Royal Commission into
Victoria's Mental Health System

WITNESS STATEMENT OF JOHN GILBERT BROGDEN AM

I, John Gilbert Brogden AM, Chairman – Lifeline Australia, of Level 12, 70 Phillip Street, Sydney, NSW, say as follows:

Background

1 I am providing evidence to the Royal Commission in my capacity as Chairman of Lifeline Australia.

Qualifications and experience

2 I hold a Masters of Public Affairs from the University of Sydney and am a Fellow of the Australian Institute of Company Directors.

3 In January 2014, I was made a Member of the Order of Australia (AM) for significant service to the community through my roles with social welfare organisations (particularly Lifeline Australia), to the business and financial sectors and to the Parliament of New South Wales.

4 I started my career as a public relations consultant and political advisor, before becoming a politician. I was the youngest member of the NSW Legislative Assembly when I was elected as the Member for Pittwater in 1996, at age 27. I held that role until 2005, and was the Leader of the Opposition in New South Wales from 2002 to 2005.

5 After I left politics, I held various executive and non-executive roles in the business and financial services sectors. For example:

(a) from 2006 to 2009, I was the CEO of Manchester Unity;

(b) from 2009 to 2015, I was the CEO of the Financial Services Council; and

(c) from 2015 to 2017, I was the Managing Director and CEO of the Australian Institute of Company Directors.

Please note that the information presented in this witness statement responds to matters requested by the Royal Commission.

6 I was appointed to the board of Lifeline Australia ("**Lifeline**") in 2009, and in 2012 I was elected Chairman of the board. My role as Chairman for Lifeline is an elected, volunteer leadership position. As Chairman, I am responsible for leadership of the Lifeline board, including:

(a) facilitating proper information flow to the board;

(b) facilitating the effective functioning of the board including managing the conduct of board meetings; and

(c) communicating the views of the board, in conjunction with the CEO, to Lifeline's member centres, broader stakeholders and to the public.

7 In addition to my role as Chairman of Lifeline, I am currently also the:

(a) CEO of Landcom, which is the NSW Government's land and property development organisation. I was appointed Chairman of Landcom in January 2012 before accepting the permanent role of CEO in May 2018;

(b) Chairman of Furlough House Retirement Village; and

(c) Patron of Sailability Pittwater, Bilgola Surf Lifesaving Club, Avalon Beach Surf Lifesaving Club and Kookaburra Kids.

8 Attached to this statement and marked 'JB-1' is a copy of my CV.

My story

9 I have depression and suicidal ideation – so that means suicide is always an option for me in my mind. I have to manage that and so I'm medicated for depression and undertake regular psychiatric counselling for that.

10 On 30 August 2005, I tried to take my own life.

11 Ten years later, on 30 August 2015, I wrote the following in The Sydney Morning Herald ("**SMH**"):

"Ten years ago today I sat in a bed at Royal North Shore Hospital sedated, bandaged, scheduled under the mental health act and under suicide watch.

The night before I had tried to kill myself.

My successful nine-and-a-half year career in the NSW Parliament – elected at 27, Leader at 33 – had collapsed through my own failings and flaws. The shame had become overwhelming and I had convinced myself there was no other way out. The

only way – in my mind the best way – to take away the shame I had brought on myself, my family, my friends and my party was to take my own life.

I thank God I am still alive today. The immeasurable love and support of my wife, family and friends, two excellent doctors and countless nurses got me through a very dark time.

Three weeks after resigning the leadership and attempting suicide I resigned from Parliament. Despite the extraordinary wave of empathy, sympathy and support I knew I couldn't get well in the public eye. I just couldn't go back.

It took me over six months to recover. To get out of bed. To get dressed. To leave the house. To look people in the eye.

This is very hard to think about and even harder to write. But what happened to me happens to tens of thousands of Australians every year. The shame and hopelessness becomes overwhelming. Some think seriously about suicide. Others try. And over 2500 each year die. Seven a day.

…

Not everyone gets another chance in life. I have recovered from my suicide attempt and live a full and contributing life. I still have depression for which I am medicated and, like any other illness, I work with it every day.

Today I live by a credo from an unscripted speech delivered by Richard Nixon as he resigned in shame and controversy in 1974. It explains my journey.

"The greatness comes not when things go always good for you. The greatness comes when you're really tested. When you take some knocks, some disappointments. When sadness comes. Because only if you've been in the deepest valley can you know how magnificent it is to be on the highest mountain.""

Suicide – a national emergency

12 Suicide is a national emergency we can no longer ignore. As I wrote almost five years ago, in the same SMH article I mentioned above:

"In the 10 years since I tried to take my own life at least 23,500 Australians committed suicide. Worse, the number of people suiciding in Australia is increasing. In 10 years the number has increased by 20 per cent.

More people die from suicide than on our roads. Over the same period the number of motor vehicle deaths has reduced by 25 per cent to 1200.

What other cause of death would we allow to increase by 20 per cent over the last 10 years without serious action?

Suicide is the largest single cause of death in Australia for men and women under 44. Whilst we have come a very long way in destigmatising and talking openly about depression and other 'common' mental illnesses, we still struggle to know how to deal with suicide. Our suicide rates are similar to other Western developed nations such as the USA, UK and New Zealand. However, our Indigenous People's suicide rates are amongst the highest in the world.

Scotland is an example of a western country that has seen a decline in suicides after setting a target in 2002 to reduce suicide by 20 per cent within 10 years. They achieved an 18 per cent reduction.

Australia has failed to implement and fund a national suicide strategy.

So my call today is for suicide to be declared a national emergency. For it to be news every day that seven Australians took their own lives. For us to publish the suicide toll the way we publish the road toll. If we don t talk about suicide we can't stem the tide and reduce it.

It is time to get angry and stay angry until we see suicides drop. The commonwealth, state and territory governments must agree, implement and fund a national suicide strategy as a matter of urgency."

13 I called for suicide to be declared a national emergency almost five years ago.

Lifeline

Overview of history and services

14 Lifeline is a 24-hour 7 day a week crisis support and suicide prevention service. We are Australia's leading suicide prevention service. Lifeline was established in 1963 and was originally part of the then-Methodist Church. The late Reverend Dr Sir Alan Walker decided there was a need for an organisation like Lifeline after he received a call from a distressed man who later suicided. By March 1963, the first Lifeline crisis line was up and running in Sydney. It then effectively spread around Australia, through the Methodist churches, which later became the Uniting Church.

15 We have just marked 57 years since answering our first call. We now operate out of 41 centres around the country. Our ownership model is quite complex, in that some of our member centres are standalone legal entities and others are parts of larger organisations, such as the Wesley Mission or Uniting Church. Lifeline Australia is the umbrella body for all of the Lifeline centres. The member centres, whether they're

standalone or part of a larger organisation, elect the Lifeline board of which I am Chairman.

16 In the almost 10 years I have been on the Lifeline board, we have gone from being a 100% volunteer service to now being staffed by around 75% volunteers and around 25% paid staff. The main reason for that shift is that we came to a situation where it was nearly impossible for us to find volunteers to answer calls between around 2:00am to 6:00am, and so we now pay people to provide that service.

17 There are around 10,000 volunteers working for Lifeline around the nation. It would be impossible to respond to as many calls as we do without the commitment of Lifeline's volunteers, particularly during spikes like the one we have had this past summer with the bushfires. Our volunteers are the backbone of Lifeline, they give their time to listen without judgement, so they can help Australians hold on to hope and save lives.

18 It is fair to say that no two centres are exactly the same, except that they use the Lifeline logo and brand, they use the Lifeline rules and regulations and they meet the Lifeline accreditation requirements. However, the common thread through most of our centres around the country is that they answer phone calls made to 13 11 14, which is our crisis number. All but four of our centres answer phone calls to that number. All Lifeline centres (regardless of what services they deliver) are subject to our internal Lifeline Accreditation Program, which focuses on compliance and continuous improvement.

19 Some centres also deliver financial counselling services and some have other social and community services; some centres are directly related to suicide prevention, whereas others are more crisis related or community related. In addition, some of the services and programs our centres provide are reactive, in that they are introduced as a consequence of a specific need or event in the community. For example, one of our Lifeline centres has an anti-hoarding program because someone in the community was a hoarder and when the authorities came to evict him, he suicided, so that centre wanted to establish a program to assist people who are hoarders.

