁹

- 4.30 Other submissions suggested that teachers are already overwhelmed and that additional allied health service such as counselling need to be resourced so that students can access help at school. Youth coalition stated:

¹⁴⁷ This table is available on the Committee website at:

http://www.parliament.act.gov.au/_data/assets/pdf_file/0006/856428/01.-Health-QTON-services-available.pdf

¹⁴⁸ Carers ACT, *Navigating the Acute Mental Health System in Canberra, A Guide for Families and Carers*, September 2014, http://www.mentalhealthcarers.org.au/wp-content/uploads/2015/02/CMH_Book_WEB.pdf (accessed on 5 May 2016).

¹⁴⁹ Submission 9, Australian Education Union, p. 2.

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.¹⁵⁰

4.31 The Committee heard that Menslink conduct a significant amount of work in schools through a number of programs including the silence is deadly campaign, which 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 approximately 7,000 secondary school students across the region are engaged.¹⁵¹

4.32 Menslink also manage a counselling service that provides face-to-face therapeutic support from professional qualified counsellors to over 200 young men each year from eight high schools and colleges. Around five per cent of Menslink counselling clients present with suicidal thoughts and/or behaviours.¹⁵²

4.33 The Menslink service is run through schools but is independent of internal school supports for a number of reasons.

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.

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.¹⁵³

4.34 The Committee acknowledges the submission from the National Institute for Mental Health Research which states:

Australia lags behind the US and Europe in implementing evidence-based suicide prevention programs in schools.

¹⁵⁰ Ms Rebecca Cuzzillo, *Transcript of Evidence*, 24 March 2016, p. 22.

¹⁵¹ Mr Martin Fisk, *Transcript of Evidence*, 24 March 2016, p. 26.

¹⁵² Mr Martin Fisk, *Transcript of Evidence*, 24 March 2016, p. 26.

¹⁵³ Mr Martin Fisk, *Transcript of Evidence*, 24 March 2016, p. 34.

To our knowledge, there are currently no evidence-based suicide prevention programs being systematically offered by education departments in Australia.¹⁵⁴

- 4.35 The lack of coordinated planning is also reflected in the AEU submission which provides that 'most ACT Government schools do not have a 'suicide response plan''.¹⁵⁵

RESEARCH

- 4.36 The Committee heard that the ACT Government has funded research to be undertaken for specific information on suicide trends in the ACT. A Health Directorate official confirmed this to the Committee.

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 Gungan, 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.¹⁵⁶

- 4.37 The Committee notes that the NIMHR at the ANU is separately testing a suicide prevention program in ACT and NSW high schools. The program uses a peer leader program to build connections between teens and trusted adults to improve help-seeking for suicide and general psychological distress.¹⁵⁷

- 4.38 As outlined earlier in the Report, further research is important and will ensure best practice service provision for young people. The ACT Government acknowledged this:

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.

¹⁵⁴ Submission 1, National Institute for Mental Health Research, p. 2.

¹⁵⁵ Submission 9, Australian Education Union, p. 4.

¹⁵⁶ Ms Katrina Bracher, *Transcript of evidence*, 24 March 2016, p. 46.

¹⁵⁷ Submission 1, National Institute for Mental Health Research, p. 2.

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.¹⁵⁸

AUSTRALIAN GOVERNMENT FUNDED SERVICES

- 4.39 The Committee notes that in total it is estimated that the Australian Government spent over \$8 billion, or \$344 per person on mental health-related services in Australia during 2013–14.¹⁵⁹ Of this, \$4.9 billion was spent on state and territory specialised mental health services. Of this, most was spent on public hospital services for admitted patients (\$2.1 billion), followed by community mental health care services (\$1.9 billion).¹⁶⁰
- 4.40 It is very difficult to ascertain the amount of funding provided from the Australian Government to the ACT Government for mental health services. Funds are distributed through generalised line items for hospital services and PHNs. No breakdown of these items is provided in the Budget. The sole ACT specific budget line provides that in the 2017-18 Budget the Australian Government has allocated \$600,000 for mental health reforms.

HEADSPACE

- 4.41 headspace is a service operated by the National Youth Mental Health Foundation and provides early intervention mental health services to 12-25 year olds. The service receives Australian Government funding under the Youth Mental Health Initiative.
- 4.42 In October 2014 headspace Canberra had approximately 70 young people waiting to see a practitioner (psychologist / social worker). These young people had been assessed as suitable for headspace's service, and most were offered an equivalent external service [with a private provider]. However, due to cost, accessibility and availability many have no option but to wait up to 6 to 8 weeks for an appointment.¹⁶¹
- 4.43 The Youth Coalition told the Committee that they know of one young person who committed suicide whilst waiting for his appointment with headspace.

¹⁵⁸ Mr Simon Corbell MLA, *Transcript of Evidence*, 24 March 2016, p. 38.

¹⁵⁹ Australian Institute of Health and Welfare 2015. Health expenditure Australia 2013–14. Health and welfare expenditure series no. 54. Cat. no. HWE 63. Canberra: AIHW.

¹⁶⁰ Australian Institute of Health and Welfare 2015. Health expenditure Australia 2013–14. Health and welfare expenditure series no. 54. Cat. no. HWE 63. Canberra: AIHW.

