THE PARLIAMENTARY JOINT STANDING COMMITTEE ON COMMUNITY DEVELOPMENT MET IN COMMITTEE ROOM 2 ON TUESDAY 10 MAY 2005

INQUIRY INTO STRATEGIES FOR THE PREVENTION OF SUICIDE

Ms WENDY QUINN, DEPUTY DIRECTOR, COMMUNITY SUPPORT, COMMUNITY, POPULATION AND RURAL HEALTH DIVISION, DEPARTMENT OF HEALTH AND HUMAN SERVICES WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR (Mr Finch) - Just some apologies. Our chair, Lin Thorp, is unable to be with us today. Some might suspect that she is celebrating her victory, but I think the truth is that she has a lot of work to do at this stage. But she will be reading this evidence. There are also apologies from Brett Whiteley and Kathryn Hay, and Brenton Best has not quite yet. But certainly this evidence, because it is recorded on *Hansard*, will be available to them. As you know, Wendy, we are at the stage now of just getting background information for our committee. You know our terms of reference?

Ms QUINN - Yes.

CHAIR - We are just looking to get the information from you as you see it about the work that you do, and we will be armed with that as we proceed. So it is over to you. You can speak for as long as you care to - you have a time limit of 10.30 - and then we will ask questions of you.

Mr MORRIS - Mr Chairman, if I may be excused. I have the Cancer Council wishing my presence at 10.30, so I will disappear in five or 10 minutes and then I will come back in a little while.

CHAIR - Okay. So, Wendy, over to you.

Ms QUINN - I will just give a little bit of information as to how I fit into suicide prevention first, and then would you like me to go through some comments in relation to the terms of reference?

CHAIR - Sure, yes, whatever, and perhaps some of your background history.

Ms QUINN - Okay. Currently, as you know, I chair the Tasmanian Suicide Prevention Steering Committee, and I have been in that role now for I think about six years. Through that time it has undergone a couple of changes in name. It was the Suicide Data Register Steering Committee -

CHAIR - It hasn't got any shorter.

Ms QUINN - No, it hasn't got any shorter, but we have changed the approach to suicide prevention rather than just on collecting data. The committee dates back to the early 1990s. I think it predates my involvement but my understanding is that it was originally formed in the early 1990s when there was a marked concern at a State government level around a marked increase in particularly the youth suicide rate. If you look at the suicide statistics in the early 1990s you will notice that there were a couple of years where we had very high rates and when you analyse the information it was mostly in the area of young people. That quite rightly caused a lot of concern across the Tasmanian community, and it was felt at the time that there was a need to, in the first instance, get a better sense of what was happening.

The information in relation to suicides, when you are using accessing information from the Australian Bureau of Statistics, is always a number of years out of date because of the lengthy period of waiting for inquest processes and confirmation. It was thought that one of the most useful things to do in the first instance was to get a number of government departments to share information and to have more up-to-date access to what was actually happening with the suicide rate, rather than having to wait for three years until the statistics found their way through the process.

The original government departments that were involved were the Department of Justice - with the coroner and the police connected to those - the Department of Education because of the youth link, and the Department of Health. They were the foundation members. There were some early agreements about the establishment of a database which is still, with a number of revisions, essentially the same information that we are collecting now. We have now more than 10 years worth of data that has been collected and that we are able to analyse.

The Tasmanian committee had some early involvement with the National Youth Suicide Prevention Strategy which commenced in about the middle 1990s, I think it was about 1995. We began to receive a small amount of funding from the Commonwealth Government that enabled us to fund some initiatives that were particularly looking at youth suicide. The committee began to provide an oversight role for use of that funding and that was where, I guess, the commencement of the role of being involved in suicide prevention began to occur.

The committee since then has had two rounds of significantly reworking its terms of reference and changing its membership. Firstly, there was a change to acknowledge the important role of suicide prevention and to have the statistical collection as a component but to begin to focus much more intently on the suicide prevention aspect. That also led to a change in the membership and the need to begin to involve some outside bodies rather than just involving State government departments.

The second major reorganisation of the terms of reference and the membership occurred in July last year and this was the one that I spoke about briefly at the forum last week. Our change there was to continue to acknowledge our need to involve an increasing array of people in line with our increased understanding that we need to approach suicide prevention as a community responsibility not just a government responsibility and to ensure that the membership of our suicide prevention steering committee reflects that. Also, we acknowledged that it is not just a Health department issue. In fact it is an issue that needs to involve a number of government departments, so we had a rejig of the

membership. There is information about the terms of reference and membership in the report that has been provided to members of the committee so I won't go through that because that is there for you to look at.

Mr WILKINSON - Were you hamstrung at all with that by way of funding or alternatively do you believe it should be even out further than you help Education and Justice?

Ms QUINN - We are hamstrung by?

Mr WILKINSON - Probably a better question is: in coming to your conclusion that it is not just a health issue, a justice issue or an education issue but the three of you should get together, do you believe it should be more of a whole-of-government approach as opposed to just those three agencies?

Ms QUINN - We do, we do believe that it needs to be broader and we now have the Department of Premier and Cabinet as a member of the committee but it is probably less an issue of funding in terms of how you manage the leadership process and more an issue of I guess trying to come up with a structure that is going to be workable in terms of the number of people that you need to engage and also the level of understanding and knowledge of the area.

Mr WILKINSON - Do you believe you have it pretty right now with the present structure that you, let us say, started since July last year?

Ms QUINN - We think it is a good next developmental step but we, as a committee, understand that we are going to need to continue to adapt it because it is still sitting largely as a health-managed issue and that should probably not be the final outcome.

Mr WILKINSON - What should be the final outcome?

Ms QUINN - The final outcome we think should be that there is an ownership of it really at a whole-of-government level so pitching it probably at a Department of Premier and Cabinet level or, alternatively, having it managed entirely from a community perspective with involvement from government. Our thinking at this stage, as a committee, is that we don't believe that we are quite ready to move to that next step so involving the Department of Premier and Cabinet was an important next step and also continuing to involve more community players was an important next step. I guess we are taking an evolutionary journey.

Mr WILKINSON - Progress - yes, okay.

Ms RITCHIE - I am looking through the make-up of the membership of the committee and there seems to be - and I am sure rightly so - lots of figures on different parts and so on but I can't see anybody on the committee that perhaps represents families who have lost people to suicide. I am just wondering if that is a consideration. I know you are looking at devolving the membership of your committee and things like that. I am just wondering why - maybe you have thought about this - there isn't anybody on the committee from that area. I understand the sensitivities of how and when people feel they can move on and be prepared to give something back after they have lost someone, and I just wonder why there isn't anybody from that area.

Ms QUINN - Well, in fact there is.

Ms RITCHIE - I just couldn't see anybody in here.

Ms QUINN - You might notice that we have three community representatives who are elected from the reference group and the reference group, which I haven't talked about yet, is the extension part of the committee and that is our mechanism for being able to involve as many people as are interested in being involved. It is like a second tier to the steering committee and we elect three of those people.

Ms RITCHIE - Is this in here? When I was looking through it initially - maybe I just haven't seen it yet - I was trying to ascertain in your annual report -

Ms QUINN - I think the dilemma with the report is that it is a report that is reflective of the work from 2002 to 2004 and the committee change that I am just describing occurred in July last year. So there is a little bit of information about that in the future directions part of the report.

What we have done is move in the direction that you are questioning and acknowledge our need to engage a broader range of people but to also ensure that we have a capacity to involve people who are working directly in the area of suicide prevention and also people who have been affected by it in a number of ways. Our reference group membership is our new mechanism for doing that. I think we are now up to about 100 members in the reference group. We essentially use an electronic form of communication, so they get an e-mailed update once a month. Last week we held our first annual forum where we invited members of the reference group and organised some speakers. We also organised some interactive sessions so that we could hear from a broader range of people what they believe the issues for Tasmania are and what should be the work plan of the steering committee.

Ms RITCHIE - Is someone from the reference group now part of the committee? Is that elected?

Ms QUINN - Yes. We now have three community representatives. Anyone who is a member of the reference group can nominate. There is a set of criteria and members of the steering committee select people from the nominees. We went through that process a number of months ago and we now have three people who are community representatives on the steering committee. They change over each 12 months. One of the people is someone whose son committed suicide a number of years ago.

Ms RITCHIE - How often do the other members of the steering committee change?

Ms QUINN - Most of them are a representative of a government department or a particular entity, so they change over when that organisation -

Ms RITCHIE - If they leave or someone replaces them or whatever?

Ms QUINN - Yes. It is up to each of the organisations to work their way through that.

We have a number of members on the committee who have been on the committee now for nearly 10 years, and that considerably adds to the continuity and the strength of it, but we also have a passing parade of people as well. It seems, as a committee, to have a reasonable balance.

Mr WILKINSON - Is there anybody in that group you have just spoken about who is experiencing suicidal behaviour?

Ms QUINN - In the reference group?

Mr WILKINSON - Yes.

Ms QUINN - In the reference group we do. Some of our members are associated with organisations like ARAFMI - the Association of Relatives and Friends of Mental Illness - and with quite a number of the organisations that provide services for people who are actively involved in the process of working with people who are currently impacted on by suicide. The membership of the reference group was, and is, left deliberately very broad. We have had some members of the community phone up as a result of newspaper articles where the reference group details have been included, and they have joined - individuals from the community who have an interest in the area. Quite a number of those have had an impact from family members. We also have organisational membership.

Mr WILKINSON - Do you believe that you now have a very broad and ideal cross-section to properly look into the issue? If you haven't, what else do you need?

Ms QUINN - We believe that we have the mechanism to create it. This was activated in July last year and it was a reasonably new concept. We continue to need to more properly communicate what it is and how people can be involved. People are scared. Often a number a the people who we need to have involved either have not heard about it yet, or need some careful explanation of what the reference group is. So they think they are being invited to join a committee, when in fact they are being invited to join a network of information which they can engage with. So we believe we have the mechanism, but we do not think we have anywhere near the level of coverage that we could achieve with it.

CHAIR - It is only in its early stages now though, isn't it.

Ms QUINN - Yes.

Mr WILKINSON - So can this committee make a recommendation? It would seem that the work you are doing and the type of groups that you have presently in train to endeavour to sort the problem out should be made more broadly known.

Ms QUINN - Yes.

Ms RITCHIE - With sharing information with the members of the reference group, I know you mentioned e-mail and that sort of thing, and obviously for those people who do not have e-mail it would be posting out things from the data base. Before the reference group evolved, how was the steering committee, in its various forms over all these years, actually interacting in getting information? Apart from collecting data about the actual

suicides that took place, how were they having any contact or discussion with people in the community?

Ms QUINN - In the community it was probably to a limited extent, and that was one of the reasons for the need to change the focus.

Ms RITCHIE - But it has been going to over 10 years, so are you saying that for 10 years or whatever they were not talking to anybody?