20 Our Lifeline centres are all funded differently. Some of them run op shops (Lifeline shops). Other funding sources include golf days, book sales, book fairs, local sponsorships and fundraising lunches or dinners.

Demand for Lifeline's assistance

21 Over the past decade, the two main trends we've seen are an increase in the number of calls (i.e. demand) but also an increase in our call answer rate (i.e. response). When I joined the Lifeline board in 2010, we were getting about 460,000 telephone calls a year

and we were answering about two thirds of those calls. Now, we get about 1 million telephone calls a year (around 2,500-3,000 calls a day). At 3,000 calls a day, that is a call from an Australian in crisis every 30 seconds. And we answer about 85% of those calls.

22 There has been a stabilisation in these two figures (call numbers and call answer rates). For at least the last six years, we have had between around 900,000 and 1 million calls each year, even though the number has gone up and down a bit within that general range. Our call answer rates have been up to 85%, and have gone up and down a bit, but are now sitting pretty consistently at 85%. We have had both an increase in the number of calls, but also an increase in our call answer rate. In addition, while 15% of calls go 'unanswered', my understanding is that many of those people ring back and have their calls answered. As Lifeline does not offer case management, we do not specifically track whether people ring us back and have their call answered, however callers (and particularly our regular callers) often tell us that this has been their experience.

23 The two biggest shifts we have seen in recent times are that calls are generally getting longer and the people calling us are more distressed. For example, in June 2020 we saw greater rates of distress (as measured by the crisis supporter identifying the help seeker as 'in crisis' and discussing suicide with the help seeker) and calls with people in crisis were of a longer duration.

24 Community factors can push or drive demand for our service. For example, there was an enormous and appropriate focus on mental health as part of the response to the recent bushfires. There was a strong message across the board – including from prominent public figures – of, *"Look after yourself, be safe, but also look after your mental health."* That created a lot of calls to us (as I discuss further below from paragraph 44).

Changes in communication methods and technology

<u>The growth of text and online counselling</u>

25 We have also seen, and continue to see, changes in the ways people want to communicate with us when they are in distress. Since 1963, we have been talking with people over the phone. Around eight to ten years ago, we saw a massive shift from landlines to mobiles (that was no different for us than anywhere else).

26 The big trend at the moment is a move to text counselling. Over the last two years we have been trialling text counselling. This trial has been funded by private funds as well as the New South Wales government and the Commonwealth government. We see text

counselling as an "and", not an "or" to our phone service. We want to offer text counselling 24 hours, seven days a week, although we can't do that at the moment because of insufficient funding. We would need significant funds to scale up text counselling.

27 A team at Wollongong University has conducted an extensive interim evaluation of Lifeline's Crisis Text trial.[1] The researchers assessed outcomes through operational data, pre- and post-text conversation automated questions (pre- and post-chat bot), and an online survey. When asked by the post-chat bot about their preferences for crisis support, almost 42% of help seekers said they would not have used another Lifeline service (i.e. phone or online chat) if text had not been available.[2] In addition, more than 87% of online survey respondents preferred Lifeline's text service over other options.[3] Survey respondents valued the privacy, convenience and sense of control offered by the text-based service.[4]

28 Two interesting trends we are seeing with the text counselling are:

(a) a large group of younger people are using our text counselling service – it is clear to us that text counselling is attracting young Australians in a way that our telephone service doesn't;[5] and

(b) the proportion of Aboriginal and Torres Strait Islander people using this service is double the proportion of Aboriginal and Torres Strait Islander people in the Australian population (5.3% of text counselling users versus 2.8% of the population).[6]

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[1] K, Fildes D, Kobel C, Grootemaat P, and Gordon R (2019) *Evaluation of the Lifeline Text Pilot Trial Final Formative and Economic Evaluation Report. Centre for Health Service Development,* Australian Health Services Research Institute, University of Wollongong.

[2] Williams, K., Fildes, D., Kobel, C., Grootemaat, P., Bradford, S., & Gordon, R. (28 April 2020). Evaluation of Outcomes for Help Seekers Accessing a Pilot SMS-Based Crisis Intervention Service in Australia. *Crisis: The Journal of Crisis Intervention and Suicide Prevention.* Advance online publication, http://dx.doi.org/10.1027/0227-5910/a000681, page 5.

[3] Ibid.

[4] Ibid.

[5] Ibid at page 4: "The mean age of respondents was 26.1 years (SD 9.6, range 11-71). More than half of the respondents (2,892/5,3861, 53.7%) were younger than 25 years of age, including 913 who were under 18".

[6] Ibid at page 4. The Report cites Australian Bureau of Statistics (**ABS**) data from 2017 for the 2.8% figure. In 2018, the ABS updated its previous, preliminary estimate a final estimate that Aboriginal and Torres Strait Islander people comprised 3.3% of the total Australian population as at 30 June 2016 (Australian Bureau of Statistics, '3238.0.55.001 - Estimates of Aboriginal and Torres Strait Islander Australians, June 2016' <https://www.abs.gov.au/ausstats/abs@.nsf/mf/3238.0.55.001> [accessed 29 June 2020].

29 From a generational point of view, it is working out almost exactly the way you would expect. Kids who text more than they talk are very interested in communicating by text, whereas a certain (older) age group still talk with us by phone. So, as that older age group dies, we anticipate there will be more text counselling and less phone counselling. However we do not anticipate text counselling to replace phone counselling for some time. We anticipate the phones will slowly drop off over time, but the texts will pick up quickly.

30 Lifeline also offers a limited amount of online crisis counselling. We run an online crisis support chat service, which is turned on and off for five hours each day (7pm to midnight). If you try to contact us through the online chat service outside those hours, you get directed to our phone number, so you are not completely abandoned. I am uncomfortable with this model and would prefer it to be available 24 hours a day. The only reason the online counselling is limited to part-time is because we do not have the money to run it 24 hours a day, seven days a week.

31 Going forward, I anticipate that text counselling might eliminate online chat. I think we will eventually have one form of written communication (e.g. text) and one form of oral communication (e.g. phone).

Benefits and challenges of text and online counselling

32 One of the benefits of text counselling is that it is more efficient. Crisis supporters can operate more than one text chat at a time, versus only one person on the phone.

33 In our experience, people come to the point very quickly in text or online counselling. There is no small talk. That is very different to a phone call, which may for example start with a person saying, *"Look, I've just lost my job, I'm a gambler. I owe tens of thousands of dollars. My marriage is in the pits, I'm sleeping in my car."* That might start as a conversation about gambling, but over a very short period of time, it becomes a conversation about suicide. In fact, around 7% of people who call us identify as suicidal at the start of the phone call, but we assess around 30% of them as suicidal by the end.

34 Text and short form message conversations tend to be more direct. Risk issues and difficult topics tend to be expressed sooner in the conversation and tackled more directly. Help seekers tend to come to the point more quickly and crisis supporters are trained to expect this and respond in a similar style. Many people find this direct style helpful, but it can be confronting for crisis supporters and our training aims to ensure they are supported and prepared for this.

35 Further, Lifeline runs a deliberate, direct intervention service, which means that we will initiate an intervention in circumstances where there is immediate risk to life.

36 One of the interesting challenges with text counselling is how we adapt our assessment model and whether we change the mode of communication based on our assessment. For example, if I am texting away back and forth with someone and I identify them as clearly suicidal, do I pick up the phone and call them rather than continue to text? It may be difficult to assess whether someone is at high risk of suicide without picking up the phone and hearing their voice.

37 Another possible challenge is that people may be worried about the use of their data, and their information sent via text. At present, our Interactive Voice Response (IVR) message tells people that we take call notes and that their call may be monitored. I think that, over time, Lifeline probably will need to record our calls, as we do our texts. I have always found it interesting that when you contact Lifeline you pour out the most incredibly personal details and are talking about maybe taking your own life, but in my observation people don't actually seem to be upset or deterred by the possibility of being recorded.

Characteristics and needs of people experiencing mental health crises who contact Lifeline

38 What we have seen for the last 57 years, is that when feeling overwhelmed or in crisis, Australians turn to Lifeline for support.