¹⁶¹ Submission to the *ACT Mental Health and Wellbeing Framework 2015 2025* Youth Coalition of the ACT, February 2015, available at: https://members.youthcoalition.net/sites/default/files/articles-internal/Youth_Coalition_Submission_Mental_Health_Framework.pdf

...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.¹⁶²

- 4.44 This is a significant concern as the Committee also heard that at risk young people are being referred to headspace as there is no alternative available. For example, A Gender Agenda confirmed 'we refer a lot of our young people to headspace'.¹⁶³
- 4.45 The Committee notes that there are a number of specialised programs funded directly by the Australian Government that may benefit young people with mental health needs. This includes the Personal Helpers and Mentors Program that supports people aged 16 years and over whose ability to manage daily activities, and to live independently in the community, is seriously impacted as a result of mental illness.¹⁶⁴ Further, the Family Mental Health Support Service operated by Marymead provides early intervention support to assist vulnerable families with children and young people who are at risk of, or affected by, mental illness.¹⁶⁵
- 4.46 The Committee also notes that the Australian Government fund a suite of services targeted at young people, such as the Early Psychosis Prevention and Intervention Centres, which do not operate in the ACT.¹⁶⁶

MEDICARE AND PHARMACEUTICAL BENEFIT SCHEME SERVICES

- 4.47 The Committee acknowledges that a significant proportion of Australian Government funding supports the Better Access initiative which subsidises the cost of accessing psychiatrists, clinical psychologists, registered psychologists and appropriately trained social workers and occupational therapists through Medicare. This has improved access for many to specialised mental health services. No evidence was provided to the Committee providing details regarding the rate of young people accessing this subsidy in the ACT.

¹⁶² Ms Sophie Hope, *Transcript of Evidence*, 24 March 2016, p. 19.

¹⁶³ Ms Mirja (Majka) McLean-Engstrom, *Transcript of Evidence*, 14 April 2016, p. 76.

¹⁶⁴ The Committee notes this program is currently transitioning to the NDIS. <https://www.dss.gov.au/our-responsibilities/mental-health/programs-services/personal-helpers-and-mentors-phams>

¹⁶⁵ Australian Government, Department of Social Services, *Family Mental Health Support Services*, <https://www.dss.gov.au/our-responsibilities/mental-health/programmes-services/family-mental-health-support-service-fmhss> (accessed on 5 May 2016).

¹⁶⁶ Orygen National Centre of Excellence in Youth Mental Health, <https://orygen.org.au/About/Our-Partners> (accessed 7 June 2016).

- 4.48 The Committee notes that in total the Australian Government spent close to \$971 million in 2013–14, expenditure on psychologist services (\$412 million) and this made up the largest component of spending.¹⁶⁷
- 4.49 Additionally, the Australian Government spent \$753 million, or \$32 per person, on subsidised prescriptions during 2013–14. Prescriptions for antipsychotics and antidepressants accounted for the majority of mental health-related expenditure during this time period.¹⁶⁸ The Committee acknowledges this significant cost contribution. The Committee cannot comment on the application of this for young people in the ACT due to limited data being available.

PRIVATELY PROVIDED SERVICES IN THE ACT

- 4.50 A number of private counsellors, psychologists and psychiatrists operate in the ACT. The Committee notes submissions that highlight these services often have a long waitlist and are prohibitive to some young people due to the cost of access.¹⁶⁹
- 4.51 The Committee is concerned that despite the Better Services Initiative Medicare subsidy, a gap still commonly exists for most private services in the ACT.
- 4.52 The ACT has one private residential health facility. Hyson Green is a 20 bed private mental health facility that offers a diverse range of inpatient, day patient and specific day/evening programs.¹⁷⁰

ONLINE SERVICES

- 4.53 The Committee heard that a significant number of young people start seeking help and information online,¹⁷¹ and that increasing the availability for high quality online therapies at no cost for young people could be an early intervention strategy.¹⁷²
- 4.54 The Committee notes that headspace operates an online service, and acknowledges that this service is also facing resource limitations. Youth Coalition state:

¹⁶⁷ Australian Institute of Health and Welfare 2015. Health expenditure Australia 2013–14. Health and welfare expenditure series no. 54. Cat. no. HWE 63. Canberra: AIHW.

¹⁶⁸ Australian Institute of Health and Welfare 2015. Health expenditure Australia 2013–14. Health and welfare expenditure series no. 54. Cat. no. HWE 63. Canberra: AIHW.

¹⁶⁹ Submission 14, Youth Coalition of the ACT, pp. 17-19 and Submission 7, Loretta Wholley, p. 5.

¹⁷⁰ Calvary Bruce Private Hospital, *Hyson Green*, <http://www.calvaryactprivate.org.au/hyson-green.html> (accessed on 5 May 2016).

¹⁷¹ Ms Emma Robertson, *Transcript of Evidence*, 24 March 2016, p. 24.

¹⁷² Submission 18, Carers ACT, p. 7.

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.¹⁷³

4.55 beyondblue has also developed an app for young people:

The app enables people to create a digital safety plan in collaboration with a health care provider or on their own. The Safety Plan consists of concrete strategies that young people (and adults) can use to decrease their risk of acting on suicidal thoughts and harming themselves. It can be shared with friends, family, health professionals and other supporters. It is designed to be available day and night via the user's smartphone so that young people can follow their safety strategies in a crisis wherever or whenever it occurs.¹⁷⁴

4.56 The Committee is aware of a number of other online supports available to young people including Bite Back, itsallright, MoodGYM, ReachOut.com, Somazone, Kids Helpline and WhatWorks4u but did not hear any evidence in relation to their service provision in regards to accessibility.¹⁷⁵

4.57 The Committee also notes the recent 2016-17 Budget announcement by the Australian Government to provide \$800,000 for an online program that works to prevent perinatal depression.

¹⁷³ Ms Sophie Hope, *Transcript of Evidence*, 24 March 2016, p. 24.

¹⁷⁴ Submission 12, beyondblue, pp. 12-13.