Ms QUINN - No, not that it was not talking to anyone. It was limited by the activities that were funded, so there were quite a number of initiatives, as you would see in the document, that have been funded now over quite a number of years, and so there was communication to a broader range of people directly through those initiatives, and there was also communication through the members and the organisations that they represent. So, for example, people who were members of, say, Mental Health Services would go back and communicate what was happening to those people, knowing that quite a number of the organisations connected to the Mental Health Service system are community-based ones. So there was communication in that way, but again we go back to the point that we do not believe we had adequate coverage or involvement, which is why we were interested in doing more.

Ms RITCHIE - And so perhaps if you were someone who did not fall into the category of the funding program - if you were someone whose older dad perhaps had suicided - you might not have perhaps received the same attention.

Ms QUINN - That is right. One of the activities that we currently have under way - and we are doing it with the assistance of the university's Department of Rural Health - is a mapping exercise and the development of another database. But it is the development of a service-oriented database, which will enable us to have a current, up-to-date set of interlinked services that are nominating that they have a suicide prevention role or aspect to the way that they provide services. With your exposure to suicide prevention, that may or may not sound like a simple exercise, but the more that we have gone into that the more that we have discovered that that is indeed a very complicated exercise, but a very important one. One of the two things that we are picking up from people around the State is that there are a lot of services out there that have a suicide prevention role as part of the way that they provide services. Secondly we were picking up that a lot of people do not know that they exist and do not know how to access those services when they need them. So we were, as a steering committee, firstly very interested in being able to get to the point where we had accessible information for people and that we could also provide that in a way that enabled people to get an easy access to that service.

Ms RITCHIE - Are you looking at places that may have not traditionally been the sort of points that you previously looked at in terms of distributing information or being liaisons for suicide prevention points like, for example, neighbourhood houses? I have had discussions with various neighbourhood houses in my area and I know that they are not seen at this point in time as a place you would necessarily go to talk to someone about suicide issues.

Ms QUINN - Yes, we are and interestingly this database firstly will be how organisations define themselves. I think that will lead inevitably to a secondary task which is how to encourage more organisations to see themselves as part of the suicide prevention agenda.

CHAIR - I am mindful of the time, Wendy.

Ms QUINN - Yes. I could go on speaking for a very long time.

CHAIR - I can tell that, I get a sense of that, so it is unfortunate that we are limited. I wanted to touch briefly on the funding. I believe that the Federal money is in question coming up perhaps in June. Can you talk to us for a moment about funding as we proceed into the future beyond June and what sort of feelings you are getting from the Federal arena in respect of ongoing funding for suicide prevention.

Ms QUINN - It relates a little bit to some of the questions that Allison was raising in that there is a need to look at suicide from a very specific funded purpose area as well as looking at it from the broader perspective in terms of a range of access to treatments and health services as well as some of the very broad population health approaches to things because if you take the full sweep, all of that is suicide prevention and so funding is actually embedded across a number of different programs.

If I talk for a moment about the suicide prevention specific funded programs, Tasmania has been part of firstly the National Youth Suicide Prevention Program and is currently part of the National Suicide Prevention Strategy. The two of the those areas are suicide prevention specific and they are both Commonwealth funded. The two areas have had funding over the last 10 years and the set of services that are outlined in the report are the particular initiatives that have been funded with that source of funding.

That funding has given Tasmania - it has varied from year to year because of the way that the funding comes through - somewhere between half a million and a million dollars worth of funding in any one calendar year, supporting those very specific projects. They were all designed to be time limited and they were all designed to be, if you like, funding that was seeding a program. They were never intended under the guidelines to require ongoing funding, and that is the usual way that we interact and obtain Commonwealth funding for quite a number of the programs that we do.

Of course our reality ends up being a little bit different to that. We have been in the situation where the State Government has been required or we believe that we have needed to advocate for ongoing funding for some of those program areas. We have had three of the projects where we have ended up finding a way to fund them with State government funding.

We also have another, I guess, set of these programs that are due to be completed over the next 12 months and we need to make another set of decisions about how we continue to provide those sorts of services into the future. There is little information coming through from the Australian Government about commitment to any further funding of a national suicide prevention strategy and even less information about, if there is a commitment, what it would look like. That means that Tasmania is in the same situation as every other jurisdiction, but it also means that we are placed in a situation where it is difficult to plan what we might do with access to any Commonwealth funding.

Our State government funding, our suicide-prevention-specific funding, has been relatively limited but that is not to say that there isn't a range of funding going into general health and community services and population health-based approaches that does not support the whole agenda.

CHAIR - Wendy, just looking at the time we will need to conclude there.

Mr WILKINSON - Can I ask whether you or the committee that you run are going to make submissions in relation to the terms of reference?

Ms QUINN - We are.

Mr WILKINSON - Because it seems obvious to me that we need to speak with you at length at some other stage for a lot longer than half an hour, to get down to a couple of issues.

Ms QUINN - I feel like I have only just begun.

Mr WILKINSON - So do we. That is good.

Ms QUINN - I am more than happy.

CHAIR - Wendy, thank you very much for your time today. Is there anything you would like to conclude with?

Ms QUINN - The area that I have the most current concern about is the area of 24 to 45-year-old men, who last year took up almost half of the statistics in terms of the suicides in this State. It is an area where we really have very little information about what is going on for these men and how to access them in terms of prevention programs. We know that our early awareness, and some of the research is indicating, that it is a group of people who don't normally access health services in the same way that older people or younger people or women do. We believe that the workplaces are probably a really important part of that.

I just wanted to leave that with you in a tantalising way for your further consideration. I am more than happy to engage with the committee in any way that might assist.

CHAIR - Thank you very much, Wendy, for your time today.

THE WITNESS WITHDREW.

Ms AMANDA STEVENS, EXECUTIVE OFFICER, TASMANIAN ASSOCIATION FOR MENTAL HEALTH WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - Thanks very much, Amanda, for joining us here today and giving up your time. Have you seen our terms of reference?

Ms STEVENS - I have, yes.

CHAIR - Okay. We will be interested to hear something about the Association for Mental Health and your connection to it. We have 20 to 25 minutes, so if you would care to talk and then we will ask some questions.

Mr WILKINSON - Amanda received a prize in November, for the work that she's done.

Ms STEVENS - I'm going to talk about that, don't worry.

The Tasmanian Association for Mental Health has been in existence for approximately 20 years. It is an incorporated not-for-profit organisation that has GDS status and is a statewide organisation running lots of different types of projects. From the annual report, you'll probably be able to see that the Tasmanian Association for Mental Health has run three projects under the National Suicide Prevention Strategy, the first one being a pilot which was called Chance Camps which was a camp for children whose parents have a mental illness. These children are at a high risk of attempting and completing suicide. Well research-based evidence that says that they are at a high risk because of isolation, because of carers at a young age, because of developing an illness themselves.

Mr WILKINSON - So these are children, Amanda, who have parents who -

Ms STEVENS - With a diagnosed mental illness, yes.

The camps run in two age groups, from 7 to 12, and from 13 to 17. For that particular pilot, there were four camps run, two in each age group. The camps were ideally a type based on adventure, fun sort of weekends to really take the kids away and alleviate some of the stress and isolation that they all felt, and to form some friendships and some community with not only the children but the parents as well.

That pilot was highly successful and, as you are probably aware, the Department of Premier and Cabinet's Social Projects Unit a couple of years later came up with the Kids in Mind Project which is a whole heap of funded jobs between the government and non-government sector with these groups of children in mind. So we are able to fund more camps and get a coordinator for the south and the north, north-west to run camps, and also run a program called Tas Kids Clubs which is like an after-school program which runs differently from the camps. The clubs are aimed at providing age-appropriate information to the children about the illnesses and also strategies to help them deal with their own stress levels surrounding those types of families and situations.

So, as you can see, they are programs that we run that we see as suicide prevention programs.

CHAIR - Just a question on the camps, the parents don't go away with their children?

Ms STEVENS - No, they don't. It is seen as respite, respite for the parents and respite for the children, however we do try to invite a parent, if they so wish, to be part of a volunteer team. They can attend a camp where they don't have children at that camp, so it's a way of getting well parents to interact with the project. We find that has a benefit, not only to the children but to the parents in staying well and being a part of a project that obviously helps them. We have had comments from parents saying it is helping them to stay well: 'I feel involved with the children. I didn't realise that this was affecting my children so much'. There is a group of them now getting together to do their own fundraising, so not only did we intend that it would help the children but we have actually helped the family unit.

Mr BEST - Through you, Mr Chair, I might have misheard this. DGR status?

Ms STEVENS - Gift Deductible Status. It just means that we are registered as a charitable organisation.

Mr BEST - Right. I'm sorry, I thought that might have been something else.

Ms STEVENS - It is just the tax lingo. Sorry, I probably should have said charity.

Mr BEST - No, that is fine. In relation to children who are high-risk, you mentioned isolation. You said 'young carers'.

Ms STEVENS - They are in some families young carers. You might get an 11-year-old boy or girl - it might be a single-family environment or it might not be; it might be two parents. If either parent goes to work full-time then you have a child who takes on, to a certain extent, a caring role for that person. So they might miss out on school events, they might not do anything in the weekend because they feel that there is an obligation there to help mum or dad out when they are unwell. When either mum or dad are unwell, especially if there is a psychosis or some sort of bipolar disorder, the normal functioning of a family like cleaning, household chores, washing up and cooking meals, tends to be the thing they let go of first because they are trying to keep themselves well. You will find that a lot of children step up into those roles of making sure that the lunches are packed for the other siblings or that tea is prepared. They are only small things but that's a lot of pressure for a young child to have.

Mr BEST - It is. I suppose we are talking here about young children who may feel the pressure and a bit of depression because of that?

Ms STEVENS - Yes. That is why they are at that higher risk. If they are not engaging in school activities or making friends outside the family environment, there is a sense of isolation. It depends who has the illness. Let us say, for example, mum has the illness. If she is spending a long time of unwellness, there is a sense of 'Is this my fault? What have I done?', so that children often do present with early signs of depression and a general sense of isolation. I am a camp leader at the camps and the kids always say, 'I'm so glad to meet other kids who are going through the same sorts of things'. The kids come from different walks of life, different financial backgrounds, and it is very

interesting. It has been hard to have kids like that from a lower socioeconomic group and kids who are quite well off, and we have had to manage that. You get all the normal teen camp antics and things like that. We have to educate about where we are going to hold the camp because if you tell these camp people that we are bringing children along because parents have a mental illness, they make an assumption that these kids are either really naughty or are going to wreck the place. They make an assumption that the kids are already really dysfunctional, and that is not the case at all. We find their behaviour just like that in any other type of school camp. You are taking kids away from their family, they are going to have heaps of fun and be a bit naughty and they are going to push all the boundaries.

Mr BEST - The camps are a wonderful thing, aren't they, in getting out of that environment and getting rid of a bit of stress. What about when the kids are in that environment in that it is some time between a camp?