39 The suicide data demonstrates that three quarters of suicides are by men, and a quarter are women.[7] More women attempt suicide, but more men complete their suicides.[8] In a 2009 study of the Lifeline caller profile conducted by the Social Research Centre, the data showed that "the highest number of calls taken relating to suicide were from the 35–44 year age group (24%), with almost 18% of calls relating to suicide from the 25–34 year age group."[9] These age brackets overlapped with the highest age specific suicide death rates for males and females (as reported by the ABS), which was said to demonstrate that "Lifeline does support the needs of a high risk group for suicide; particularly for women, who make up an average of two thirds of Lifeline's callers."[10]

40 The main reasons people call us at Lifeline are relationship issues, mental health concerns and financial issues. We use a broad definition of relationships at Lifeline – it

[7] Australian Bureau of Statistics, '3303.0 - Causes of Death, Australia, 2018'

[8] Department of Health, 'The Mental Health of Australians 2: Prevalence in different population sub-groups' <https://www1.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-m-mhaust2-toc~mental-pubs-m-mhaust2-8~mental-pubs-m-mhaust2-8-2#2> [accessed 29 June 2020].

[9] Lifeline Caller Profile Booklet, <https://www.lifeline.org.au/static/uploads/files/42470-lifeline-social-data-booklet-web-wfvlammylwfb.pdf> [accessed 29 June 2020], page 6.

[10] Ibid.

means that something is going wrong in a person's life with their relationships that is distressing them and causing them to call us. That could be something happening at work, with a boyfriend or girlfriend, with kids or with any other relationships. Because financial issues are another major reason people call us, a number of our centres provide telephone or face to face financial counselling.

41 The critical thing in the context of suicide prevention work is that suicide is an act of impulse. You can be a very unwell person mentally, you can have really bad depression and it can get worse, or you can have bipolar, and yet you may never ever think about suicide. By way of example, a Queensland study estimated that 43.3% of non-Indigenous people who took their lives between 1994 and 2007 had no contact in their lifetime with mental health services; the rate for Indigenous people was even lower at 23.8%.[11] People contact Lifeline, out of the blue, never having spoken to a psychiatrist with a mental health issue. If we can get them through that phone call or that week, we may never talk to them again.

42 If we draw an analogy with physical health, the worse your cancer gets, the more likely you are to die; the worse your physical health gets, the greater your likelihood of mortality. That is not the same with mental health. Something could just go wrong, out of the blue. Your life could be going along perfectly and your marriage breaks up. Your life could be going along perfectly and your business collapses, or your son becomes a drug addict. Suicide can come from a very situational position, very quickly, and feeling suicidal can come and it can go. You might have a period of your life where you're feeling suicidal.

43 Not everyone who calls us is themselves in crisis or in an emergency or suicidal. They might be ringing to say things like, "*Listen, I'm really worried about my boyfriend, or I'm really worried about my daughter, she's doing this, or my brother, he's doing that. What do I say? How do I do it? How do I talk to them?*". We encourage people who are having those concerns to ring us and we will give them advice on how to talk with that person. Without our help, those people might otherwise do nothing or they might have the conversation but do it a clumsy way. A lot of people suffer in silence thinking, "*Oh my God, I'm really worried about my best friend but I don't know how to talk to her*". Whereas, if you walk past somebody who has had a heart attack or is bleeding, you'd stop and render assistance, even if you just ring Triple 0. We have a different attitude towards mental illness because most people don't know what to do; they think they need to be a psychologist and they worry about saying the wrong thing.

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[11] Sveticic J, Milner A, De Leo D. Contacts with mental health services before suicide: a comparison of Indigenous with non-Indigenous Australians. *General Hospital Psychiatry* 2012;34(2):185-191. doi:10.1016/j.genhosppsych.2011.10.009.

Measurement of outcomes and success

44 It is hard to measure the outcomes of what we do. Though we have not been disadvantaged by it, one of the great challenges with Lifeline, which I always struggle with, is that we deal with anonymous individuals who (for the most part) we do not case manage. This makes measuring what we do much harder than, for example, a clinical drug trial where you come in, the centre knows who you are, they take all of your family history, every inch of your body gets studied, they put you on a drug trial and then test you every week.

45 In contrast, we take people at random times in their life. They may call once and we may never hear from them again. They may have completed suicide, they may get over their bad day and never worry again or go and get clinical support. Then, out of the blue, someone will write us a letter or stop us in the street and say, "*Listen, Lifeline saved my life 15 years ago*", or, "*I talked to Lifeline when I was 17 and I was having problems here and there*". Often, their contact with us was a long time ago, which makes it hard to measure our service.

46 While we don't undertake case management, we do try to measure how we manage people through what we call "safety plans". This is where we get people to develop and work through a plan with us, where they might agree, for example, to go and see their GP or go and see a psychologist or a counsellor. The purpose of a safety plan is to keep a person who is experiencing suicidal ideation safe every day. The safety plan encourages someone to do certain things, but of course we cannot force them to go to the counsellor or fill in a script for their medication or ease off the drinking, or do whatever else the safety plan might recommend. Depending on how much we know about the person, and depending on how much they tell us about things like their location, the safety plan can be more specific (e.g. refer people to specific services). We create an average of 120 safety plans each year, and we consider that the implementation of safety plans is a measure of our success.

47 We also know that call rates can spike in response to certain issues or events, and we can measure that. It is not that these spikes signal mass suicides but more that we need to offer a different service in response to these calls. In my time, we have had three spikes:

(a) The first one was when Robin Williams, the actor, took his own life. When it became clear that he died by suicide, we had a one off 25% increase in calls for one week.

(b) When Charlotte Dawson, who was a media personality based in Sydney, took her own life, we had a 10% increase in our calls for about a week.

(c) When the bushfires started in earnest in December 2019, from that day to March 2020, we had a sustained 10-15% increase in our calls. On 30 January 2020, we introduced a dedicated Lifeline helpline for people in bushfire-affected communities (13 HELP).

48 These three spikes were about very different issues – two were about high profile suicides, the third concerned a massive natural disaster.

49 Now, with the novel coronavirus COVID-19 global pandemic and the resulting enforced closures, financial stress, social isolation and concern about health, we are experiencing the highest number of calls in the history of Lifeline.[12] Our call numbers have gone as high as 3,200 calls a day during the pandemic.[13]. During one week in mid-March alone, 23% of callers to Lifeline discussed COVID-19.[14] That number increased during the three weeks to 12 April 2020 to more than 50% of callers discussing COVID-19.[15] As at June 2020, our sample (i.e. our calls with help seekers) indicates that COVID-19 remains an ongoing concern in the community.

50 I think one of the great strengths of Lifeline is our brand. We are probably the best known of the crisis helplines in Australia. We are a household name in that sense. We are almost like an emergency service, and people will call us at any time based on any issues. We have a brand that is trusted and well known. In my view, we are commensurate with the Salvation Army, surf lifesaving services and probably the firefighters after this recent summer, in that people trust us. That trust is really important.

The limitations of current helpline services and areas for future improvement

51 Helpline services are part of the solution, but are not the only solution. Data indicates that for those who have attempted suicide, helplines were the fourth most common 'first

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[12] Lifeline, 'Victorian Government contributes $2.1M to ensure Lifeline continues essential service delivery throughout COVID-19' (Media release, 12 April 2020), <https://www.lifeline.org.au/static/uploads/files/20200409-media-release-victorian-government-contributes-2-1m-to-ensure-lifeline.pdf> [accessed 29 June 2020].

[13] See for example Matt Neal, 'Good Friday was Lifeline's busiest day ever as coronavirus puts strain on mental health' (ABC News 19 April 2020) <https://www.abc.net.au/news/2020-04-19/good-friday-was-lifeline-busiest-day-ever-coronavirus-anxiety/12161104> [accessed 29 June 2020].

[14] Lifeline, 'Lifeline will continue answering calls through COVID-19' (Media release, 18 March 2020), <https://www.lifeline.org.au/static/uploads/files/20200318-lifeline-to-continue-answering-calls-through-coronavirus-final-wfmgdbkq.pdf> [accessed 29 June 2020].

[15] Lifeline, 'Victorian Government contributes $2.1M to ensure Lifeline continues essential service delivery throughout COVID-19' (Media release, 12 April 2020), <https://www.lifeline.org.au/static/uploads/files/20200409-media-release-victorian-government-contributes-2-1m-to-ensure-lifeline.pdf> [accessed 29 June 2020].

point of contact' with the health system after ambulance/police, accident and emergency departments, and family/friends/neighbours/strangers. Notably, this research places helplines higher than GPs and other clinical services as a first point of contact for those reaching out for help.[16]

52 The number one way to prevent suicide is to remove or reduce access to the means of suicide. The huge fences we see on bridges are an example of means reduction. Because suicide is an active impulse, if at the moment you want to kill yourself you cannot because there is a fence there, that fence can actually stop you from attempting suicide.