¹⁷⁵ Links to all these websites are available at Helpful contacts and websites, online support:
<https://www.beyondblue.org.au/who-does-it-affect/young-people/helpful-contacts-and-websites>

5 FUTURE CONSIDERATIONS

- 5.1 Throughout the Inquiry the Committee heard a significant amount of evidence in relation to the practical operation of existing services. In the hearings the Committee also asked service providers and peak bodies what change they would like to see in relation to the mental health and suicide prevention activities in the ACT. This section of the report will review the contributions made in response to the Committee.
- 5.2 This chapter will focus on the key messages heard from the sector relating to the themes of early intervention, education and access to services.

EARLY INTERVENTION

- 5.3 Submitters and witnesses advocated for early intervention as a key strategy to prevent and reduce youth suicide and self-harm. Evidence supported a focus on early intervention services in two key areas: (1) targeted support and treatment for young people with a mental illness and (2) general services and support for children and young people to raise awareness of mental illness, suicide and self harm, and to build resilience.
- 5.4 Youth Coalition stated simply ‘we urge the committee to consider early intervention and prevention’.¹⁷⁶ The Committee notes that stakeholders across the spectrum including service providers, peak bodies and the ACT Government acknowledged this as an essential element of an effective package to reduce youth self harm and suicide in the ACT.
- 5.5 The AEU discussed this issue in the context of targeted early intervention and more general prevention programs:

Early intervention is targeted towards identifying and treating risk factors and can be used to identify symptoms of emotional or behavioural disturbances that may lead to or be associated with mental illnesses in children or adolescents. Prevention programs can include coping skills training, suicide awareness, small groups on managing strong emotions, friendship building skills, mindfulness, anger management and building resilience.¹⁷⁷

¹⁷⁶ Ms Emma Robertson, *Transcript of Evidence*, 24 March 2016, p. 18.

¹⁷⁷ Submission 9, Australian Education Union, p. 2.

5.6 Menslink strongly support the development of early intervention measures stating:

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.¹⁷⁸

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.¹⁷⁹

5.7 The Committee heard from the Minister for Health, the Minister for Aboriginal and Torres Strait Islander Affairs and Minister for Children and Young People in regard to what actions are being undertaken now in relation to early intervention. The Minister for Health stated:

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 Gudan 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.¹⁸⁰

¹⁷⁸ Mr Martin Fisk, *Transcript of Evidence*, 24 March 2016, p. 29.

¹⁷⁹ Mr Martin Fisk, *Transcript of Evidence*, 24 March 2016, p. 32.

¹⁸⁰ Mr Simon Corbell MLA, *Transcript of Evidence*, 24 March 2016, pp. 37-38.

5.8 Officials from CSD advised the Committee:

...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.¹⁸¹

5.9 The Minister for Aboriginal and Torres Strait Islander Affairs informed the Committee that:

Here in the ACT the Gugan Gulwan Youth Aboriginal Cooperation has released a DVD titled “It’s okay to talk about it,” a suicide prevention video or DVD featuring personal stories from the Aboriginal and Torres Strait Islander community. The video is an early tool that brings awareness to the growing mental health issues facing young people and will assist in suicide prevention.¹⁸²

5.10 An area raised by many submissions was the role of early intervention within school environments.

SCHOOLS

5.11 A number of strategies for the development of early intervention activities in schools were raised. Submissions considered better mental health training for teachers, additional specific mental health resources and greater ties between schools and the community sector as areas for development.

5.12 Youth Coalition told the Committee:

I do not think there is anywhere near enough done in schools... 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.¹⁸³

...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.¹⁸⁴

¹⁸¹ Ms Maureen Sheehan, *Transcript of Evidence*, 24 March 2016, p. 14.

¹⁸² Dr Chris Bourke MLA, *Transcript of Evidence*, 14 April 2016, p. 59.

¹⁸³ Ms Sophie Hope, *Transcript of Evidence*, 24 March 2016, p. 22.

¹⁸⁴ Ms Emma Robertson, *Transcript of Evidence*, 24 March 2016, p. 17.

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.¹⁸⁵

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.¹⁸⁶

5.13 This sentiment was echoed by the NIRMH:

Although parents and teachers should not be expected to provide psychological support, they are fundamental in referring young people to appropriate professional care...Gatekeeper training programs are designed to improve the recognition and referral of people at high risk of suicide. Such programs have been found to improve knowledge, skills and attitudes in a range of settings.¹⁸⁷

5.14 In relation to existing mental health resources in schools the AEU notes that, currently, the workload and under-resourced school psychologists' service too often limits school psychologists from playing an fully effective role in early intervention and prevention strategies for self-harm and suicide risks in children and adolescents.¹⁸⁸ This sentiment was shared by a school principal who stated that ‘the number of School Psychologists in ACT Government Schools be increased to meet the ratio of 1:500’.¹⁸⁹

5.15 In relation to the link between schools and existing community services, the Minister for Health highlighted the potential role schools could play:

...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.¹⁹⁰

¹⁸⁵ Ms Sophie Hope, *Transcript of Evidence*, 24 March 2016, p. 19.

¹⁸⁶ Ms Rebecca Cuzzillo, *Transcript of Evidence*, 24 March 2016, p. 21.

¹⁸⁷ Submission 1, National Institute for Mental Health Research, p. 2.

¹⁸⁸ Submission 9, Australian Education Union, p. 4.

¹⁸⁹ Submission 9, Australian Education Union, p. 6, Submission 7, Loretta Wholley, p. 4.

¹⁹⁰ Mr Martin Fisk, *Transcript of Evidence*, 24 March 2016, p. 45.