Ms STEVENS - That is where we have the Taskids Club. We try to run them in between camps, but it doesn't always work out like that. It is a bit confusing in that the Champs Camps and the Taskids Club are two separate projects in the south and they are combined in the north, north-west. That is because of funding opportunities. Some projects are funded from this pot of money and other projects are funded from that pot of money. But under the Kids in Mind social project units we are trying to bring them all under the one pot of money so they can all be evaluated at June 2006. The Premier's department has made a commitment that if the projects are successful and are externally evaluated, they will become part of mainstream funding.

Mr BEST - If someone between these age groups of 7 to 12 or perhaps even more so, 13, 14 or 15, is very withdrawn and very down because of the isolation, what is the main way that you can support someone like that or how can you bring them out of that?

Ms STEVENS - Well, in that age group we actually only have the camps, which is very limited. On the mainland they have a program called PATS, Paying Attention To Self, which exactly like the Taskids Club but it is for that older teenage group, say, 13 to 17, and that is a peer support group; they go and do things between camps.

Mr BEST - But they don't have anyone they can talk to, do they then?

Ms STEVENS - No. We work really closely with the youth centres like Youth Ark, the one out of Glenorchy, and the The Link. We actually have a staff member of The Link who sits on our management committee, so we have representation from lots of different areas in the community.

I suppose one of the things that helps us run this project is that the Tasmanian Association for Mental Health itself has a statewide freecall number that people can ring and get any information about mental health or any sort of referrals. We get calls from parents, students, all sorts of people wanting to know what is in their area. That is not specifically anything to do with the Champs Camps or the Taskids Club. It is general; we call it the mental health information line.

CHAIR - It's a 1800 number?

Ms STEVENS - It is a 1800 number. Sometimes we get hold of kids through that. We are a whole-of-population-focused organisation so we tend not to specifically concentrate on any age group. However, we do run projects that are sometimes age specific, therefore we have a tendency to attend the youth expos, but we also attend the seniors expos and we also attend the more generic health expos as well. We like to cover all our bases.

Mr WILKINSON - Which state does it the best?

Ms STEVENS- Suicide prevention?

Mr WILKINSON - Yes.

Ms STEVENS - I have not thought about that.

Mr WILKINSON - Obviously people have endeavoured to work out the best methods of suicide prevention and have the best projects in place, so if you were looking at that State what do you think it would be?

Ms STEVENS - It would probably be a toss up between Western Australia and New south Wales.

CHAIR - Are we going okay?

Ms STEVENS - I think we are. I might get on to talking about the other projects that we have run. We got funding under the NSPS to do a suicide bereavement kit -

Mr WILKINSON - I know that is what you got the prize for, but in relation to the terms of reference are you putting in a submission to that?

Ms STEVENS - Yes, we are, to that. It is actually quite lengthy because I have done State by State comparisons and things like that as well. I have collated a lot of data that we had sitting from our consultations over the years and I have tried to pull some of that into the report for you guys as well.

Mr WILKINSON - Okay, great.

Ms STEVENS - Tasmania is not doing a fantastic job but we are doing what we can with the limited resources that we have.

Mr WILKINSON - So how can we do it better?

Ms STEVENS - I am concerned that the focus has to be whole of population, with certain organisations and non-government organisations in that whole of population doing specific projects. I think if you lose the whole-of-population focus and concentrate on particular men or youth, then another area falls down. I think you have to keep the focus on whole-of-population. I think that your suicide projects need to be not based on the individual who you are trying to help but on the whole-of-family because I think in doing whole-of-family you will actually pick up information about why the 25- to 44-year age group is a problem. There is lots of research to say that these men are more successful because of the method that they choose, but why are they doing it? I think that age group

will be really hard to tap into. We know that. Do we do it through the workplace or do we actually do it through families? Do we do it with a two-pronged approach and come in through the family and through the workplace? I don't know. We have some really big construction businesses at the moment - Fairbrothers, Vos - and surely they would have an interest in saving employees.

Mr WILKINSON - So we shouldn't be just identifying or focussing on a certain group. It should be a whole-of-community approach, rather than identifying the individual person who has tried suicide or completed a suicide. We should be looking at the families that they come from and trying to sort out the reasons why they may have attempted suicide or actually been successful.

Ms STEVENS - Yes, and different access. Let us use our Neighbourhood Houses or let us offer the licensee of local rural pubs a course in suicide prevention. Obviously these men are going to go to pubs. Why can't we offer bar staff some prevention and assistance training.

Mr BEST - I just want to make one quick comment. It is relevant because it is in relation to Pit Stop. I was involved with the launching of that up on the north-west coast and I thought, 'This is going to be very interesting'. I thought you might get some men who will participate but at the Penguin market and in a couple of other places the blokes just lined up left, right and centre to go through it. I couldn't believe it about people who I thought would normally have no interest whatsoever in their health. So I think some of the things that you are kicking around here are quite relevant, like the thing about the pub. You might be surprised exactly how many people, if it is pitched right, might use something like that.

Ms STEVENS - You will get a lot of people who disagree with that because they will say that it is not an appropriate environment. It is an environment where the problem might exist with either alcohol, pokies or whatever, but if it is a location where you can get people to go then that surely should outweigh -

Mr WILKINSON - Not only that, it is where people are most likely to talk, isn't it? Often, if you have a couple of drinks, whatever they might be, you are more willing to talk than otherwise because you are not suppressing it but you are willing to get it out there.

Ms RITCHIE - I think that is really important in relation to looking at other alternatives. I think for some groups perhaps the traditional view, that you take your sick or unwell relative to the hospital for treatment, isn't working for everybody. You read the letters saying that we took our brother or whatever to hospital fives times but he didn't get well, so clearly I think we have to look at those other things.

My question was harking back in relation to the numbers of the programs that ran for the children. How do you actually find them and do you think there is a whole lot more out there that we don't know about that you are not seeing? I am sure there are.

Ms STEVENS - Yes.

Ms RITCHIE - How are they identified and how do they get to you?

Ms STEVENS - That is something that we struggle with all the time. We are in contact with the Division of GPs. We are in contact now with the new school structure.

Ms RITCHIE - With the clusters?

Ms STEVENS - With the clusters. We get referrals from the schools. We get referrals from Adult Mental Health teams. We are trying now to go to the private hospitals, such as Hobart Clinic and St Helen's, which have psychiatric units, to identify the adults and ask them about their children.

Ms RITCHIE - That was going to be my next question. Once, say, a school refers some information to you about a child that they are worried about who presents with identifiable problems, but when you go to the parent maybe you meet with some resistance. What happens there? Do you find that is a real problem when you are actually trying to get in there to perhaps help the family unit as a whole?

Ms STEVENS - No, there has been no resistance to the camps or the clubs. We always meet with the parents and with the child before they actually go to a club or on a camp, and we have not actually found any resistance to that.

Ms RITCHIE - Are many of the children coming from a family where there is just one parent and that parent has the illness?

Ms STEVENS - Yes.

Ms RITCHIE - And, where there are two parents, do you find that maybe the parent that is well says, 'No, there is nothing wrong with our family, thanks very much', or that sort of thing?

Ms STEVENS - We have not come across any referrals as yet that have brought up that problem. Obviously you still have to have a permission slip from a parent. We have not had that problem so we do not have strategies in place as to how we might deal with that. Even if the parent is unwell and they have not signed the permission slip, you still cannot remove the child to come on camp.

Ms RITCHIE - No. I was just thinking in terms of the first contacts that you might make from any referral - I presume that the school does not necessarily have to have told the parent they referred some information about a child, or do they?

Ms STEVENS - Yes, they do.

Ms RITCHIE - They do. So the school then might be the place of frustration, or whoever is identifying that we think this person might need something?

Ms STEVENS - Most of the time the project officers of the camps or the clubs and the teacher are all working together in communication with the family, and it is about providing information about what the clubs are about. It is about telling them that it is a respite opportunity as well, and most parents are relieved to take up that opportunity. The clubs are a bit different in that we have had comments from some parents saying 'I don't think my illness affects my children', and then the project officers just leave

information about how and why it does, and things like that. Most parents come around and say, 'well, I will let them go this time', and when the child comes back and there are obviously improvements in their behaviour or their understanding, then the parents are really supportive of it. Probably a lot of parents are a bit dubious about it the first time, but when the kids return home and there is obviously a marked difference, then they think this is a good thing.

Ms RITCHIE - Just finally, how many numbers are you talking about at the moment that you have participating in the camps and things?

Ms STEVENS - There are 15 places in each of the camps, and they are normally full. In Taskids Club there are eight places, and they are running at about five in the club, so they are not actually running at capacity yet. But we are looking at ways to try to identify the hidden children. I suppose I am specifically interested in this program because since I was 13 I have been a child of a parent with a mental illness, and our family would never have identified to the school or any health system that there was an issue in our family. I am sure I am not the only person who was like that. So we are trying to identify ways of finding those kids by fliers are school, or going in and doing some education with the parents and friends associations and things like that. So we are just looking at other avenues to try to get -

Ms RITCHIE - And also, I suppose, get perhaps some of the parents to engage because you need that before you can actually, in most cases involve the -

Ms STEVENS - It depends what group of the community you are looking at. We see the lower socioeconomic families accessing all the health that they can so they are easy to identify. The children are easy to identify and the parents have a tendency to accept all the camps and clubs and any type of help they can.

If you are talking about middle to upper class, where people still get mental illness, there is a lot more of 'This stays in our family, this is our problem, this is our business'. They are accessing the private system, they are accessing their local GPs so they are not as identifiable. Because they are not as identifiable, it is harder to educate the adults about mental illness because of the stigma that is associated with it.

CHAIR - Amanda, I am really conscious of the time, our next people are waiting to come in.

Ms STEVENS - There are two things that I really want to say. The focus has to be whole of community and inter-agency, not just mental health. It has to come from education, health and justice - it has to be a broad thing.

I have left some brochures about what we do. I will leave the bereavement kit.

CHAIR - Thank you. You mentioned something about a report when you first started.

Ms STEVENS - Yes. I will talk about the report, everything about this and everything about all our projects in the submission that I will give you.

This started off as a suicide bereavement kit specifically focused on helping families and communities after a suicide bereavement, but after our community consultations we had

to go back to the funding body and talk to them about changing the focus to looking at all facets of bereavement. So we came up with the Tasmanian Community Bereavement Support Kit which won an award.

Also we are currently - and it will finish at the end of this month - looking at an Aboriginal suicide prevention package as well.

CHAIR - Amanda, you will be putting recommendations in your submission to us, won't you?

Ms STEVENS - I certainly will.

CHAIR - We thank you very much for your time today. That was far too interesting and I am sure we could have kept going right up to lunch time. Thanks very much, Amanda.

THE WITNESS WITHDREW.

Mr JIM CONNOLLY, ADMINISTRATOR OF COURTS, MAGISTRATES COURT OF TASMANIA AND **Ms JENNY SCOTT**, MAGISTRATES COURT CLERK - CORONER'S OFFICE WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - Jim and Jenny, thanks very much for joining today. Apologies from our Chair, Lin Thorp, who is not able to be with us today and also Kate Hay, Brett Whiteley and Tim Morriss are apologies as well - nothing personal!