Duplication

53 Ten years ago, the Lifeline number would have flashed up a couple of times a week on television or at the end of a newspaper article. Now, the Lifeline number is displayed somewhere almost daily. The other difference is that now, our phone number is put up with other helpline numbers. Personally, I am a little critical of that approach because I think it creates a level of confusion. There is only one Triple 0; there are not multiple numbers when your house has been broken into or when somebody has had a heart attack – you ring one number. I think there has been a proliferation of helplines that do the same thing, or very similar things. Yet Lifeline receives the largest number of calls per annum of the mental health helplines contacts, and more calls than the largest other Australian helplines combined.[17] In my view, there is a lot of time and effort and money wasted in duplication and multiplication in that process.

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[16] NHMRC Centre of Research Excellence in Suicide Prevention, 'Care After a Suicide Attempt: A report prepared for the National Mental Health Commission', <https://www.mentalhealthcommission.gov.au/getmedia/1f87b145-987e-4bc8-95af-6c4157de074f/CAASA-report> [accessed 29 June 2020], Table 5.

[17] Lifeline received 914,581 calls in FY18/19, Lifeline, 'Annual Report 2018 – 2019' <https://www.lifeline.org.au/static/uploads/files/web-lifeline-annual-r-2018-19-wfgeyleavrdw.pdf> [accessed 1 July 2020]. Though it is not a definitive list, the largest other Australian helplines received between them 597,047calls during the same period: in FY2018/19 Beyondblue reported that it received 192,895 contacts to its Support Service via phone, webchat and email, Beyond Blue, 'Annual highlights 18/19' <https://www.beyondblue.org.au/docs/default-source/default-document-library/beyond-blue-annual-highlights-2018-19-web.pdf>, page 8 [accessed 1 July 2020]; Ontheline (which includes Mensline and Suicide Call Back Service) reported that it answered 119,968 sessions, On the Line, 'On the Line Annual Report – 2018/19' <https://ontheline.org.au/wp-content/uploads/2019/10/OTL_ANNUAL-REPORT-2019_DIGITAL_FA-web-version.pdf> [accessed 1 July 2020]; and Kidshelpline answered 147,351 contacts to its counselling service, of a total of 284,184 attempts to contact that service, Kids Help Line, 'Key Insights 2018' <https://www.yourtown.com.au/sites/default/files/document/KHL%20Insights%202018%20Infographic.pdf> [accessed 1 July 2020].

Challenging caller groups

54 We have an extraordinary number of people who are repeat callers, who could call us up to 30 times a day. These people may be in some form of crisis, and in some cases suicidal. Many are desperately lonely or highly distressed and may have no one else in their lives who they could call those 10, 20 or 30 times a day. In fact, there are people who ring us so often they'll actually stop our crisis supporter halfway through and say, "*No, no, no, you're meant to ask me this question next, not that question*" because they know our pattern or assessment model so well.

55 We need a better way to manage those frequent callers, because it is not good for us and it certainly is not good or healthy for them to be calling us 30 times a day. The better we can manage these callers, the better equipped we will be to take the emergency calls that come through, because the frequent callers block the phone lines from people who are literally standing at the edge of a cliff trying to get through to us. If we can manage those frequent callers, we will get to a 100% call answer rate very quickly.

56 I understand from my discussions with colleagues at Lifeline and our counterparts that this challenge is common across the different helplines and mental health services. Frequent usage is a well-known phenomenon across international helplines.[18] In addition, frequent usage patterns are reported in relation to other health services.[19] Whilst I cannot definitively say the same individuals are simultaneously using various helplines at high levels of frequency, there is a high probability this is the case.

57 A related issue is line shopping, which is where people constantly phone helplines – they try Beyond Blue, they try us, they try other services. These are people who are having a horrible time and I feel for them terribly. On the one hand, maybe it is a good thing they call us because if they were not ringing us maybe they would be harming themselves. But they need more than what we can give them. These people need to be managed better, not just so we get them off the phone to clear our lines and answer 100% of our calls, but so that they are getting a better service – and getting the services they actually need.

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[18] Pirkis J, Middleton A, Bassilios B, Harris M, Spittal M, Fedszyn I, Chondros P, Gunn J. Frequent callers to Lifeline. Melbourne: University of Melbourne; 2015, <https://www.lifeline.org.au/static/uploads/files/frequentcallersonline-wfjgoupivizd.pdf> [accessed 29 June 2020].

[19] Hudon, C. et al (2017) Case management in primary care among frequent users of healthcare services with chronic conditions: protocol of a realist synthesis. *BMJ Open*, 7(9), e017701, <https://doi.org/10.1136/bmjopen-2017-017701> [accessed 29 June 2020].

58 We also have a group of 'unwelcome callers'. Unwelcome calls are those classified by the client supporter as offensive, abusive, menacing or harassing, either towards the individual client supporter, or the organisation.[20] They include threats of death or violence, personally directed abuse, sexual harassment or sexually violent content. For example, the unwelcome caller group includes male perverts who call to listen to female voices and masturbate on the phone. Thankfully that is a crime and so we get the Federal Police involved, who are able to deal with the matter. While unwelcome callers are not a large proportion of our calls, almost all of our crisis supporters have had a call from a pervert after a couple of years in the role. This is a shocking disincentive to our volunteers and our staff, and something we need to deal with.

Anonymity – a benefit and a limitation

59 The basis of Lifeline, and other similar helpline services, is that you are ringing an anonymous person and you will tell someone you have never met things you simply could not bring yourself to tell people you know and particularly those closest to you – your wife, husband, mother or father. This anonymity has both an upside and a downside. The upside is that the ability to talk to a stranger is a reason people call us and then talk with us about the deepest, darkest moment of their life. That is a plus (because it gives us the opportunity to help and support them), but it is also a negative in the sense that we cannot really case manage people (because they call us on a confidential basis and so we can't proactively follow up with them).

The ability to provide follow-up through an outbound service

60 We are a confidential service and the majority of calls to Lifeline come from people who do not block their numbers. If we had enough resources, we could provide an outbound service. For example, you might ring up today and tell us you're feeling suicidal. We get you through the call, and we are comfortable that you are okay. We should probably be ringing you the next day and a week later and a week later and a month later. As it currently stands, we might save you for a day, but we don't have the capacity to ring you the next day or the day after and say, "*Listen, how you going?*".

61 An outbound service could also help with the frequent callers I mentioned above, as we could then say to those people, "*Look Sally, we will ring you three times a day. We'll check in on you, we'll see how you're going. Don't ring us 30 times a day, we'll ring you three times a day and we'll check in to see that you've done this today, you've done that today*".

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[20] This is as defined in the Communications Alliance Ltd Industry Code C525:2017, Handling of Life Threatening and Unwelcome Communications, <https://www.commsalliance.com.au/__data/assets/pdf_file/0018/56223/C525_2017.pdf> [accessed 1 July 2020]. We adopt this definition internally at Lifeline.

62 For Lifeline, in my view, an outbound service would need to be focused around the crisis, not necessarily providing extra services. It might get to a point where we are comfortable the person will link to another service. At the moment there is an enormous gap between crisis and stability and we could help fill that gap by providing a little bit of follow up until the gap is closed.

Better integration between services

63 At Lifeline, we do not offer a whole spectrum service. We have been very strict over 57 years of not trying to do all things. Our work is very much concentrated on crisis and suicide prevention. We are a proudly non-clinical service. We do not have certified psychologists or counsellors on the phone – we have people who are trained to a TAFE certificate level, but we are not clinicians. A helpful analogy might be the TV series M*A*S*H – they do not do the complicated surgery; they patch you up and send you off. That is a positive way to think of us at Lifeline. It sounds like a negative, but it is not. It is very positive. We are very cognisant of our role in the continuum and whilst so many other charities and organisations want to keep spreading, we just want to keep getting deeper, keep doing what we are doing, but do more of it and do it more deeply including through things like text counselling.