- 5.16 The Committee notes that beyondblue submitted that the ACT Government should encourage schools to adopt a whole of school mental health promotion framework.¹⁹¹ Early intervention and the role of schools could be a significant part of such a framework.
- 5.17 The Committee is aware of concerns about contagion but notes the evidence provided to the Inquiry about the importance of suicide and self harm being discussed in schools.¹⁹²

COMMUNITY AND PEER EDUCATION

- 5.18 The Committee heard from a number of submissions that further work is required in relation to general community awareness with a particular focus on providing peers, parents and service providers the tools required to appropriately engage with a young person when they disclose thoughts of self harm or suicide.
- 5.19 The Committee acknowledges the significant amount of submissions that suggested young people seek help from those they know initially. This places a significant amount of pressure on a peer, parent or role model if a young person discusses their concerns with them. That was highlighted by a number of submissions. Youth Coalition state:

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.¹⁹³

- 5.20 A school principal endorsed this sentiment stating ‘family/friends desperately need training to support their child’.¹⁹⁴
- 5.21 A Gender Agenda provided evidence about the volume of phone calls they receive from parents:

We keep a log. How many calls a week do we get? Four at a minimum a week. Those range from being from health professionals, teachers, occasionally young people, but it is usually their parents who call. Their parents are often very distressed. We can spend anywhere up to an hour on the phone with them, part of that time just being, “Take a deep breath and calm down. It’s going to be okay”.¹⁹⁵

¹⁹¹ Submission 12, beyondblue, pp. 16-17.

¹⁹² See for example, Submission 10, Name withheld, pp. 4-5, Submission 8, Suicide Programs, pp. 4-8.

¹⁹³ Ms Emma Robertson, *Transcript of Evidence*, 24 March 2016, p. 17.

¹⁹⁴ Submission 7, Loretta Wholley, p. 3

¹⁹⁵ Ms Mirja (Majka) McLean-Engstrom, *Transcript of Evidence*, 14 April 2016, p. 74.

- 5.22 beyondblue submitted that more needs to be done to help parents have a conversation when a young person approaches them for assistance.

A significant barrier for young people with a mental health condition and their families is a poor understanding of mental health conditions. Research suggests that around one third of parents (36.4 per cent) who have children with a mental health condition report that they did not seek help for their child because they were unsure if their child/adolescent needed help, they did not know where to get help, or they thought the problem would get better by itself. Public awareness and education initiatives delivered through website, media, social media and marketing channels coupled with school and workplace-based initiatives can be used to ensure maximum reach and exposure to relevant information.¹⁹⁶

- 5.23 In relation to service providers, beyondblue submitted that training gatekeepers in detecting and dealing with mental health conditions and suicide risk should be a priority for the ACT Government.

A gatekeeper is anyone who is in a position to identify whether someone may be contemplating suicide. It is important that gatekeepers, such as teachers and those working in youth services, have the right knowledge and skills to identify young people at-risk of suicide, and support them to access the care they need. Suicide prevention training of front line staff, including police, ambulance and other first responders, is also important. Training should aim to develop participants' knowledge, attitudes and skills for identifying individuals at risk, determining the level of risk, and then referring at-risk individuals for treatment.¹⁹⁷

- 5.24 The NIMHR submitted:

Gatekeeper training programs are designed to improve the recognition and referral of people at high risk of suicide. Such programs have been found to improve knowledge, skills and attitudes in a range of settings. However, implementation of such programs has not been conducted at a departmental level in Australia, and a lack of online programs limits the dissemination of gatekeeper programs for teachers and parents.¹⁹⁸

- 5.25 The submission from NIMHR addresses the concern that talking about suicide can inadvertently lead to the ideation of suicide for some.

¹⁹⁶ Submission 12, beyondblue, p 10.

¹⁹⁷ Submission 12, beyondblue, p 11.

¹⁹⁸ Submission 1, National Institute for Mental Health Research, p. 2.

Identifying students at risk of suicide or other mental health problems has previously been shown to be a low risk strategy, with no evidence to indicate that asking young people about suicide engenders suicidal thoughts... there is scope to develop screening tools that minimise sensitive questioning and take advantage of new methodologies currently being tested by NIMHR researchers to allow flexible, precise and rapid assessment. Screening programs in isolation may not be effective, but when combined with clear pathways for referral, they can lead to more direct linkages to care for at-risk students.¹⁹⁹

- 5.26 In relation to future work required the Minister for Health provided the following evidence:

I think the challenge is with broadening out and building the understanding around what the right response is... The message has to be for those around them [young people], 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.²⁰⁰

- 5.27 The beyondblue submission highlights that the ACT Government could promote existing resources that support young people and their families.

beyondblue has developed a suite of resources to help people have a conversation with someone they are concerned about – this includes information for people who are worried that someone may be thinking about suicide. beyondblue has also developed and disseminated information for people who have attempted suicide and their family/friends, including resources supporting Aboriginal and Torres Strait Islander communities.²⁰¹

- 5.28 The Committee also notes that NIMHR research indicates that stigma reduction and educational campaigns may increase professional help seeking for suicidal ideation.²⁰²

STIGMA

- 5.29 The Committee received evidence that highlighted stigma around suicide and self harm continues to affect young people and may prevent them from seeking help.²⁰³

¹⁹⁹ Submission 1, National Institute for Mental Health Research, p. 2.

²⁰⁰ Mr Simon Corbell MLA, *Transcript of Evidence*, 24 March 2016, p. 53.

²⁰¹ Submission 12, beyondblue, p 13.

²⁰² Submission 1, National Institute for Mental Health Research, p. 2.

²⁰³ See for example, Submission 4, Mind Blank, p. 2.