I hope you understand that we are information gathering at the moment for our terms of reference. The time is available to you if you now would care to make a presentation to us and the members present will have some questions for you.

Mr CONNOLLY - Just for the record my position is Administrator of Courts, Magistrates Court of Tasmania, with statewide responsibility. The Magistrates Court of Tasmania is divided into a number of divisions representing the jurisdictions that it exercises. One of those divisions is the Coronial Division, colloquially known as the coroners office, and one of the statutory positions I hold is Chief Clerk of the Coronial Division apparently, which is a statutory position under the Coroners Act 1995 which commenced in 1997 and replaced the Coroners Act 1957. Under the new legislation the coronial jurisdiction is exercised almost exclusively by magistrates who are, by virtue of their position as magistrates, ex officio coroners as well.

The chief magistrate is the head of the coronial jurisdiction in Tasmania and there are a number of magistrates/coroners who exercise the coronial jurisdiction because they have a particular interest in the subject matter or they have a particular expertise that they can bring to the coronial investigation process.

In the north of the State, the coroners are predominantly Peter Wilson, based in Launceston, and Don Jones, based in Burnie. In the south of the State, Magistrate Ian Matterson and Magistrate Olivia McTaggart exercise the coronial jurisdiction predominantly in the south. If there is some particular case that comes before them in which they are uncomfortable or they feel they should disqualify themselves then on occasions some of the other magistrates will pick up some of those coronial cases, but the general rule is that those four coroners that I have mentioned exercise the coronial function.

Under the 1957 Coroners Act the coronial function was also exercised by quite a number of what we call lay coroners who are not magistrates but with the new legislation a policy decision was taken that magistrates who are coroners are more experienced and better placed to conduct the coronial function. I just point out here as well that in the community there is a general perception that all coronial cases proceed to a public inquest. That is not the case, in fact a relatively small proportion - I would say it would probably be somewhere around the 5per cent mark - of total deaths reported to the coroner actually proceed to a public inquest. The other 95 per cent are finalised by way of what we call chambers findings where the death is investigated and affidavits and other documentary evidence is obtained by the coroner's staff and the matter is then considered by the coroner in chambers to see whether it needs to go to a public inquest or

not and, if not, it is finalised by way of chambers findings, and predominantly all suicide deaths are finalised by way of a chambers finding.

There are exceptions where an inquest must be held and in the Coroners Act where a person dies if they are in a prison, remand centre, police watchhouse, even in a police vehicle pursuit, they are deemed to be persons in custody and because of the vulnerable nature of those people who don't have control over their own fate and their fate is determined by the State at the time, their death, then the policy is that there must be a public inquest to reassure the community that the State is not abusing its powers. There are also mandatory inquests required where people are held in care. That means that under the Mental Health Act, they are held in a facility as involuntary patients, and that sort of thing. Again, because they are vulnerable members of the community, public interest is considered appropriate because the community has to be confident that there's been no misadventure or criminal conduct involved in reporting the death of someone in that vulnerable class of members of the community.

Mr BEST - Just in relation to the chamber findings, and obviously the need to go to a public inquest, what you are saying is unless there are some exceptional circumstances, nine times out of 10, basically, without using statistical figures you are looking at a chamber finding. I am not quite sure who might be involved, but I think you mentioned there would be some staff and perhaps some magistrates people involved in that chamber finding. Do you think there's a role for magistrates in progressing suicide prevention? Do you think there is anything that they could offer, do you think?

Mr CONNOLLY - Absolutely. That is one of the or probably the major objective of the jurisdictions. It is what we call a preventative jurisdiction, and it is intended to prevent future deaths occurring. There is a motto for the Victorian Coroners Court that a lot of coronial jurisdictions have adopted, and that is you learn the lessons from the dead to protect the living. That's predominantly why there would be a public inquest to ventilate issues in the public arena that can be of benefit for the community in changing systems, product design, all sorts of processes that have far-reaching impact.

That's the major reason for the coronial jurisdiction, and if you have a look at any of the coroner's findings - and we publish them on our magistrates court web site - you will find that the coroner is required, under the Coroners Act, to find out who died, when they died and why they died. But they are also invited then to make recommendations. So you have findings about certain matters of fact, and then you have recommendations as to how systems or product design, or whatever the issue is, may be improved in future to avoid further deaths.

Mr WILKINSON - A typical example of that, Jim, would be the deaths in custody with the hanging points.

Mr CONNOLLY - Absolutely, yes, and in fact just last week, which is particularly appropriate for this committee, one of our coroners, Rod Chandler, handed down findings into two deaths that occurred by way of suicide of patients who were in the Department of Psychological Medicine at the Royal Hobart Hospital. There were some very tragic cases where one woman suicided by jumping off the Tasman Bridge, and another woman suicided by jumping off the Argyle Street car park. His findings amounted to 16 pages, and he makes recommendations about procedures for the

management of patients in the Department of Psychological Medicine. So there is definitely a role for the coronial jurisdiction to play.

Mr BEST - Can I just go one step further, then, and say that the committee has heard about the high-risk group being males - not excluding other people, obviously, but there are some higher risk groups than others - who are aged 25 to 44 years. Is there anything in particular that you might have on file in relation to that, or is it too general for you to comment?

Mr CONNOLLY - No, it's not too general. I don't have that information to give it to you here -

Mr BEST - No, I wasn't asking for it today so much.

Mr CONNOLLY - but I was going to also mention to you that I think almost five years ago now we implemented a new coronial case management system, an IT system, in Tasmania which has an interface and uploads data into the National Coroners Information System. I do not know if you are aware of that -

Mr BEST - No.

Mr CONNOLLY - but it is a relatively new development. It is the first one in the world where there is a single database of all coronial cases that is accessible electronically. It is used as a research tool by coroners, pathologists, injury and death prevention organisations, anyone from motor vehicle manufacturers associations to the Royal Surf Lifesaving Association. It is managed in Melbourne by the Victorian Institute of Forensic Medicine, and I think all jurisdictions in Australia now participate and contribute data to that, so it is a very valuable database, and both the national one and the Tasmanian one that I mentioned that we implemented can now be electronically searched and we can put search parameters in there to give the method to spot potential suicide. If you wanted males between certain ages, we could give you information about the mechanism of death, whether it was by hanging, carbon monoxide poisoning, the various mechanisms by which people unfortunately take their own lives, and it is all available in the coroners office.

Mr BEST - What about preventative measures then?

Mr CONNOLLY - Regarding the preventative measures, coroners themselves cannot enforce their recommendations. Once they hand down their findings and recommendations on a particular death - because that is what they are and they must focus on a particular death - they are functus officio, so they have no power to enforce anything from there. And that is why we publish these findings, selected findings, in the media and on our web site, as a way of putting into the public arena the recommendations. If they just sat on a file they would not achieve much, and then it is really up to government and Parliament and anyone in the public forum to make submissions.

CHAIR - Jim, I just want to ask a question specific to that. You say you publish the findings on a web site. Is that all the coronial inquiries, all the deaths?

Mr CONNOLLY - No, it is only the ones where we consider there is an issue of public importance. We do not think it is appropriate, for example, in a lot of, say, the suicide deaths to publish those because that is traumatic for the family and friends.

CHAIR - But that will be going to your database?

Mr CONNOLLY - Yes, it is definitely all captured in the database, but we only publish from that the types of matters that I have just mentioned, and we do take our responsibility pretty seriously about taking into account the views of family and friends of the deceased. It is obviously a very traumatic experience for anyone to go through, and to have details published in some public forum can be very disturbing to some people.

Mr WILKINSON - When you go through your annual report, you have here the inquest and investigation, self-inflicted, completed during 2003-04, with the hangings close to 30, carbon monoxide, drug overdose et cetera. What is not in those reports, though, is the age groups, which could be useful for this committee. Would we be able, by just asking you if necessary, to access the age groups -

Mr CONNOLLY - Certainly.

Mr WILKINSON - regions, sexes?

Mr CONNOLLY - Yes, we could tell you down to suburb, or whether they are left-handed or right-handed. Not quite that but it is a very rich database that captures a lot of information. We also receive the police report-of-death form because the police are usually the first persons on the scene. We get that electronically and we get autopsy and toxicology reports electronically that are loaded into that database. There is lots of information there.

When you mentioned our annual report of 2003-04, we did not publish as much information in that as in previous annual reports. The feedback that we have had since we published that annual report is that people would prefer that we put more detail than we had in the previous edition. Following the current financial year's annual report, when that is produced, we will be reverting back to the more detailed information. If you want even more detailed information, it is available. I will provide you with a pamphlet that describes generally the National Coroners Information System. We don't have one for our local Tasmanian coronial case-management system. This was an initiative of the Australasian Coroners' Society. I think it started as a concept in the early 1990s and was gradually designed and built. It has had some funding difficulties because it is intended eventually to be self-funding. Organisations pay a fee to get access to the database for a particular subject matter. It is very much subject to ethics committee rules about access to identified or de-identified information. There are a number of security levels and it is a very good system.

Mr MORRIS - Coming back to your recommendations. Once a recommendation is made it is basically in the public arena and that is the end of it as far as the coroner is concerned, isn't it?

Mr CONNOLLY - Yes.

Mr MORRIS - So there is no-one who has the responsibility to track those recommendations or to see what becomes of them?

Mr CONNOLLY - No, not within the Coronial Division because, as I mentioned, our function is finished. We publish them in the media and on our web site.

I should have introduced Jenny Scott. She is the coroner's clerk, based in Hobart. She is a Department of Justice employee and has a wealth of experience in the coronial jurisdiction since way before my time. I won't ask her to say when, but I have only been involved in it for the last seven years or so. Jenny manages the Coroner's Office administration, basically. The staff who assist the coroners on the individual cases are seconded police officers. We have had two FTEs in the south - police officers - and two FTEs in the north. The Coroner's Office is in both Hobart and Launceston. One of Jenny's roles is that, when these matters are completed, if there is an issue that is relevant to a particular government agency or organisation or even to the private sector, she will send a copy that is directed to those agencies. It says, 'Here are the coroner's findings and recommendations for your information and for whatever action you deem appropriate'. An example of the coronial findings that have been directed to private-sector organisations is deaths where one of the causes or the sole cause of death is the prescription and administration of some form of therapeutic drug. That would be sent to the Australian Medical Association, the divisions of general practice and that sort of thing.

In the AMA journal and the Provisions of General Practice newsletter we ask them to publish issues that we feel are important to us. There is one case that I can recall not so long ago about insulin dependent diabetics and the management of those people. With the Department of Psychological Medicine in the Royal Hobart Hospital that goes to the Health department but if it is a topical issue and the media are interested in it, it gets into the public forum that way.