64 Another analogy I like to use is that we are like the ambulance at the top of the cliff; we just keep you alive and then we hand you over to the specialist heart or brain surgeon. We are very focused on what we do and proud of our role at that point in your life. We then hand you over to the experts for longer term care. It is that process of 'handing you over' that I think needs improvement.

65 At Lifeline we use a third-party commercial data service and application designed to enable Crisis supporters to search for health, human and social services to provide referrals to help seekers who contact us. Currently, we provide a referral to the help seeker who then must initiate contact with the service themselves (that is, we do not currently offer 'warm' referrals).

66 In my view, we need better coordination between services and the ability to connect the services. We need a network where, if I am talking to you and I have provided you all the help I can, I can connect you directly with a service that can provide the additional help you need. Meaning I can hand you over not to a *warm* contact as they say in sales, but to a *hot* contact – so, I would literally say, "*Listen Peter, I'm now going to hand you over to Sally Smith, she's from Beyond Blue (for example) and she will take you along your next step on the journey. But we've got you safe now, we've sorted a few situations out, but we're now handing you on to somebody who can take you the next way*". Just giving 'Peter' a number to call or hoping that he will go and visit a service himself is not

good enough, in my view. The lack of connection and interconnectivity between services is a real problem for us and, more particularly, for the people who call us.

67 My understanding is that the Federal government considered a way to address the lack of integration between services a few years ago. The idea of that was that there would be one phone number where all mental health crisis calls would go through and then the calls would get distributed out from them. That sounds great in principle, but it obviously proved too hard to do. With a proposal like that, you also get contests about which is the right brand to be the front of that call service.

68 Returning to my analogy, the problem with patching people up is that some of them will get better by themselves, but others won't. Some will get worse an hour later. Unless they ring us again, we do not have the capacity to know what happens with them at the next level. As I mentioned above, Lifeline answers around 85% of our calls. If we could do it, I would like to be able to refer someone on to the next level of help – to actually hand them over to another service which has greater capacity to serve that person.

Accessibility – communication methods and people with cultural and linguistic diversity (CALD)

69 Helplines are easy to access in the sense that everybody has a phone. It is very different to when Lifeline started in 1963. Most people can also text, and certainly the generation that want to text us have text services. Thinking of Lifeline specifically, there are still improvements that can be made to increase our accessibility and reach.

70 As I mentioned above, while we currently offer text counselling and online chat, we only have enough funding to run those for part of the day. It would be excellent if we could get text counselling up to full capacity, 24/7, and we would very much like the online chat to also exist as a standalone 24/7 service.

71 One of our other weaknesses is that we are not great at helping people who speak a language other than English. Currently, we need to use interpreters, and I can only imagine that if you speak a language other than English and you want to end your life and you are having to go through an interpreter then back again, it would make it more difficult. The small amount of research we have facilitated indicates that there is a preference amongst people of CALD background, specifically those of Chinese heritage, to prefer a crisis support service offered in-language.[21] In addition, international data support the position that trauma rather than ethnicity per se is

[21] Cultural Perspectives, Chinese Lifeline Feasibility Study: Final Report (December 2017) <https://www.lifeline.org.au/static/uploads/files/chinese-lifeline-feasibility-study-edition-2-for-public-release-wfjbvqhqjrdu.pdf> [accessed 29 June 2020].

associated with suicide risk.[22] What we do not know is, are there large numbers of Arabic and Asian language speakers who just do not call us because they do not think we will be able to communicate with them? If we had everything we wanted, we would at the very least have Chinese speaking and Arabic speaking Lifeline staff because we would then have the top three languages spoken in this country covered (English, Arabic and Chinese). It would be nice to be able to serve those communities directly, rather than through translators.

Indigenous communities – the need for a tailored service

72 Another weakness is that we don't have a specific service for Indigenous Australians. That is a problem because suicide rates are much higher for Indigenous Australians than non-Indigenous Australians. A dedicated service would recognise the ridiculously high, tragic proportion of Indigenous Australians who take their own life. It is horrific, absolutely horrific. We need to look at how we can better service and better target Indigenous communities, and maybe our practice model needs to be slightly different for those communities. We have submitted a request for funding to the Federal government for a dedicated service for Indigenous people.

Ensuring Lifeline meets best practice standards

73 Lifeline has a bespoke framework of skills and interventions specially designed by us, for Lifeline to deliver crisis support effectively and safely. The Lifeline practice team brings clinical expertise and mental health best practice to service design, quality assurance and support structures underpinning the Lifeline service. All crisis supporters undergo 30 hours of training, plus a supported probationary period, to ensure they have the skills, confidence and empathy to meet the needs of our help seekers.[23] Ongoing performance and quality assessment processes are in place to develop and support all our crisis supporters and other support staff.

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[22] Supporting material can be found in the following papers: Beristianos, M. H., Maguen, S., Neylan, T. C., & Byers, A. L. (2016). Trauma exposure and risk of suicidal ideation among ethnically diverse adults. *Depression and anxiety*, 33(6), 495–501. https://doi.org/10.1002/da.22485; Leiler, A., Hollifield, M., Wasteson, E., & Bjärtå, A. (2019). Suicidal Ideation and Severity of Distress among Refugees Residing in Asylum Accommodations in Sweden. *International journal of environmental research and public health*, 16(15), 2751. https://doi.org/10.3390/ijerph16152751.

[23] See further Lifeline, 'Crisis Supporter Training' <https://www.lifeline.org.au/about-lifeline/training/telephone-volunteer-training> [accessed 29 June 2020].

Digital technology

The opportunities of digital technology for improving access to, and delivery of, mental health services

74 We recently saw an interesting example of the use of digital technology in Queensland, after the horrible murder/suicide in Brisbane (where a man killed his wife and four children and then killed himself). The Queensland government contracted Lifeline to get our people on the ground, in that neighbourhood straight away, with Lifeline branded vests on, walking the streets, knocking on doors and seeing how people were. I think that was fantastic. I see no reason why digital technology should not be used to further target communities that have been affected by something like that or by any other tragedy or disaster like a flood or mass shooting. In a lot of these situations, there are counsellors there when the event has happened or, for example, between 9:00am to 5:00pm, but if you are distressed at 2.00am in the morning, what do you do? Lifeline is there for that, but there might be other services as well.

75 Just as they do with bushfire alerts, where every mobile phone in the area receives an alert saying, "*Stay at home, it's too late to leave*" or "*You've got another hour to leave before the fire comes*", I wonder what the capacity is to use these tried and true methods to identify communities and target them with messages like, "*There has been an incident. You might be aware of it. If you are feeling in any way distressed, please ring Lifeline, we're here to help.*" For example, if there is a suicide at a school, you could send a targeted message to every student and teacher at the school or even everyone in that school community. These alerts could be done by geographical zone, or in some other way.

76 I have been to a couple of conferences overseas where they're looking at other ways to use digital technology to monitor people's mental health. For example, can we use an understanding of the way people use technology as a way to monitor their mental health and wellbeing? In the future, technology could possibly offer the capacity to monitor a person's social media activity, texting and use of mobile phone, and if the data shows that their usage gets quite frenetic (e.g. they are ranting and raving on social media), that could be a signal that they are not well. There could also be the capacity to use digital tools to monitor physical location, which could for example raise an alert about suicidality if a person who is suicidal is near a well-known suicide hotspot.

77 There is also talk of using artificial intelligence ("**AI**") in mental health services, although it is a long way into the future. For example, if you are on the phone, the AI may be able to recognise that your voice is at a certain pitch which is associated with being more suicidal or more unwell.

78 Digital technology opportunities arise in relation to using AI to help understand crisis contacts. Lifeline is currently undertaking such a project, in which the profile of persons seeking help, and the impact of the contact on the help seeker, is being mapped. There is precedent for such approaches internationally, including at Crisis Text Line. Although that service does not disclose details of their approach they state:

> "Most crisis lines respond to texters in the order in which they arrive. We act more like a hospital emergency room, where a person with a gunshot wound gets helped before a person with a broken leg. We call it texter triage. An algorithm runs in the background and assesses a texter's suicidal risk based on their first few messages. Texters at high risk get marked as "code orange" and move to #1 in the queue. During the Presidential Election, when we saw volume 8x our normal, we were still able to reach high-risk texters in an average of 39 seconds. Shorter wait times mean lives saved."[24]

79 In my view, one of the most promising opportunities is to use digital technology for more outbound services. For example, we could use the technology to automatically text or call people to say, "*Have you taken your medication?*" or "*Good to talk to you yesterday. How are you feeling today?*". Those little follow-ups could make a difference. It is similar to how we receive a text from the doctor or dentist saying, "*Just reminding you your appointment is next Tuesday*". Where there is agreement about what is good and what is bad for the person's mental health, those things could be built into the alerts.