5.30 beyondblue submits that stigma is one of the most common barriers to seeking help and that stigma can:

- Discourage young people from disclosing suicidality or a mental health condition to others, due to concerns and fears that people will treat them differently, and their medical information will not remain confidential.
- Negatively impact on young people's willingness to seek help for mental health problems – 62.9 per cent of 13 – 17 year olds with depression, who did not seek help, reported that they were worried about what other people might think, or did not want to talk to a stranger.
- Negatively impact on recovery as people may develop discriminatory attitudes or lower expectations of young people with mental health conditions, which impacts on their participation at school and then at work.²⁰⁴

5.31 The Minister for Health stated "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."²⁰⁵

5.32 The Youth Coalition supported this view.

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.²⁰⁶

5.33 The Minister for Health also linked stigma and the role of education with early intervention activities.

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.²⁰⁷

5.34 An ACT Health official informed the Committee about activities undertaken to reduce the stigma associated with self harm and suicide.

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.

²⁰⁴ Submission 12, beyondblue, pp. 10 -11.

²⁰⁵ Mr Simon Corbell MLA, *Transcript of Evidence*, 24 March 2016, p. 54.

²⁰⁶ Ms Rebecca Cuzzillo, *Transcript of Evidence*, 24 March 2016, p 18.

²⁰⁷ Mr Simon Corbell MLA, *Transcript of Evidence*, 24 March 2016, p. 39.

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.²⁰⁸

5.35 The Minister for Multicultural and Youth Affairs informed the Committee that:

...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.²⁰⁹

5.36 A CSD official further provided:

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 [stigma] 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.²¹⁰

²⁰⁸ Mr Ross O'Donoghue, *Transcript of Evidence*, 24 March 2016, pp. 46 -47.

²⁰⁹ Ms Yvette Berry MLA, *Transcript of Evidence*, 24 March 2016, p. 1.

²¹⁰ Mr Nic Manikis, *Transcript of Evidence*, 24 March 2016, p. 5.

5.37 In relation to stigma and the need for community education, Youth Coalition stated:

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.²¹¹

5.38 Youth Coalition also highlighted that men particularly struggle with stigma:

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.²¹²

5.39 Menslink informed the Committee about their Silence is Deadly campaign:

...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 region²¹³ ...

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 stressors... 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.²¹⁴

²¹¹ Ms Sophie Hope *Transcript of Evidence*, 24 March 2016, p. 23.

²¹² Ms Sophie Hope, *Transcript of Evidence*, 24 March 2016, p. 21.

²¹³ Mr Martin Fisk, *Transcript of Evidence*, 24 March 2016, p. 26.

²¹⁴ Mr Martin Fisk, *Transcript of Evidence*, 24 March 2016, pp. 30-31.

HELP SEEKING BEHAVIOUR

- 5.40 Related to the discussion about stigma, the Committee heard evidence about the need for young people to be encouraged and supported to adopt 'help seeking behaviours'. It was suggested that reducing stigma would assist break down negative stereotypes of people with mental health issues and encourage young people to seek assistance as soon as possible.
- 5.41 Young people report a number of barriers to seeking help including:
- uncertainty about where to go for help;
 - feelings of shame or embarrassment;
 - perception that they should be able to deal with challenges themselves;
 - prior negative experiences of poor treatment from health professionals or other support services; and
 - long waiting times to access services.
- 5.42 These barriers often result in young people making a decision to delay seeking help or avoiding it all together.
- 5.43 Youth Coalition highlighted that education and reducing stigma are two important components to facilitate help seeking behaviour:
- Mental health education in schools, including information about supporting others with mental health issues, is a key way to reduce stigma, promote help seeking behaviour and improve knowledge, understanding and ability to respond to mental health concerns. However, young people tell us there is little to no mental health education in primary school and when it is introduced in high school, it can often be limited and not well integrated.²¹⁵

ACCESS TO SERVICES

- 5.44 Another key theme that emerged from the evidence was the significant amount of pressure on existing services to provide adequate service to an increasing number of at-risk young people. Gaps in service, information sharing and long waiting times for ACT Government, Australian Government and non government services dominated discussion in this respect.

²¹⁵ Submission 14, Youth Coalition of the ACT, p. 38.

FUNDING

- 5.45 Service providers across the spectrum identified a shortage of funding as an area of concern. The Institute for Professional Standards and Safeguarding, Archdiocese of Canberra and Goulburn stated:

While it is generally felt that those people who respond to youth suicide and self harm in the ACT, do so with a great deal of professionalism and integrity, there are areas for improvement. Namely, additional resourcing is needed to meet the growing response to young people in need of these services.²¹⁶

- 5.46 Menslink identified that there is a need for more counsellors for their programs:

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.²¹⁷

- 5.47 A school principal provided her view on current resourcing:

...more funding [is] needed to assist CAHMS, Cottage, STEPS – access is ad hoc, counsellors and social workers are constantly changing, they are underfunded and staff are stretched. We don't always have the best relationship here, but I know that they are doing the best they can, just as we are.²¹⁸

- 5.48 beyondblue stated that the ACT Government should endeavour to coordinate investment and improve the efficiency and effectiveness of programs and services through leveraging investment between Commonwealth and ACT sources.²¹⁹

- 5.49 The impact upon young people seeking assistance and their families was discussed in relation to waiting times and the effect this may have on young people seeking assistance.

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

²¹⁶ Submission 6, Institute for Professional Standards and Safeguarding, Archdiocese of Canberra and Goulburn, p. 4.

²¹⁷ Mr Martin Fisk, *Transcript of Evidence*, 24 March 2016, p. 34.

²¹⁸ Submission 7, Loretta Wholley, p. 4.