Mr MORRIS - That is the one I wanted to come to in relation to this issue. The political response that came from that, which was generally very good, was that most of the recommendations have already been picked up and are being implemented. It was the 'most' bit that worried me and that said to me that there was at least one recommendation which was not being picked up and acted upon. It just seemed to me that there really is perhaps some sort of responsibility for the Health department to explain at least back to the coroner as to why a particular recommendation was not picked up and in terms of completing the loop, it just seems that there is still that gap. The political response was generally appropriate but it has still left a little gap there that should be filled, in my opinion. If nine-tenths of every set of recommendations are picked up that is fantastic but if there is still one-tenth of them that are not picked up, I think there needs to be an explanation as to why. Can you just comment on that?

Mr CONNOLLY - Sure. In discussions that I have had, particularly with government agencies that have been the subject of certain recommendations, the feedback on some of the recommendations are that either they do not agree with the recommendation because of circumstances, technology processes or whatever have moved on since the death and have been overtaken by other means of addressing that risk. On occasions, some of these recommendations can be very expensive to implement and I think it would be naive if we didn't acknowledge that but I suppose with the role of governmment these days, with

everything we do we do a cost-benefit analysis and a risk assessment and work out whether it is feasible to do.

The other thing that I think you should bear in mind is that whilst coroners do their best to investigate a matter as best as they can they are always, by definition, one step removed. They have to be impartial but they don't always have the depth of knowledge, try as they might, of the subject matter that other people involved in that subject matter do have and so I think it is natural to expect that you will get some disagreements on occasions to the recommendations that coroners make. Of 10 recommendations they might say nine are feasible, they are well founded and we can afford them.

Mr WILKINSON - Just quickly, Jim, I noticed too when we are looking at stats and looking at numbers, the inquests and investigations from motor vehicle fatalities are in a separate area - driver, passenger, motorcycle, pedestrian and bicycle - and they are not in the self-inflicted suicides, I take it. Is that saying that all of the driver-involved accidents have been not classed as suicide? It seems to me to be.

Mr CONNOLLY - That would be correct.

Mr WILKINSON - Therefore if we wanted to have a look at those, because there are some arguments that people who drive up a highway into a tree, for example, may well be suicides, we can access that type of information as well?

Mr CONNOLLY - The information is there for bona fide research purposes. We do attach conditions to access to that data in the database for researchers to ensure that only D identified information is published, that sort of thing.

Mr WILKINSON - Is there any comment that the coroner puts cause of death questionable or something along those lines? In all of those, as he said, cause of death may be questionable?

Ms SCOTT - There are different ways that he can actually classify it. He may say 'by misadventure' or 'there is insufficient evidence to say that he took his own life' or 'I leave the finding open'. It depends. There is still a lot of stigma attached to suicide in findings. The coroner has to have the evidence there to make that finding of suicide and in most single motor vehicle accidents that maybe deemed to be a suicide the coroner just cannot find the evidence.

Mr CONNOLLY - Usually prior to his or her conclusion, if it is the case that the deceased previously suffered from episodes of some sort of mental illness of whatever category and steps out the events leading up to the fatal event, the findings will be left open.

Mr WILKINSON - So therefore if we looked at those driver deaths and motor cycle deaths, we would be able, by looking at the finding and what the coroner said, to get some indication of whether it is a question mark at the end or, alternatively, when it is obviously a motor vehicle accident.

Mr CONNOLLY - The most clear-cut case would be if there was a suicide note that had been left saying, 'I'm going to commit suicide', but in the cases where the deaths had been reported to us - and we get on average about 600 deaths per year reported to the

coroner - quite a number of those, although they are reported to the coroner because they are reported to the police and they appear to be sudden and unnatural deaths, if the deceased's medical practitioner subsequently in the next 48 hours is prepared to issue a certificate saying that this was a natural death then they are excluded from the caseload of reported deaths. If the GP is not prepared to certify that then the next stage is that the coroner decides that an autopsy is required. If so, and the body of deceased is still under the control of the coroner, the coroner then directs the relevant forensic pathologist to conduct an autopsy. Then we get a preliminary report back from the forensic pathologist saying the deceased died from such and such. That enables the body to be released prior to burial or cremation and then we subsequently receive a formal full report from the forensic pathologist that goes through the autopsy in fairly great detail.

Mr WILKINSON - And finally in relation to those statistics for drownings and jumps, is jumping from the Tasman Bridge classed as a drowning or a jump?

Ms SCOTT - It depends what the pathologist actually finds. The coroner may find that a fall from the Tasman Bridge is a drowning or he may find that it is multiple injuries. In one case back in 1987 the coroner found that someone actually fell from the Tasman Bridge, but the numbers are extremely small.

Mr CONNOLLY - While you are counting those, in the case of Samantha Brown, Coroner Chandler handed his findings down last week that death was caused by jumping from the middle span of the Tasman Bridge. The coroner makes comments, for example, about better procedures for managing the patients in DPM and better liaison between DPM staff and Tasmania Police once DPM realised that a patient was unaccounted for. There's also a recommendation in there about even a design change to the pedestrian walk on the bridge to make it more difficult for people to suicide by that means. Everyone knows colloquially that jumping off the Tasman Bridge is a common way to express suicidal thoughts.

CHAIR - Were you checking numbers, then, Jenny?

Ms SCOTT - Yes, I was. Since 1982 there have been 32, and a couple of those people have not been found. Another myth is that it will be successful, but earlier this year someone did actually survive from the jump, and their partner died as the result of that jump. So there were two.

CHAIR - I am cognisant of the time. Are there any thoughts you would like to leave us with at this stage, Jim, or have you covered everything?

Mr CONNOLLY - Just to, I suppose, emphasise the fact that we do have a very rich database that may be of use to your deliberations.

CHAIR - How do we access that?

Mr CONNOLLY - Contact either Jenny Scott or myself. It may be that one of your staff could come to the Coronial Division and look at the database to see the sort of data that we capture. Then that person could advise the committee about some ways forward, or some areas that we might want to investigate in further detail.

CHAIR - Great, thanks very much for that. I am very pleased to hear that people are actually reading your annual report.

Mr CONNOLLY - I was gratified, with the effort that goes into preparing it. Anyway, again our web site is www.courts.tas.gov.au/magistrate. There is a lot of useful information on there. All our annual reports are published on there, and also the coronial findings that we do publish are also available on that web site.

Ms SCOTT - And the court list for upcoming inquests.

Mr CONNOLLY - The court list for upcoming inquests as well. So I will leave that NCIS pamphlet for you, and there's any further information you need, please contact us.

CHAIR - Jim and Jenny, thank you very much.

THE WITNESS WITHDREW

Ms CONSTANCE ALOMES, MANAGER, LIFELINE HOBART INC., WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR (Mr Finch) - Thank you very much for coming alone, Constance. We are just gathering information at this stage to address our terms of reference. We will hand over to you to tell us about Lifeline and the work you do and then we will chip in with questions.

Ms ALOMES - Thank you very much for the invitation to come along. It just struck me, as I was listening to the previous presentation, that what we are dealing with at Lifeline are the people who are still alive and the people who have issues with self-harm. I will tell you how we try to deal with that.

I have been involved with Lifeline for 15 years and I am the service director, which means I manage all the services of Lifeline. The core service of Lifeline is the 24-hour telephone counselling service. There are other services, such as visiting services and victims-of-crime services, but Lifeline is primarily a 24-hour telephone counselling service that operates all through Tasmania.

I will be talking today about the role of the Lifeline telephone counselling service and suicide prevention. Obviously we deal with a lot of other issues that people have when they ring us. However, although the percentage of calls we get about self-harm is small compared to others, it is one of the most high priority things that we do. I will talk a little bit about the scope of the TC service and how it responds to suicide prevention. I will also talk about the data collections that we use. Unfortunately, because we are a non-government organisation and our IT is not very sophisticated, we are right now involved in a recovery of all the data for the last 18 months, so I don't have the stats to bring to you today. I am hoping, if you are interested, that I can forward those on to you. I will talk a little bit about what we are collecting because I think it is quite significant in terms of the whole issue of suicide prevention. It gives a good caller profile about who is struggling with those issues of self-harm. I will make a very brief statement too about the role of the media in suicide prevention and about some other more proactive responses that we are considering at Lifeline so that we can not just be reactive to the people who are at risk of self-harm but also be doing more proactive things with the volunteer force that we have.

Just a word about Lifeline so you can put that into context. We are part of a national grid of 45 centres. We are a non-profit, independently incorporated community-based organisation. The majority of our work force are trained and supervised volunteers, backed up by paid professional staff who have qualifications in psychology, welfare, counselling et cetera. In Hobart we have been going for over 32 years. If you look at our service in general, what we are trying to do is provide a safety net and support to people who are struggling with a huge range of issues. They can be relationship problems, family violence, grief, acute emotional distress, anxiety and depression, and of course suicide risk. We operate 24 hours a day and we are in the unique position, because of that, to produce a really rapid response to callers. Many of our callers call after hours and also on weekends. Demand for the service is very high then, as you can imagine, because a lot of other services are closed.

As to our counselling model, there is just so much you can do with trained volunteers so we have a counselling model that is based on containment, which means that you look for supportive counselling. It is very client centred. We also emphasise individual responsibility for that caller, about what they can do to improve their situation. It is an approach that is pretty suitable across a wide range of situations and it is very non-directive. When we have a person who is at risk of self-harm, whether it is a low, high or medium risk, we take on a much more direct role and our counsellors are trained to do that. I also might add that for every counsellor who is on duty there is a supervisor on call 24 hours a day who backs up that counselling. So no decision to intervene is ever made without supervision.

People who access the telephone counselling service increase our own help-seeking for their personal problems because we have a huge database - it is national but a particularly good one for Tasmania. Part of the telephone counsellor's job is to not only do counselling but to give that person information and to refer them on. Because it is a confidential and, for the most part, anonymous service we don't really know whether those pathways to care have been activated or not. Mind you, a lot of our callers who are struggling, whether it is with suicide or with other issues, call us repeatedly, so we can find out what they have actually done to secure help.

Mr WILKINSON - Is there any common thread which runs through all of those phone calls that you get?

Ms ALOMES - Yes, I am going to talk a little bit as we go more about the vulnerability. Because I do not have the stats in front of me I have actually isolated some more anecdotal evidence about what we actually hear, what the vulnerabilities are. It does, of course, include the group that you are concerned about. I think of our callers to the adult counselling service, the major age of our callers is 25 to 45. As you can imagine most of them are women but that ratio is changing a bit. It used to be that maybe only one-quarter were men and three-quarters were women, but now more than a third would be men who seek help.

The aim is to address the suicide risk and to bring help as close as the phone. We do have one telephone number and people can access that from anywhere for the cost of a local call. That is brilliant because you have people in remote and rural areas in Tasmania who can ring Lifeline and talk for 40 minutes without getting an STD charge. In theory that is wonderful but we do have some access problems that we are fixing on at the moment.

Our overall goal is to work cooperatively with all the other service providers. We are only one bit, I guess; we are the ones who are catching the people who fall through the cracks. We catch the people as that crisis starts to build and we also catch the people who are just hanging on with that one finger, so there is a great range. I will talk a little more about that as we go on.