80 Digital technology also has the benefit of anonymity – for example, you might not tell your mum that you have gone off your medication, but you might tell an anonymous text service.

The role for digital technology as a complement to face-to-face and traditional service delivery options

81 In my view, there is an enormous capacity for digital technology to complement face-to-face service delivery for mental health. By way of analogy, many people record the number of steps they do every day; we need to think about how we could use technology in a similar way to improve people's mental health. At Lifeline, we look at the system from a prevention, intervention and postvention perspective. Digital services at Lifeline are complemented by community-based services around prevention and postvention. Having a range of complementary service delivery options is, in our view, the ideal way to navigate the service ecosystem.

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[24] Crisis Text Line, 'Helping The Highest-Risk Texters First' <https://www.crisistextline.org/data-philosophy/> [accessed 29 June 2020].

82 For example, many mentally unwell people fight against taking medication, because they see it as a failure or a weakness. In addition to the face-to-face services from their clinician, people may be assisted by a gentle digital reminder, "*Have you remembered to take your medication?*". Or maybe every day at midday a person may be comforted by the fact that they get a text from their counsellor saying, "*Is everything okay? If not, give me a call or text me*". Or a person might have a mental illness that manifests itself in a certain situation like when they are on public transport, so they may be helped by a message every morning and every evening checking in about how they are going on public transport, and telling them, "*Remember to breathe*".

83 A couple of years ago, I was very distressed and I took a couple of weeks off work. My doctor gave me a daily program to go through with him. That program could be text prompted. For example, it could prompt me by asking whether I have done certain things in the program, and could also ask me to rate how I am feeling today (e.g. on a scale of 1-10).

84 The benefit of combining this kind of digital technology with traditional methods of service delivery is that the clinician could then track your mood. They would begin to get a rhythm and a database of your mood. In my view, that would enable them to better treat you. For example, the data may show that a person is always down on certain days. Or it may help to confirm their diagnosis or otherwise add to the clinician's understanding of their patient. It is important to bear in mind that if you are mentally ill, you do not always know what is happening in your life. You are not always in control so you might not see the triggers that are really obvious to someone else who is trying to help you.

Suicide prevention

The "Better off with you" initiative

85 "Better off with you" is a suicide prevention initiative. It involves people who have lived through suicidal thoughts and suicide attempts sharing their stories about coming out the other side. The campaign has a number of elements – for example, there is a podcast and social media and radio advertisements. I have been part of the campaign and have shared my story.

86 There is a concept in suicidality of burdensomeness, which is where you feel you are a burden on someone and you convince yourself that the best way to lift that burden is to take your own life.[25] It does not affect everybody but for those it does affect, it is a heavy

[25] The integrated motivational-volitional (IMV) model is one of the best-accepted theories of suicidality. It makes reference to perceived burdensomeness as a factor in suicide. See

burden. It may be thoughts like: "*I'm dragging others down, I've embarrassed other people, I can't put food on the table, I'm bloody hopeless, I can't get a job*". To a rational person standing outside, none of it may make sense. But for the person experiencing burdensomeness, they feel like, "*I'm putting a burden on you, the best way for me to fix this is to help you by taking my own life*". It is very hard to passively kill yourself. Suicide is a very active action – you need to actively kill yourself. For some people, it is the burdensomeness that forces you to act.

87 The idea of "Better off with you" is, literally, we are better off *with* you. Do not think we are better off without you. Do not think the best thing is for you to go. The idea is to directly address this element of suicidality with stories of people saying, "*I thought I was a burden but I really was not a burden*". As I say at Lifeline, we are not making a moral judgement or a religious judgement or a values-based judgement, but you are better off alive than you are dead.

88 As I mentioned earlier, I was leader of the opposition in New South Wales from 2002 to 2005. My political career ended in a suicide attempt. The thing that pushed me over the line, when things went really bad, was that in my mind it made perfect sense that suicide was not only the right thing to do, but the best thing to do because I was a burden on others as a result of everything that had happened.

89 Personal stories get used more frequently now when talking about mental illness, and particularly depression. For example, we hear a lot about footballers or other high profile figures talking about depression, and that is good that they are talking about it. Whenever we talk about suicide, it is like a wet horse blanket falls over the whole discussion and people listen to every word you say. I used to be in politics so I am used to people not listening to me when I talk, but when I talk about suicide *everyone* listens. It is extraordinary. People do not touch their phones. They listen to every word you say, particularly if you are sharing your own experience.

90 The particular problem with suicide awareness, and the importance of the "Better off with you" campaign, is that you do not hear a lot from people who have tried to take their own life but come through the other end with a positive story. It is those stories, and the concept of burdensomeness, that are the focus of the "Better off with you" campaign. It is about saying, "*Yes I know you think you are a burden but you're really not a burden and there's a way through*".

O'Connor, R. C., & Kirtley, O. J. (2018). The integrated motivational-volitional model of suicidal behaviour. *Philosophical transactions of the Royal Society of London. Series B, Biological sciences,* 373(1754), 20170268. https://doi.org/10.1098/rstb.2017.0268.

Areas for improvement in the way mental health services respond to people at risk of suicide, their families and carers

91 In my view, four headline areas that require improvement are:

(a) People admitted for suicide attempts who are at risk of suicide being discharged from hospital after a couple of days when they should be kept in hospital for longer.

(b) A lack of follow up services after someone is released from hospital for acute mental health problems. I elaborate on the lack of an aftercare ecosystem in Australia further below.

(c) A lack of training for primary health care workers. Modelling suggests that training for GPs to serve as gatekeepers so that they can recognise, respond and refer to suicidal persons is one of the most impactful ways of reducing suicide.[26]

(d) While there is an increasing awareness of mental illness, there is not as much awareness of the risk of suicide.

The need for an effective aftercare system

92 The greatest indication of the likelihood of suicide is a previous attempt of suicide.[27] There are cases where people kill themselves within hours of leaving hospital after being admitted for a suicide attempt. Effective postvention services are provided in other parts of the health system, including through hospitals. For example, some hospitals provide follow-up care for postpartum mothers, where a midwife comes to the home every week or twice a week for a short period of time after the mother and baby are discharge from hospital. This tells us there is an understanding of these kinds of services. The services offered in those other areas should be considered as a potential model for to how postvention services could be provided for people who have attempted suicide.

93 The lack of an aftercare ecosystem in this country at the moment is a barrier to better responsiveness to people who are at risk of suicide and their families and carers. There is a lack of funding which is amplified by the never-ending complexities of the Australian

[26] Page A, Atkinson J, Heffernan M, McDonnell G, Hickie I. A decision-support tool to inform Australian strategies for preventing suicide and suicidal behaviour. *Public Health Research & Practice*. 2017;27(2):e2721717, available at <https://www.phrp.com.au/issues/april-2017-volume-27-issue-2/a-decision-support-tool-to-inform-australian-strategies-for-preventing-suicide-and-suicidal-behaviour/> [accessed 29 June 2020].

[27] Christiansen E, Jensen BF. Risk of repetition of suicide attempt, suicide or all deaths after an episode of attempted suicide: a register-based survival analysis. *Australian and New Zealand Journal of Psychiatry*. 2007;41(3):257-265. doi:10.1080/00048670601172749.

Federal system in relation to which level of government is responsible for funding and providing services. The short window (three months) after discharge from hospital in relation to a suicide attempt is covered but beyond that, funding is needed for programs such as Eclipse (which I discuss below) to offer support to people who have attempted to take their own lives.