²¹⁹ Submission 12, beyondblue, pp. 16-17.

some services in the ACT. So there is a need to respond quickly when young people seek help.²²⁰

5.50 The impact of waiting times in Canberra were also discussed:

Waiting lists to private and public mental health care (counsellors and child psychologists) are too long and expensive. We have families travelling up to Sydney to access care this causes great concern and pressure on the family.²²¹

GAPS AND LIMITATIONS OF SERVICE PROVISION IN THE ACT

5.51 The Committee heard that despite long wait lists, a residential mental health facility was identified as the largest gap in service. One submission stated:

Hospital services in the ACT are appalling for young people, the government must allocate funds to establish a targeted Mental Health Facility in a Hospital for young people with high needs.²²²

5.52 Youth Coalition also spoke to a lack of mid-range services available:

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... 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.²²³

5.53 Menslink also reflected on this need:

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.²²⁴

5.54 System co-ordination was identified as an internal area that had a significant effect upon service provision. This was expressed in one submission:

We believe we are doing all we can with the services offered to us. However, we are constantly frustrated by the gaps and duplicate roles of agencies.²²⁵

²²⁰ Ms Rebecca Cuzzillo, *Transcript of Evidence*, 24 March 2016, p. 18.

²²¹ Submission 7, Loretta Wholley, p. 3.

²²² Submission 7, Loretta Wholley, p. 3.

²²³ Ms Sophie Hope, *Transcript of Evidence*, 24 March 2016, p. 19.

²²⁴ Mr Martin Fisk, *Transcript of Evidence*, 24 March 2016, p. 26.

²²⁵ Submission 7, Loretta Wholley, pp. 2-3.

5.55 The submission went on to say

Our current services are no longer serving our youth or communities well. There is fragmentation and an uncoordinated response, which is leading to serious consequences.²²⁶

5.56 Planning and service co-ordination was raised as a matter for the Committee to consider:

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.²²⁷

5.57 This was also identified by beyondblue who state that the ACT Government should:

Develop partnerships between educational, youth agencies, primary care and specialist mental health services so that young people, and their families, who require higher levels of assistance than a school can offer are able to access these supports and services quickly and easily.²²⁸

5.58 Data sharing was identified as an area for improvement in a number of submissions.

We need a commitment to share data and information: the delivery of integrated services will only be achieved if local public services agree to allow access to and share data about service users, recognising the need to meet their legal obligations, whilst developing a more systematic and timely approach to the use of data between partners.²²⁹

5.59 Submissions referenced that legislation would need to be amended in order to facilitate increased information sharing.

The individual's right to privacy must be balanced against the needs and interests of children and young persons, and of their families, in receiving services relating to acts of self-harm or suicide. The protection and safety of the young person must take precedence.

²²⁶ Submission 7, Loretta Wholley, p. 3.

²²⁷ Ms Emma Robertson, *Transcript of Evidence*, 24 March 2016, p. 25.

²²⁸ Submission 12, beyondblue, p. 16.

²²⁹ Submission 7, Loretta Wholley, p. 4.

In the ACT, for this to occur, changes to current legislation will need to occur. It is suggested that the procedure implemented by NSW legislation in the use of Chapter 16A is a prototype already in existence with proven results.²³⁰

COMMITTEE COMMENT

- 5.60 The Committee notes that there a number of groups within our community that could benefit from additional information and support. Peers, family groups and service providers can all struggle to know how to respond when a young person comes to them seeking assistance. The ACT Government should undertake to support them as much as possible through the utilisation of existing resources.
- 5.61 The Committee notes that stigma continues to surround the topic of self harm and suicide generally and that this is particularly so in relation to young people. It is a confronting topic and one that is not easily discussed by young people, or the community as a whole.
- 5.62 The Committee believes that there are three primary areas for further development. Early intervention, education and access to service all require additional examination once funding and research outcomes are finalised.

Recommendation 3

- 5.63 The Committee recommends that the ACT Legislative Assembly consider re-examining this matter when funding and research outcomes are made public in order to determine the most appropriate way to further develop early intervention measures, education approaches and access to service for suicide prevention activities in the ACT.**

²³⁰ Submission 6, Institute for Professional Standards and Safeguarding, Archdiocese of Canberra and Goulburn, p. 4.

6 CONCLUSION

- 6.1 The Committee would like to thank all the organisations and individuals that contributed to the Inquiry. Your stories were heard and it was a privilege to hear from family members able to speak about their personal experience in order to make positive change for other families and young people struggling.
- 6.2 The Committee notes the significant amount of information provided by service providers and peak bodies, including research organisations.
- 6.3 The Committee notes the uncertainty for community organisations who are waiting to understand how the introduction of PHNs will affect their operation and potentially scope of service.
- 6.4 The Committee also notes that waiting times are a direct result of there being greater demand than there are resources available to service providers.
- 6.5 The Committee notes that as the NDIS continues to roll out, there may be changes to the way that some mental health services are provided. This is important to consider when assessing gaps and duplication and will be a matter to consider when funding arrangements are announced.
- 6.6 The Committee looks forward to learning what agreements are made in relation to funding, the findings of current research being undertaken and how the new ACT policy framework will be applied once presented to the Legislative Assembly.
- 6.7 The Committee believes that a specific youth focus is required when thinking about mental health supports in the ACT and reform. Being an adolescent can be a struggle for many due to the changes in their physical development; being a young person in the world of social media and changing family dynamics is even more difficult. Families need access to tools and support to enable them to best support young people through what can be a challenging time in life.
- 6.8 The Committee notes the NMHC finding that suicide is the result of a complex interaction of variables which may or may not include mental illness. Suicide prevention is not the same thing as prevention and treatment of mental illness. The Committee encourages the ACT Government to consider the development of suicide focused responses in addition to general mental health services.