We have had to look at it from the point of view of what we are about and where we stand in suicide prevention. It is safety first; our policy is that we are evaluating human life and safety comes first. Our first priority in dealing with people who are at risk with self-harm is to maximise the safety of those people. We do that in a number of ways. We do intervene; we work along with emergency services after a risk assessment has

been done. We have a very good relationship with the ambulance service and with the police but very few of our calls need an intervention because when people do ring, no matter what they tell you - 'No, I don't want you to know who I am; no, I don't want your help' - the reason they are ringing is because they do want the help. They are very ambivalent about the path that they are thinking of taking. The ambivalent thought is such that our counsellors are trained to actually work with that ambivalence; that is a real key to working with people who are suicidal.

Beyond that we value human life and try to get people to a safe place psychologically or physically. With our referral database we are offering ongoing support and counselling. We actually do a lot of encouraging, putting them into some more life-affirming path with help of counselling, trying to get people to address those sources of pain and distress that led them down the path in the first place. It is a really personalised service that we offer.

Again, those people who are not at high risk can access the service anonymously. If there is no immediate risk to their life or the life or somebody else, then we do not necessarily want to know who they are because it is a thin end of the wedge, ringing up and talking through. It is a very difficult thing to do.

CHAIR - Constance, you say you know they are calling regularly; they do not divulge their name but you recognise their voices?

Ms ALOMES - We might recognise a voice. Many people appreciate the anonymity and the confidentiality but other people say, 'Hi, it's me'. The telephone counsellor, who is randomly on roster to keep their anonymity, will recognise it. We also would be contracting with the caller. The telephone counsellor would say, 'The person is not an immediate risk; they are really struggling, they are in terrible emotional pain', so they might make a recommendation for them to see their GP, to access counselling. 'Here is where you can go to access counselling, and also ring us once a day.' So we might contract with them for that so that we know that person will ring us at a certain time. They will get whoever but a note is made so that the counsellor coming on duty will know that so and so is going to be ringing around this time and here is his story, so we know about it. They give us permission to do that, to share those stories. The people are informed, they come in, they know how to handle that call, they know what the issues are about. It is a little bit more proactive than just 'Hello, it's Lifeline' and then taking whatever comes in.

As I said, we try to work with a team approach with all the other service providers and get people on to longer-term supports because we are joining on the spot basically, and we don't have the capacity any more to offer follow-up face-to-face counselling. So we try to slot them into help that they can get to get them through that crisis which, for most people, does not last forever.

When we talk about issues of self-harm, we are talking about a person who is directly at risk, that person who rings in about themselves; we are talking about a person who is bereaved by the suicide of another and these people are in a higher risk category themselves or a person who is concerned with a suicidal behaviour or thoughts of somebody else, so a third party. Somebody might ring in and say, 'I'm so worried about my kid, what shall I do?' so we work along with that person to help them. That person at

risk may not ring in themselves but we work with the families to help in that situation. Our telephone counsellors are trained to pick up on all the underlying nuances because not everybody rings up and says, 'I'm going to kill myself'. People ring up and they tell you stories and if you are trained to listen you know that this might be about suicide. When people ask direct, then our counsellors will actually go through our very formalised risk assessment process that happens on the phone. The counsellors can then look at that situation and say, 'Is this person at low, medium or high risk? How urgent is this risk? Here is what needs to happen'. Then they are able to identify it and help that person mobilise their coping resources and the other supports in the community or get the SOC, the supervisor on call, to authorise an intervention. That is basically the way it works. But of the calls that we take, maybe 6 to 8 per cent are about self-harm and only 1 per cent of the calls that we take would require an intervention, if that. So most people are at risk but they have not actually moved into the hardest category where they have pills on hand or whatever.

Mr BEST - Thank you for your outline of the mechanics of your operation - the hands on and how that works. It is quite an insight. I am just wondering strategically what you feel the role of Lifeline is perhaps in progressing suicide events and the overall picture. What do you think needs to happen in the area of suicide? For example, what do you think could happen to reduce it? I am not pointing the finger and saying, 'What could you do better?', I am saying, 'What do you think we could all do better?'

Ms ALOMES - One of the things that I was looking at here, when you look at the statistics and the vulnerabilities that people talk about that have fed into the suicidal crisis, you will see that we are talking about so many mental health problems. We don't diagnose problems because our people are volunteers but so many of our calls will reveal, 'Yes, I have been diagnosed with schizophrenia; yes, I have been diagnosed with depression; or yes, I am under the care of …', so there is a whole area there where people have diagnosed problems. Some people will ring and they are not under the care of anybody and very clearly they have mental health problems that are not being addressed. So there is one area there -

Mr BEST - That is an area of improvement as far as you can see.

Ms ALOMES - That is right, so let us look at that. We are looking at early detection perhaps in other arenas, whether it be through school systems, whether it be through workplaces, or whether it be through just community awareness. Some of the things Beyond Blue has been trying to do in that area are quite good but there is a whole area there.

Mr BEST - So what you are saying essentially here is that there are people who aren't well, they think something is not right, they don't know what it is and they are not being identified? That is really what you are saying.

Ms ALOMES - Yes, they are not seeking help.

Mr BEST - No, because they don't know and other people haven't picked up on it.

Ms ALOMES - They are not seeking help because they don't want to be identified as having a mental health problem because there is a stigma involved in that or they come from an emotional place that says they have self-defeating coping styles or something like that, or

they don't know where to go, or 'No, I can't afford it', or 'I know the waiting list is really long'. These are the kinds of things that we hear, so that is a vulnerability. Another vulnerability is social factors, such as extreme family dysfunction, which we hear a lot. That is associated with a lot of suicidal thoughts and behaviours about being totally unconnected to any service, being unconnected within a family, lack of family support and extreme isolation.

Mr BEST - So what are you saying could happen there, do you think?

Ms ALOMES - Again, it's that preventative stuff where you look at teaching families how to relate better, teaching families how to cope with stress, teaching people how to solve problems - your life skills which go way back over the preventative arena. Some of the stuff that we hear is about not having a clue how to tackle their own problems and issues, so there's an education thing that happens there. It is not a case of suicides there and here are people just struggling every day struggle. There is that bit of it, too. People have limited personal resources within themselves to actually tackle their problems, and there is a whole social system where they feel isolated and alone and cannot quite get back onto the bandwagon.

That is why we feel it is very important, with that 131114 number, to have it as 'cost of a local call' so that the people who are in remote or isolated communities have access to Lifeline. It's a first step. Often you look on the database for referral and there's not much there in that community. In a small community, people don't want to be seen to be walking into the council's door; they don't even want to go to the doctor because everybody knows everybody, and there are those issues as well.

Mr BEST - And this is what you're trying to do to help someone who phones up, of course, and then I suppose you have to be very careful. I know you did go through some of the processes there as to how you say to someone, 'Go and get help' - you don't put it like that, obviously.

Ms ALOMES - It is like, 'Have you thought of …?', 'Are you telling me this, that or the other?' 'I wonder if you've ever considered' - that kind of thing, because of the non-directive nature, the fact that we are volunteers and not psychologists. We have to contain our volunteers as well as help to contain our callers. So what we actually offer is limited - it is that safety net. I'll talk a little bit of some of the more proactive responses where, within Lifeline, we might be able to help - again we have the crisis end of it. We're not at the prevention end of it in that strictly preventative sense. I don't know that I could give you any more information than that.

Mr BEST - No, that's fine, thank you.

Ms ALOMES - I was going to talk a little bit about the data collection. We actually have several different sheets; we put these on the computer and then we shred them for confidentiality. We can actually look at suicide because we get the caller's gender, we can get the starting time of the call and the ending time, which tells us if it's after hours or if it's during the week. We can get the caller focus - who they worried about, themselves or somebody else - what their relation status is, are they suffering from aloneness. Are they connected to somebody, who referred them, what medical care they are under, if they're receiving treatment for mental health. These are all the things that

actually come out in the data. We have all this information, and with our new system we could also look at whether they have prior suicidal behaviour and at what time period did they have that suicidal behaviour.

CHAIR - So your people who are taking the phone calls are actually taking this information down?

Ms ALOMES - Yes, these are the sheets we used. Then somebody gets the sheets and they put the data into a big collection and then they supervise from the information and they shred the sheets.

Ms RITCHIE - Is that the information that will be conveyed to us later?

Ms ALOMES - Yes.

Ms RITCHIE - So you'd be able to tell us, for example, in the last year we had 20 callers whom we deemed were suicidal; showing the percentage of them who rang late at night.

Ms ALOMES - Yes. They were this age, they were men, they had relationship problems. So we will be able to ask the new database to pull out that information so that we can say, 'In the winter, these many people were depressed in this age group and of this gender'. Those kinds of things can very much inform services, which we haven't been able to do in the past. Also, as I said today, our system is down, so I cannot get those stats for you at the moment.

Ms RITCHIE - Just one other thing. You mentioned that you had very small rate of intervention or cases requiring intervention. Do you think that is because when people are at the stage where they actually do call, they are ready to receive help and that you're probably not really getting those who have unfortunately just gone and -

Ms ALOMES - I don't believe anybody just goes. It is about ambivalence. Those people who don't have minimal ambivalence are not going to seek help, although some do. As I said, those people are determined. They may have already taken pills, they might have the gun or the rope, whatever, but because they did ring there is that little bit that you can look at, and they will actually tell you where they are. If you establish a rapport and hear the pain that they are suffering, they will tell you where they are.

Ms RITCHIE - Do your callers who ring up and who are assessed as being relatively high risk in relation to suicide want to speak to the same person each time they call? Do you find that is a problem because they might say to your volunteer 'I'd like to speak to you again', and how do you deal with that?

Ms ALOMES - Occasionally people do, but the majority of people are speaking to Lifeline, and that is why there are no names exchanged. Some people do, but we do not offer that, and if they want ongoing one-on-one service there are others options that we need to refer them to. But some people are pretty canny about the rostering, and so they know when people are on.

Mr MORRIS - Just quickly, what are the big trends, the changes that have happened over the time of Lifeline? Are the types of calls and the number of calls significantly different from the first couple of years to the most recent few years?

Ms ALOMES - I will say that we have an artificial ceiling on the calls that we can take at the moment, so the number has not changed that much, because we only have one person on at a time, and there is only so much you can do in a 24-hour period. Gender is changing. It was predominantly women who accessed the service 10 years ago. Now, as I said, there is a greater percentage of men. The age has not changed very much. It is 25 to 45 age group, around that area. We get a few younger people, a few older people. I think the calls appear to be more complex in terms of what is happening to people socially, economically and again in mental health. We do not know, because of the nature of the service and the research we have not been able to do, are people perhaps ringing more because they know about us more; do we do better advertising; are they ringing because there are a lot more problems out there? We are not really sure why they are presenting with these particular problems. My guess is that life is more complex, the problems are more complex, and I think that people have a more difficult time accessing help basically.

Mr MORRIS - Just on that, do you say there is an unmet demand for your service?

Ms ALOMES - Yes.