Best practice models for responsive suicide prevention

94 The 'Survivors of Suicide Attempt' (**SOSA**) program is run by a well-established mental health service "Didi Hirsch Mental Health Services" in Los Angeles, California. Individuals who participated in an evaluation of the SOSA support group experienced measurable reductions in suicidal desire and intent and significant increases in hopefulness and resilience.[28] The program meets the requirements of the US Suicide Prevention Best Practice Registry, which only accepts evidence-based programs.[29]

95 Lifeline has adapted the SOSA program for use in the Australian context – the program we are running here is named 'Eclipse'. 'Eclipse' meetings are a lived-experience support for adults who have non-fatally self-harmed and as such are a form of aftercare. The sessions complement clinical service provision and allow lived experience to be shared in a safe, non-judgemental, facilitated environment over an eight-week period. The primary objective of the Eclipse program is to keep people safe by equipping participants with tools and skills for coping and planning should suicidal impulses take hold in the future. Preliminary results from the formal evaluation of Lifeline's 'Eclipse' groups support the positive outcomes reported in relation to survivors of suicide attempt support groups in the United States.[30]

96 It is important to fund aftercare services which do not have time limits attached to them. Currently, there are services that are only funded to provide support for up to three months following a person's suicide attempt. Those strict time limits should be lifted; while support for the initial three month period is helpful, funding should also be provided for ongoing aftercare support for those who have attempted suicide. Suicidal ideation cannot be dictated by strict timeframes. A person may benefit from a peer support group like 'Eclipse' well after that initial three month period.

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[28] Hom, M. A., Davis, L., & Joiner, T. E. (2018). Survivors of suicide attempts (SOSA) support group: Preliminary findings from an open-label trial. *Psychological Services,* 15(3), 289–297. https://doi.org/10.1037/ser0000195.

[29] Suicide Prevention Resource Center, 'Resources and Programs' <http://www.sprc.org/resources-programs/manualsupportgroups-suicide-attempt-survivors> [accessed 29 June 2020].

[30] Hom, M. A., Davis, L., & Joiner, T. E. (2018). Survivors of suicide attempts (SOSA) support group: Preliminary findings from an open-label trial. *Psychological Services,* 15(3), 289–297. https://doi.org/10.1037/ser0000195.

The role of emergency services, emergency departments and crisis support services in helping to prevent suicide attempts by people in crisis

97 I feel very sorry for the police and ambulance officers who are often the first responders to the scene of a suicide or attempted suicide. They see all sorts of hideous things. We need to provide first responders with better training, support and services to handle these situations. We need to help them get through it themselves and cope with the trauma that they can experience as a result of seeing, and having to report, such scenes.

98 In my view, part of the broader problem that needs to be addressed is how the police respond to people with mental illness. The local police and ambulance officers, and local emergency departments, have a lot of knowledge about their community. There needs to be better connectedness and information sharing between these organisations. There should be a better flow of data so that when the police get a call out, they know before they enter a property that there is a person there who is known to have had significant mental health issues. This could operate in a manner similar to how the police check the firearms registry so they know if there is a firearm in the house before they go in.

99 There is currently a lack of information sharing between the emergency services, emergency departments and other local institutions like the local schools. For example, if there is a suicide cluster you would find out about it in a country town because everybody knows everybody else. But in suburban areas like Melbourne, your next-door neighbour could suicide and you would never have any idea if you didn't already know them. But the local police always know what is going on in their area. They know where the suicides are occurring, they know if they are arresting mentally ill people and putting them in jail. That information needs to be shared more effectively.

100 Where I live, on the northern beaches of Sydney, a 14 year old boy from a local school killed himself. The very next week, a 12 year old girl from the same school tried to kill herself in the same way. Thankfully she did not die but she was badly injured. At that point, the school and the local police worked out that they had a problem with this school and this means of suicide or attempted suicide. The quicker they front foot their response the better. To do that effectively, the school and the police need to have the right resources, knowledge and training.

101 Training is key to better support the capability and confidence of frontline workforces to work with people in a suicidal crisis. Gatekeeper training should be provided for a range of front-line workers. This kind of training gives people the confidence to recognise, respond and refer to people showing signs of distress.

Mentally Healthy Workplaces

The structures, conditions and programs required for a Mentally Healthy Workplace

102 My knowledge and experience primarily relates to office type work environments. I really worry about what happens at, for example, the local milk bar with five staff – how do they have the resources to put in place all the structures, conditions and programs needed for a Mentally Healthy Workplace?

103 My experience is the majority of people who have mental health problems that manifest in the workplace (or that do not manifest, for that matter) have those mental health problems from outside the workplace. It may be the case that what happened in the workplace was the straw that broke the camel's back, but they may bring a whole number of issues into the workplace, for example a violent relationship and mental health problem. While that would apply for the majority of people, no doubt there is a group of people whose mental illness is caused by what happens at work.

104 The first thing an employer or workplace has to do to create a Mentally Healthy Workplace is to think of mental injury in the same way they think of a physical injury. The law requires that but I do not think people think that. For example, you cannot walk onto a building site without putting on a helmet and other protective gear. There are signs everywhere, there are locks, there is training, there are checks. Yet we send people into mentally stressful environments every day of the week without a second thought.

105 The greatest problem we have with mental health in the workplace is that many workplaces struggle with how to manage somebody with mental illness. If somebody walks into the office on a Monday and they have not changed their clothes since Friday, they smell, they have alcohol on their breath and they are disruptive in the workplace, HR teams tend to want to discipline or manage that person out, even though they could be having a mental health episode. Indeed, there is evidence that unkempt appearance is associated with mental health stigma.[31] Instead, we need to stop and think, "*Okay, that person has gone from being happy-go-lucky to disruptive, what's happened there?*" or "*They used to be quite balanced. If there's something happening, let's get them some mental health support, let's see what's going on, maybe they've got a problem at home, maybe they've got a problem at work*".

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[31] Matthew Schumacher, Patrick W. Corrigan, Timothy Dejong (2003). Examining Cues that Signal Mental Illness Stigma. *Journal of Social and Clinical Psychology:* Vol. 22, October, pp. 467-476, available at <https://guilfordjournals.com/doi/abs/10.1521/jscp.22.5.467.22926> [accessed 29 June 2020].

106 I understand that managing employees with mental illness is not easy and we are not as experienced in that as we are in managing physical illness. But frankly, I think it is a human rights issue. It is certainly a quality and safety issue. In my view, it will take a significant legal claim against an employer, and potentially a change of the law, before employers will take concrete steps to effectively manage employees with mental illness. In my view it is also going to require, at least in some cases, a fundamental job re-design to ensure a Mentally Healthy Workplace.[32] We need to redesign the workplace and our roles to take out unnecessarily stressful or mentally risky or unsafe experiences.

sign here ►

print name John Gilbert Brogden

date 7 July 2020

[32] See for example the work of the Centre for Transformative Work Design, <https://www.transformativeworkdesign.com/> [accessed 29 June 2020].

Royal Commission into
Victoria's Mental Health System

ATTACHMENT JB-1

This is the attachment marked 'JB-1' referred to in the witness statement of John Gilbert Brogden dated 7 July 2020.

JOHN BROGDEN

Career Overview

Executive Roles

Landcom **2017 – present**
Chief Executive Officer

Australian Institute of Company Directors **2015 - 2017**
Managing Director & Chief Executive Officer

Financial Services Council **2009 - 2015**
Chief Executive Officer

Manchester Unity Australia **2006 - 2008**
Chief Executive Officer

Parliament of NSW
Leader of the Opposition **2002 - 2005**
Shadow Minister **1999 - 2002**
Member for Pittwater **1996 - 2005**

Cuscal **1995 - 1996**
Public Affairs Manager

Cosway Australia **1994 - 1995**
Public Affairs Consultant

NSW Government **1989 - 1994**
Ministerial Adviser

Non-Executive Roles

UrbanGrowth NSW/Landcom **2012 -2017**
Chairman

Lifeline Australia **2012 - present**
Chairman

Furlough House Retirement Village **2011 - present**
Chairman

BBI– The Australian Institute of Theology **2012 - 2016**
Chairman

NIA Limited (health.com.au) **2011 - 2015**
Director

Sydney Ports Corporation **2010 - 2012**
Director

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Abacus Australian Mutuals **2006 - 2009**
Independent Chairman

Australian Health Insurance Association **2006 - 2008**
Director

Australian Friendly Societies Association **2006 - 2008**
Director

Qualifications

Master of Public Affairs (MPA) **2002**
University of Sydney

Fellow of the Australian Institute of Company Directors (FAICD) **2014**

Community

Patron of Bilgola Surf Life Saving Club
Patron of Avalon Beach Surf Life Saving Club
Patron of Sailability Pittwater
Patron of Kookaburra Kids
Member of the Order of Australia (AM) for significant service to the community through representational roles with social welfare organisations, particularly Lifeline, to the business and financial sectors and to the Parliament of New South Wales.