Ms Joy Burch

Chair

2 June 2016

Appendix A NMHC Review Strategic Directions and Recommendations

The nine strategic directions and associated recommendations are as follows:

1. Set clear roles and accountabilities to shape a person-centered mental health system

Recommendations:

1. Agree the Commonwealth's role in mental health is through national leadership and regional integration, including integrated primary and mental health care.
2. Develop, agree and implement a National Mental Health and Suicide Prevention Plan with states and territories, in collaboration with people with lived experience, their families and support people.
3. Urgently clarify the eligibility criteria for access to the National Disability Insurance Scheme (NDIS) for people with disability arising from mental illness and ensure the provision of current funding into the NDIS allows for a significant Tier 2 system of community supports.

2. Agree and implement national targets and local organisational performance measures

Recommendations:

4. Adopt a small number of important, ambitious and achievable national targets to guide policy decisions and directions in mental health and suicide prevention.
5. Make Aboriginal and Torres Strait Islander mental health a national priority and agree an additional COAG Closing the Gap target specifically for mental health.
6. Tie receipt of ongoing Commonwealth funding for government, NGO and privately provided services to demonstrated performance, and use of a single care plan and eHealth record for those with complex needs.

3. Shift funding priorities from hospitals and income support to community and primary health care services

Recommendations:

7. Reallocate a minimum of \$1 billion in Commonwealth acute hospital funding in the forward estimates over the five years from 2017–18 into more community-based psychosocial, primary and community mental health services.
8. Extend the scope of Primary Health Networks (renamed Primary and Mental Health Networks) as the key regional architecture for equitable planning and purchasing of mental health programmes, services and integrated care pathways.
9. Bundle-up programmes and boost the role and capacity of NGOs and other service providers to provide more comprehensive, integrated and higher-level mental health services and support for people, their families and supporters.
10. Improve service equity for rural and remote communities through place-based models of care.

4. Empower and support self-care and implement a new model of stepped care across Australia

Recommendations:

11. Promote easy access to self-help options to help people, their families and communities to support themselves and each other, and improve ease of navigation for stepping through the mental health system.
12. Strengthen the central role of GPs in mental health care through incentives for use of evidence-based practice guidelines, changes to the Medicare Benefits Schedule and staged implementation of Medical Homes for Mental Health.
13. Enhance access to the Better Access programme for those who need it most through changed eligibility and payment arrangements and a more equitable geographical distribution of psychological services.
14. Introduce incentives to include pharmacists as key members of the mental health care team.

5. Promote the wellbeing and mental health of the Australian community, beginning with a healthy start to life

Recommendations:

15. Build resilience and targeted interventions for families with children, both collectively and with those with emerging behavioural issues, distress and mental health difficulties.
16. Identify, develop and implement a national framework to support families and communities in the prevention of trauma from maltreatment during infancy and early childhood, and to support those impacted by childhood trauma.
17. Use evidence, evaluation and incentives to reduce stigma, build capacity and respond to the diversity of needs of different population groups.

6. Expand dedicated mental health and social and emotional wellbeing teams for Aboriginal and Torres Strait Islander people

Recommendations:

18. Establish mental health and social and emotional wellbeing teams in Indigenous Primary Health Care Organisations (including Aboriginal Community Controlled Health Services), linked to Aboriginal and Torres Strait Islander specialist mental health services.

7. Reduce suicides and suicide attempts by 50 per cent over the next decade

Recommendation:

19. Establish 12 regions across Australia as the first wave for nationwide introduction of sustainable, comprehensive, whole-of-community approaches to suicide prevention.

8. Build workforce and research capacity to support systems change

Recommendations:

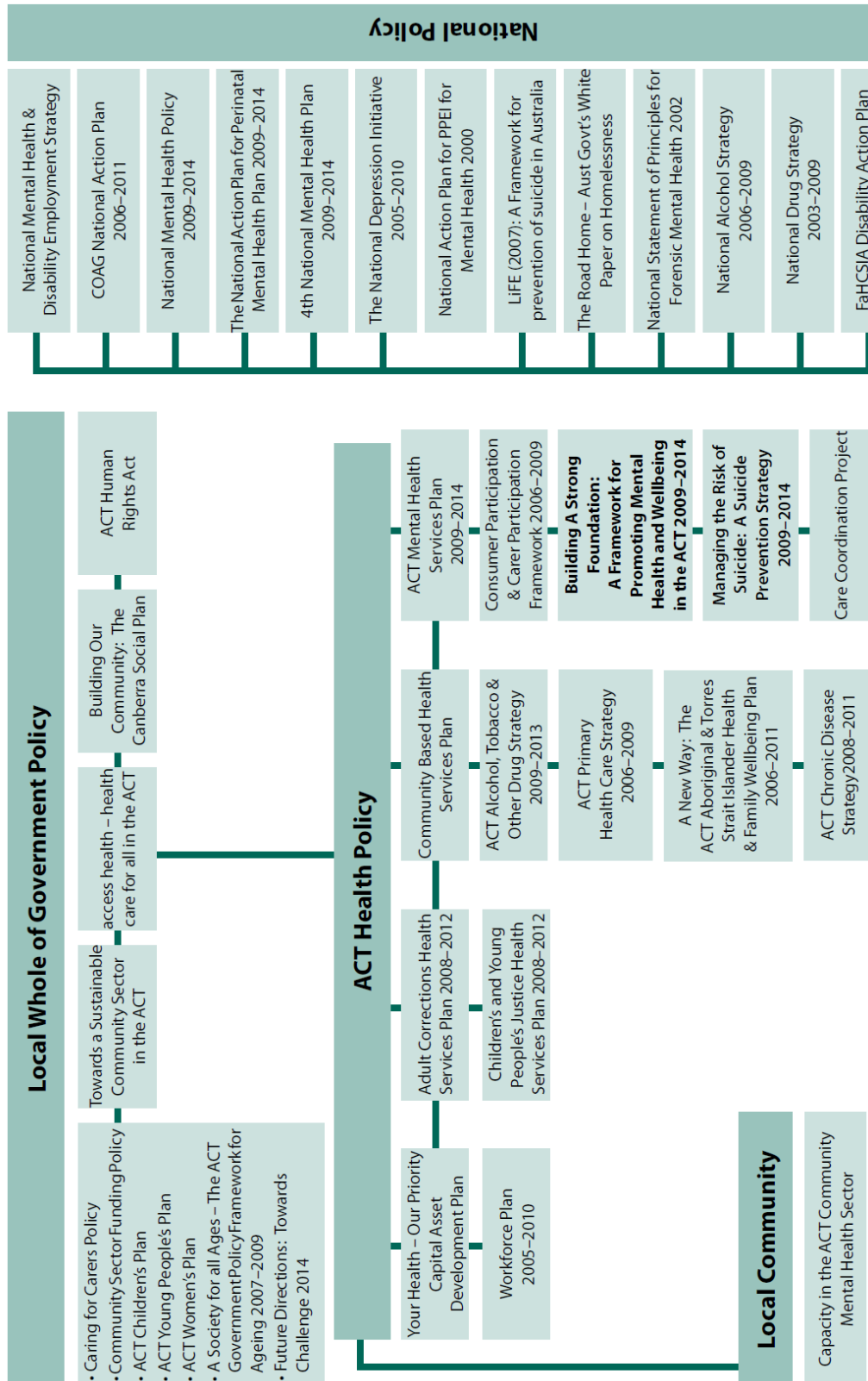
20. Improve research capacity and impact by doubling the share of existing and future allocations of research funding for mental health over the next five years, with a priority on supporting strategic research that responds to policy directions and community needs.
21. Improve supply, productivity and access for mental health nurses and the mental health peer workforce.
22. Improve education and training of the mental health and associated workforce to deploy evidence-based treatment.
23. Require evidence-based approaches on mental health and wellbeing to be adopted in early childhood worker and teacher training and continuing professional development.