Mr MORRIS - Do you have any idea of the quantum of that?

Ms ALOMES - Yes. Fifty per cent of our callers cannot get through, and that is a Telstra analyser, but we are working now with the State Government to address that and over the next three years that will be addressed.

Mr MORRIS - Addressed, or dealt with -

Ms ALOMES - We have a plan.

Mr MORRIS - as in to be able to accept all the calls that come in?

Ms ALOMES - We will never get 100 per cent of the calls. We are looking to get 85 per cent.

CHAIR - Is there anything else you would like to submit to us today?

Ms ALOMES - I just wanted to say that, as I said, we are reactive. We take those calls. The other thing is that we really think that - we have done this before, we had the resources - we need to be able to contract with those people at risk to say, 'We want to support you by telephone and we will contract with you. We will ring you once a day'. We will ring out, and we will actually get our volunteers to do it in a different setting to be able to spend an hour on the phone with that person, just to support them; if we have to ring them every day for three weeks, whatever it is, to make sure they seek help, so we are looking at that service. We are also looking to restore the face-to-face crisis counselling, which means that people who ring in overnight in that crisis, moderate to high risk, can

come in the next day and see a counsellor who will not give them long-term counselling but deal with the self-harm issues.

CHAIR - They are not established yet; that is what you are working to?

Ms ALOMES - No, we used to do it, but the resources have been very tight over the last three years and so it is one service that we cut.

CHAIR - Okay. You were going to mention something about the media.

Ms ALOMES - I was just going to say that a few years ago we did make a request to the *Mercury* that, when they feature a story about self-harm, they put Lifeline's telephone number on the bottom of that because a key message needs to be that there is help.

CHAIR - Did you get cooperation with that?

Ms ALOMES - Absolutely.

CHAIR - The *Mercury* did that?

Ms ALOMES - Yes, very much so.

CHAIR - We appreciate very much the time that you have put in and the report that you have given. As you go away from here you will probably think, 'I should have mentioned this or I should have mentioned that' -

Ms ALOMES - I am just thinking all those things, yes.

CHAIR - So please feel free to submit other information.

Ms ALOMES - Is it of interest to the committee if I were able to generate a report of the calls in 2004 that featured self-harm and some of the issues that have come up?

CHAIR - Yes, thank you.

THE WITNESS WITHDREW.

Mr DAVE WILLANS, YOUTH NETWORK OF TASMANIA, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - Dave, apologies for being a bit late but we have had some really interesting people in here today, and I am sure you are going to be one of those as well.

Mr WILLANS - I think you Are going well.

CHAIR - We are information-gathering at this stage. Have you seen our terms of reference?

Mr WILLANS - I have.

CHAIR - Thank you very much for making yourself available. If you would like present and then we will ask questions.

Mr WILLANS - I do not want to present for too long. I thank you for the invitation. I am the executive officer of the Youth Network of Tasmania. I am a social worker gone wrong by profession. I am involved primarily in community development work. The Youth Network of Tasmania is the peak body for the youth sector in the State, a similar role to TasCOSS, but focused on the youth sector. We are funded through the Department of Education via the Office of Youth Affairs to improve the community's response to youth issues. The way that we seek to do that is to involve young people and service providers in identifying and responding to those issues. That is the short blurb about the organisation. I am not going to give you any more about that.

The way we tend to work is through three quite well established and autonomous regional groups - one in the north, one in the north-west and one in the south. I will try to avoid a whole list of acronyms that I could give you today. I guess my expertise in relation to suicide prevention is in relation to coordination issues rather than service delivery as such, and it is those issues that I would really like to talk to you about.

Most of the issues that come onto our table come to us via the regional groups that we work with. In 1999 there was a meeting of the northern youth coordinating committee in Launceston and the subject of that particular forum - they have a forum every month, prior to their other business of the meeting - was youth suicide prevention. All of a sudden there were about 40 people there who do not normally attend any of the meetings. They were passionate and fired up and they had a very strong range of views around these issues. There were some key players in the sector from the Commonwealth Department of Health and Ageing and from the Department of Health and Human Services who have come on line to provide coordination around suicide prevention and a whole lot of people from various community organisations in the youth sector. There was some very lively debate. The thing that was immediately clear to us was that there was a range of views, that people feel passionately about these views and that there was no mechanism for them to talk to each other. They had not met each other; there was no communication structure in which they could talk to each other. There was no way it was happening. As the peak body, our role is to try to work with that and do something with it.

The next thing we did was convene a statewide forum to see whether the Launceston-specific experience of that was true at a statewide level. If it was, it was definitely our job to do something about it. It was, so we convened a meeting and had the same sort of reaction. At that meeting we tried to thrash out how we could coordinate responses to youth suicide prevention in Tasmania. With the help of the Commonwealth Department of Health and Ageing, and Health and Human Services, both of whom had offices specifically focused on this, we developed a thing called Tasmanian Youth Suicide Prevention - I have some terms of reference for this here, if you want to have a look at them. The purpose of that group was to set up a statewide structure that would facilitate communication between all these players, get information out to all the people working in the field of suicide prevention and get people talking to each other. The way that we aimed to do that was through using the existing structures in the sector - the three, strong, regional, youth sector peak bodies. We started to set this up and it was immediately obvious to us that there was so much energy and passion around the issues that it was going to take more work than we had the capacity for, so we sought some funding for it. We got funding from the Commonwealth and some funding from the State to set up this statewide coordination network around youth suicide prevention. That worked pretty well. We set up groups in each of the regions that brought together all the key players in relation to suicide prevention in each region. Each of those groups looked at what the problems were. Most of the problems on a regional basis were about the relationship between government and non-government service providers and the referral networks between those players, particularly the referral process back from the government sector into non-government services for postvention. There were some local nuances around that, but that was the primary issue: because so many of the organisations have different philosophical positions in relation to suicide prevention, that was having a considerable impact on the way referrals worked or didn't work. In fact, because those philosophical differences were there, organisations were not referring to each other, and that was a major problem. The main divide was between government and non-government, but not necessarily so. What we were trying to do in each region was to facilitate the process to unblock that and to get those referral processes working.

Mr BEST - What were these philosophical differences that you are referring to?

Mr WILLANS - Some of the philosophical differences were around who should be involved. Firstly, who is qualified to work in relation to suicide prevention? Do you need to have a social work degree or a TAFE degree, or is being a volunteer who has had experience in those areas and been passionate about it enough? There was that sort of difference.

CHAIR - Professional jealousies?

Mr WILLANS - Professional differences and jealousies. There is also a very fraught issue around the extent to which young people should be involved in this. There was a strong feeling in the youth sector, driven by a gentleman who is no longer part of the sector but who was there when this process started and who was very influential, that young people should be involved in the whole business of responding to youth suicide. He facilitated those processes with young people and was involved with the whole movement, and some people were aligned with that. Then there were the people from the government side who felt that there was strong evidence from New Zealand and other places that

having young people involved was counterproductive and put them at risk. There were those sorts of ideological differences.

Mr BEST - How many groups are we talking about here?

Mr WILLANS - How many community organisations are interested in the problem?

Mr BEST - No, in relation to the paper that we have been given with these philosophical differences.

Mr WILLANS - The steering committee was very small. There were only six or eight people who were committed to meeting on a monthly basis to work on this. There was a wider e-mail list that I think had about 100 people on it and then there were the regional groups that had various numbers involved in each of the regional processes, so there might be 10 to 15 organisations or individuals involved in each region.

Mr BEST - The second page, 'Participation and Consultation', notes that the ultimate decision was that the committee not be open to young people under 18 years of age. That was the consensus between these six people?

Mr WILLANS - Yes. Part of the process of thrashing out the terms of reference was to bring all those players together and to have those discussions so that the two sides could work with each other. What we came down on for the terms of reference was that the evidence seemed to be very strong that it was dangerous. We have a thing called the Tasmanian Youth Consultative Committee that could provide an effective way of consulting with young people and obtaining young people's views, so we decided to use that mechanism to obtain those views.

Mr BEST - Thank you very much for that overview of what your involvement has been. What are some of the opportunities, I suppose, for want of a better word, that have thought about strategically about reducing the incidence of suicide or preventing suicide?

Mr WILLANS - I am not quite sure how to answer that question. Can I come back to that in a minute?

Mr BEST - Sure.

Mr WILLANS - I do not know whether you are assuming that this network still exists but I have to tell you that it does not.

The Commonwealth decided in 2002 that it would no longer fund a youth-specific approach to suicide prevention, that it wanted a whole-of-population approach to suicide prevention and so funding did not continue, which we were not too upset about. It was not an ongoing project anyway but we were naturally disappointed. So we looked around for an auspice that could do a similar job for the sector in relation to whole-of-population suicide prevention. We looked at the Tasmanian Association of Mental Health and we looked at the Mental Health Council of Tasmania and various other organisations, and at the time that we looked at it there was not anybody who was willing or able to pick up that auspice to do that work. The net result is that that network has now fallen over and the point that I was trying to make by initiating the discussion is that

we do not now have any coordination mechanism beyond the reference group that is associated with the Tasmanian Suicide Prevention Steering Committee.

Mr BEST - Surely, though, if there is a genuine interest - and I understand that the funding is one issue - in youth suicide, that would not prevent people from discussing it or the continuation of the committee. Are people being paid to attend the committee meetings or something?

Mr WILLANS - No, nothing prevents people coming together to discuss it but in order to get good processes and processes that will achieve specific outcomes within specific time frames and which therefore people who have some skill and some nous will sign on to you need to be able to resource the matter quickly. If the process is just off the side of the desk, eventually those sorts of processes are hard to maintain over time. People get disillusioned with them and people who stay in those sort of processes, the people who have lots of compassion and commitment and lots of time and some of the better operators do not participate.

Mr BEST - It is interesting. We heard earlier from a group that pretty much are doing it on their own.

Mr WILLANS - Sorry?

Mr BEST - We heard earlier from the Tasmanian Association for Mental Health and what actions they are doing for young people and how they have gone about it.

CHAIR - You made a comment, you are not asking a question?

Mr BEST - Well, either way it can be taken as a question.

Mr WILLAN - Well, my comment in relation to your question would be that someone such as the Tasmanian Association for Mental Health needs to be adequately funded to provide coordination in the community sector around suicide prevention issues because in the absence of that, those organisations tend to fight amongst each other or there is not the degree of collaboration and cooperation amongst all the organisations and between the government and non-government agencies that will give better outcomes for people who are at risk.

Mr BEST - It seems very bureaucratic with people fighting each other. It seems contra -

Mr WILLANS - It is and it shouldn't be like that.

Mr BEST - No, it shouldn't be. That is an issue then we need to look at.

Mr WILLANS - I think the experience you will find in any sector, in housing and in the youth sector before there was a functioning peak, as much as we would all like to think that everybody would collaborate and work cooperatively with each other, experience tends to demonstrate that that does not always happen. When they are competing for scarce funding, they believe that they are doing the right job with the people then sometimes those relationships tend to break down and if they do break down, unless

there is some sort of mechanism to bring those players together and to get them to continue the conversations, they stay broken. I think that is the risk.