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Profile

Leadership
In business and public life I have been privileged to lead a range of organisations. I have been successful by setting a clear direction, committing to a strategy, establishing clear responsibilities for the team, giving them the authority and resources to deliver and vigorously pursuing outcomes. I have adapted my leadership style and tone to the specific situation facing the organisation I led.

During my time at the Australian Institute of Company Directors (AICD) we increased membership to 40 000 (the largest director institute in the world), maintained the highest standards in governance education, improved member services and significantly increased profile and advocacy.

As CEO of the Financial Services Council (FSC) I broadened the policy agenda, increased our influence with Government and improved the public profile of the financial services industry in Australia.

As CEO of Manchester Unity from 2006 to 2008, I revitalised a $250m company and drove a merger with Australia's third largest health insurer HCF setting a record price for a private health insurance company.

I have pursued my passion for public service as the Chairman of charitable organisations providing services in suicide prevention, mental health, care for the elderly and Catholic education.

In 2002 at the age of 33, I became the Leader of the Opposition in New South Wales after entering Parliament at the age of 27.

Profit Improvement & Balance Sheet Strength
At Manchester Unity I improved profitability and net assets. Profitability increased by 92% from $11.3m in FY06 to $21.7m in FY08 and net assets increased by 63% to $153m.

Process Improvement & Enhanced Member Service
At Manchester Unity I significantly reduced costs whilst improving member service. Significant process improvements resulted in higher service levels for members. Processing times for member claims reduced by 75% with improved service quality. This was achieved with 8% fewer staff.

Strong Communication
I built a career in public life as a passionate advocate for individuals, communities and causes. As a compelling public speaker and presenter to audiences of all sizes I have successfully fought and won many battles in the public domain. I used these skills in business to raise the profile of the AICD, Manchester Unity and the FSC.

Change Management
Organisational culture is the foundation of long term success. At Manchester Unity I led the cultural transformation from secrecy and blame shifting to a culture of transparency,

collaborative problem solving, staff incentives, reward and recognition and high staff engagement on costs and profitability. As Opposition Leader I drove change to establish strong team discipline and transparency.

Career Summary

Australian Institute of Company Directors **January 2015 - May 2017**
Managing Director & Chief Executive Officer

The AICD is the largest institute of directors in the world, providing governance education, director development, member services and advocacy for over 40 000 members including directors and senior leaders from business, government, ASX, private and the not-for-profit sectors. During my tenure:

- Membership increased by 9%;
- Profile grew significantly;
- The advocacy agenda broadened to challenge the space traditionally occupied by the Business Council of Australia;
- Overall member satisfaction (NPS) increased after a four year decrease;
- New membership initiatives such as the appointment of a Chief Economist, better use of video content and more targeted communications;
- Successfully attained membership of the World Economic Forum as Australia's sole business representative body; and
- Adopted and advocated a target for 30% woman on ASX 200 Boards.

Financial Services Council (FSC) **2009 – 2015**
Chief Executive Officer

The FSC represents Australia's retail and wholesale funds management businesses, superannuation funds, life insurers, financial advisory networks, trustee companies and public trustees.

In 2015 the FSC had over 130 members responsible for investing more than A$2.1 trillion on behalf of 11 million Australians.

During my time as CEO we significantly increased the profile of the FSC and the retail financial services industry and expanded our influence with Government.

Achievements include:

- Significantly increasing non-membership revenue through new sponsorship and events. (Quantify)
- Increased policy and research capacity (quantify if possible);

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- Broadened policy mandate to extend into broader economic issues that affect the Australian economy in which the industry invests (eg tax, workforce participation, productivity);
- Broader engagement with the Australian Government at the policy and political level through direct engagement with Prime Ministers Gillard and Rudd. Prime Minister Gillard attended FSC events on three occasions during her tenure, including a roundtable with industry leaders. Prime Minister Rudd attended a FSC event in 2010 (in contrast, the previous Prime Minister attended one event in the prior ten years under my predecessors);
- Expanded the mandate to include Trustee Companies and independent Financial Advisory businesses;
- Increased more direct engagement with CEOs through CEO only events;
- Engagement at the editorial level of Australia's financial press; and
- The regular placement of opinion articles in business media.

Manchester Unity Australia Ltd **August 2006 - December 2008**
Chief Executive Officer

Manchester Unity was founded in Australia in 1840. By 2006 it operated as a modern mutual providing health insurance, financial products and retirement and aged care services to over 180 000 Australians. In FY08 it employed 400 staff on nine sites across New South Wales with total revenue in excess of $250m. In 2008 Manchester Unity was listed by BRW as one of Australia's 200 largest private companies.

I was appointed CEO in August 2006 with a mandate to turn the company around, establish a clear strategy, revitalise the management team, change the culture and reduce costs.

I inherited a dispirited and underperforming management team. Whilst the health fund was growing membership ahead of the industry average, profit was poor and operating expenditure was 50% above the industry average. The company lacked strategy and focus.

My immediate objectives were to:

- Create an open, transparent and performance based culture;
- Commence work on a clear strategy;
- Reduce expenditure and restore profitability;
- Openly report data on performance to all senior management;
- Introduce a culture of collaborative problem solving across business units; and
- Improve staff engagement in general and, in particular, participation in process improvement.

My achievements included:

- Increased group profit from $11.3m to $21.7m (can you benchmark CAGR versus industry);

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- Increased group revenue from $196m to $254m (can you benchmark CAGR versus industry);
- Increased membership from 87 500 to 91 000;
- Increased net assets from $94m to $153m;
- Reduced staff (FTE) numbers from 409 to 376;
- Improved member service quality and levels in claims processing and call response times;
- Reduced management costs from 13.7% of revenue to 11.6% of revenue (on a run rate to drop to 10.5% in FY09, bringing it into line with the industry average); and
- Increased staff engagement and transformed organisational culture.

In my first 100 days I implemented the following changes:

- A weekly Executive Committee meeting of the eight senior staff to review and discuss performance indicators against benchmarks;
- A re-structure that included the appointment of a new Chief Information Officer, combining all member service business units under one manager, merging the sales and marketing teams, appointing a qualified General Counsel and Company Secretary, appointing an Internal Auditor, replacing the General Manager of the Retirement and Aged Care business and eliminating 15 positions across the business;
- The appointment of a Head of Strategy to commence an urgent strategic review and develop a new three year strategic plan with detailed focus on the first 12 months;
- Reviewing and improving staff reward and recognition programs;
- Cancelling a failing management arrangement with a retirement village;
- Establishing an Emerging Leaders program to target and develop talented staff;
- Abolishing the annual 'Corporate Culture Day';
- Revising the company's advertising and marketing strategy to eliminate all 'above the line' marketing expenditure and refine and improve the 'below the line' strategy;
- Moving senior staff offices off the 'executive floor' to be with the staff they manage; and
- Establishing bi-annual CEO briefings to all staff.

With demutualisations and consolidation in the private health insurance sector starting in 2007, it was clear that Manchester Unity was a target for acquisition. Despite improved performance, Manchester Unity faced the reality that as a mid size player we were not able to achieve the scale necessary to continue to be competitive.

We chose to seek the best outcome for our members by achieving greater scale and financial security through a merger that served the best interests of our members.

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In December 2008 we completed the friendly merger of Manchester Unity with Australia's third largest health insurer, HCF. The sale price of $256m was $17m above the top of the value range set by the independent expert and set a 'per member value' record for a private health insurer in Australia. Manchester Unity's constitution required 40% of members to participate in the vote and 80% of voting members to vote in favour. We received record support with 78% of members voting and 99.1% voting in support of the merger.

Lifeline Australia **2012 – present**
Chairman

Lifeline was established in 1963 by the Central Methodist Mission in Sydney as a telephone counselling service for people at risk of suicide. In 2017 Lifeline will receive 880 000 calls from Australians in crisis – an increase of 30% in just two years.

I have been a director and Patron of Lifeline for eight years and was elected Chairman in 2012. I have worked to focus our professional staff, 42 centres and 11 000 volunteers on increasing the number of calls we answer through a series of initiatives including increasing our fund raising by 300% and improved systems. The most significant achievement has been aligning our diverse membership to this single objective.