9. Improve access to services and support through innovative technologies

Recommendations:

24. Improve emergency access to the right telephone and internet-based forms of crisis support, and link crisis support services to ongoing online and offline forms of information/education, monitoring and clinical intervention.
25. Implement cost-effective second and third generation e-mental health solutions that build sustained self-help, link to biometric monitoring and provide direct clinical support strategies or enhance the effectiveness of local services.

Appendix B Local Whole of Government Policy



Source: ACT Government, ACT Health, *Managing the risks of suicide: A suicide prevention strategy for the ACT 2009–2014*, p. 8.

Appendix C List of Submissions and Exhibits

The Committee received submissions from the following organisations and individuals:

1. National Institute for Mental Health Research
2. White Wreath Association Ltd
3. Name Withheld
4. Mind Blank
5. Australian Institute for Suicide Research and Prevention
6. Institute for Professional Standards and Safeguarding
7. Loretta Wolley
8. Suicide Programs.
9. Australian Education Union - ACT Branch
10. Name Withheld
11. ACT Child and Young People Death Review Committee
12. beyondblue
13. SupportLink Australia
14. Youth Coalition of the ACT
15. Families and Friends for Drug Law Reform - ACT
16. Aboriginal and Torres Strait Islander Elected Body
17. Mental Health Community Coalition ACT
18. Carers ACT
19. ACT Government
20. Royal Australian and New Zealand College of Psychiatrists

The Committee received one exhibit:

1. Menslink

Appendix D Public Hearings and Witnesses

The Committee held two public hearings and heard from the following witnesses.

THURSDAY 24 MARCH 2016

- Ms Yvette Berry, Minister for Housing, Community Services and Social Inclusion, Minister for Multicultural and Youth Affairs
- Mr Nic Manikis, Director, Community Participation Group, Service Strategy and Community Building, Community Services Directorate
- Mr David Matthews, Acting Deputy Director-General, Community Services Directorate
- Ms Maureen Sheehan, Executive Director, Service Strategy and Community Building, Community Services Directorate
- Ms Rebecca Cuzzillo, Policy Director, Youth Coalition of the ACT
- Ms Sophie Hope, Youth Advocate, Youth Coalition of the ACT
- Ms Emma Robertson, Director, Youth Coalition of the ACT
- Mr Martin Fisk, Chief Executive Officer, Menslink
- Mr Simon Corbell, Minister for Health
- Ms Katrina Bracher, Executive Director, Mental Health, Justice Health and Alcohol and Drug Services, ACT Health
- Mr Ross O'Donoghue, Executive Director, Policy and Government Relations, ACT Health
- Mr Ian Thompson, Deputy Director-General, Canberra Hospital and Health Services, ACT Health

THURSDAY, 14 APRIL 2016

- Dr Chris Bourke, Minister for Aboriginal and Torres Strait Islander Affairs, Minister for Children and Young People
- Dr Mark Collis, Executive Director, Office for Children, Youth and Family Support, Community Services Directorate
- Mr David Matthews, Acting Deputy Director-General, Community Services Directorate
- Ms Mirja (Majka) McLean-Engstrom, Community Engagement Coordinator, A Gender Agenda

Appendix E Questions taken on notice

Question No.	Topic	Minister/Portfolio	Date of public hearing	Date answered
1.	Services for young people	Minister Corbell/Health	24 March 2016	5 April 2016
2.	Young people with a diagnosis of depression or mental illness	Minister Corbell/Health	24 March 2016	5 April 2016
3.	Ongoing treatment for young people who access the health system	Minister Corbell/Health	24 March 2016	5 April 2016
4.	Young veterans	Minister Bourke/CSD	14 April 2016	26 April 2016