CHAIR - Yes, and Amanda too was very keen to embrace the whole-of-population concept as well.

Mr WILLANS - Who was keen?

CHAIR - Amanda Stevens from the Tasmanian Association for Mental Health.

Mr WILLANS - Yes, I am sure that that is the case.

Ms RITCHIE - My question relates to that. One of the important points that Amanda Stevens made in closing was that she believed that we need to really embrace this whole-of-community approach to suicide and suicide prevention. Do you think that is right and that we should be heading that way? I am also wondering, looking at the report of the Tasmanian Suicide Prevention Steering Committee, do you have participation in that?

Mr WILLANS - Yes, I am on the reference group of that.

Ms RITCHIE - Do you feel that you are getting adequate input through that process to represent young people?

Mr WILLANS - There was some thought that the reference group would be an appropriate mechanism to provide coordination for the community sector in the absence of the sort of thing that we were doing before. I would have to say that after, say, 12 months - I think we are 12 months down the track or so now - there is some evidence that that reference group won't perform that role. I think the Suicide Prevention Steering Committee is good at coordinating government responses to suicide prevention but the reference group doesn't seem to be up to providing the coordination that is required within the non-government sector.

Ms RITCHIE - You are talking about the broader reference group here, aren't you, not the three elected or selected members?

Mr WILLANS - No.

Ms RITCHIE - Are you talking about the broader reference groups? That is my understanding of the way that works.

Mr WILLANS - I don't want to denigrate the work of that committee in any way. They are good people and they are doing very good work. The problem is a structural one. The community reps on that committee don't have any structural relationship to the community sector, they represent their own individual organisations but they don't represent any regional or other peak bodies that would allow them to consult widely with constituents in the community sector and feed back. So whilst they are probably the best people on the community sector in relation to suicide prevention issues, they have the most knowledge, they don't have any structural relationship with the wider sector that would allow the wider sector to be engaged in those processes. I guess my message is that the wider sector, the community sector, now feels fairly disengaged. So my take is

that the Suicide Prevention Steering Committee would feel that from where they sit things are working quite well and my message is that from where we sit things are not working so well.

Ms RITCHIE - I raised the issue earlier today with Wendy Quinn when she was here - I was just looking at their 2002-04 report which you have probably been through - about the interaction they are getting from the people who represent families who have been through it and all that sort of stuff. She made the point that this reference group was now how they were feeling they were getting this feedback, but I am concerned that maybe that is not enough.

Mr WILLANS - I would argue that there needs to be a non-government coordinating body that has structural links to the Suicide Prevention Steering Committee. That is the way that it should work. I am fortunately not here advocating that that should be my organisation and I am not advocating any particular organisation, I just think that there needs to be an organisation that has that role.

Ms RITCHIE - So you are not actually on the committee as such though?

Mr WILLANS - No, I am on the reference group and the reference group is the body that the steering committee thinks can perform that coordinated role in the community sector and I think that is where they have things a bit wrong.

Ms RITCHIE - Okay, thank you.

CHAIR - So you don't think the three members that come from that reference group is a strong enough representation or embraces what Allison is talking about? You don't think three members carry that message through to the steering committee?

Mr WILLANS - My problem with those three members is that they don't have any structural relationship with all the other people in the community sector who want to participate in these processes.

CHAIR - The ones that are there now do you mean?

Mr WILLANS - Yes. They have word-of-mouth relationships and they may know each other but there is no mechanism for all the players in the community sector who want to have a voice in these issues to participate unless they ring up one of those members and say, 'Are you doing this or would you like to raise that?'. There is no forum and there is no mechanism through which those community representatives can actually operate - there is no mandate for them.

Ms RITCHIE - One more question. When you look at the make-up of the steering committee - a lecturer, a senior policy officer, project officer - you see that it is all very departmentalised. How do you think that the three people who get a guernsey as part of the reference group actually interface with these other persons?

Mr WILLANS - Very well, but I would say the community representatives probably have more expertise and more knowledge than most of the other people on the committee. I

have been a member of this committee in the past, so I think the knowledge of those community representatives is well-recognised on there. I do not have any doubt that -

Ms RITCHIE - Do they have the same voting rights on the committee and all that sort of stuff?

Mr WILLANS - Yes. It is just who they represent, and how much of the sector, how much of the views of the sector, what percentage of the views of the sector they represent. I would have to say it is probably only a fairly small part of it.

Ms RITCHIE - Thank you.

CHAIR - Dave, are you going to be making a submission?

Mr WILLANS - No, I had not intended to. Do you think I should?

CHAIR - Yes, I think so, just to enunciate your recommendation that you presented to us. We are looking for those sorts of ideas or recommendations to come through to us so we can assess them and perhaps put them into our final report.

Mr WILLANS - Yes.

CHAIR - So you might keep that in mind, and we would appreciate what came through.

Mr WILLANS - I am happy to do that. I was not quite sure how best to provide input. There is one question I have not yet had a chance to answer, and that is whether the whole of population - I think it was you, Allison, who asked that?

Ms RITCHIE - Yes. We have had strong messages that this is the right way to go.

Mr WILLANS - There is one point I would like to make, and that is that if we want good responses to this stuff we have to have a community development approach. So if all of the energy and enthusiasm is coming from people who are interested in youth suicide prevention, then we need to support that in some way, and if that has spin-off benefits for other parts of the population then that is good. But what happened in this case was that the Commonwealth, in their infinite wisdom, decided that the statistics indicated that youth suicide was fixed now and so we would have a whole-of-population approach, so they ceased funding for youth suicide prevention, and the State followed suit because the Commonwealth is where the money comes from. So the State just went along with it without really challenging it too hard and, as a result, something that had come from the bottom up, the real grass-roots community development energy, just stopped and has been replaced by nothing, because the people who made the policy around whole-of-population haven't felt it is incumbent upon them to replace with anything else what they took away.

I don't know whether that answers your question, but it says something to me about how we develop our policies in relation to these sorts of issues, that this top-down stuff that takes no notice of what is happening on the ground has the capacity to just bowl over what is possible to achieve.

Ms RITCHIE - Thank you for that. It is just interesting to get another look through the glass, I guess.

CHAIR - Have you submitted your thoughts on that to any Federal representatives, or to the Federal Government, Dave?

Mr WILLANS - I think they know how I feel. I think they have heard my views. But one of the problems with Commonwealth policy-making processes is how does somebody in a position like mine in Tasmania have even the slightest impact on those Commonwealth policy decisions. But certainly I think the Commonwealth representatives in Tasmania were very disappointed about that, as were the Tasmanian representatives, but that seems to be the way that some of our policy processes work, with just this top-down stuff.

CHAIR - What about this latest budget by the Treasurer tonight? You don't think there is going to be any sort of additional funding, because we have heard that there is some sort of funding lapse coming up around June this year. Do you think they are going to provide more funding, or that there is a focus in this area?

Mr WILLANS - There may well be. It will reflect the Commonwealth's agenda in relation to this particular issue at this point in time, and will have lots of strings attached about what it will drive and what it won't drive. So hopefully there will be more funding. I will be interested to see how that comes down.

CHAIR - A whole-of-population approach means we are embracing all sectors of the community, so there must be something in there for the youth sector.

Mr WILLANS - Yes, and I am not here pushing a youth sector agenda. It is the whole-of-population stuff. I am happy to go along with a whole-of-population approach. I think we should be doing that, but my problem is that we are not doing it; we are not providing coordination. So if there were something in the Commonwealth that would support coordination on a whole-of-population basis, that would be good.

CHAIR - While we are on the subject of funding, did you say the Youth Network of Tasmania is dissolved?

Mr WILLANS - No, the Youth Network of Tasmania is still there. This was a sub-committee. Tasmanian Youth Suicide Prevention was a subcommittee of the Youth Network of Tasmania. If somebody tries to defund the Youth Network of Tasmania, I reckon you'd hear about it.

CHAIR - So how do you get on these days? Where do you draw your funds from?

Mr WILLANS - For the youth network?

CHAIR - Yes.

Mr WILLANS - We're funded through the Department of Education, and we're on a reasonable sustainable basis. We're not whinging about money, I wouldn't like to use this forum for that. We are fairly well recognised by government and our role is fairly secure. It is just in terms of our capacity. What we do is respond to the needs of the

sector. When something like this comes along and there's an urgency about it, we need to get the resources to do these projects for however long they need to be done for; that's the challenge for us. Our core is there, the dripbag works quite nicely. The bag is there and the drip is coming down -

CHAIR - And there is a recipient.

Mr WILLANS - It's the capacity to work on the projects.

Ms RITCHIE - You need a syringe driver.

Mr WILLANS - Yes - or a pump.

CHAIR - Thanks. You did mention it earlier, I do recall now. Thanks very much for that. Is there anything else you'd like to present to us?

Mr WILLANS - No, I think I've said more than enough.

CHAIR - Okay. Any questions? Dave, thanks very much for your time; we appreciate that very much.

Mr WILLANS - My pleasure, I hope it's been useful.

CHAIR - As I say, we'd be interested to hear if you have a submission with recommendations. Get it through to us -

Mr WILLANS - By?

Mr CHARLES - We'll be going for a while yet. The official closing date is the sixteenth of this month, but we won't hold you to that.

CHAIR - We're right beyond that day; it's not a problem.

Mr WILLANS - Thanks for the opportunity.

THE WITNESS WITHDREW

Ms HELEN BARRETT, STATE PROJECT OFFICER, MIND MATTERS, DEPARTMENT OF EDUCATION WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - Helen, we will make a start. As you know, we are just gathering information at this stage from various people. Thanks very much for coming along and making yourself available to give us this presentation. Mind Matters is something that we have been reading about, of course, so it will be good to find out how it works and what it is doing in the schools. If you want to make a presentation to us, then we will ask you some questions.

Ms BARRATT - Okay. Mind Matters was funded under the National Mental Health Strategy, so it is a program that was developed in 2000, or in 1999 it was trialled in some pilot schools and then developed and it was released to schools around Australia in the year 2000. It is a national resource, and it was funded to the extent that every secondary school in Australia received a free copy of the kit. That is every government school, every Catholic school and every independent school. So it was significantly funded, and since then there have been people like myself. I am the State project officer at the moment for Tasmania, so in other States there are other project officers who continue to run training so that schools are kept up to date with the information in a kit so that people are trained and able to really go through the activities and get a really good understanding of the research that underpins it. Also by doing the activities themselves it is reinforcing their own messages about their own wellbeing, and also people are more likely to use activities which they have done themselves.

CHAIR - The teachers, are you saying?

Ms BARRATT - The teachers, yes. We have two-day training. The funding came from the Commonwealth Department of Health and Ageing, and then the ongoing sponsorship has been with the APDC, the Australian Principals Development Council, and the Curriculum Corporation, so they are the two auspicing organisations that have run the day-to-day management of Mind Matters.

CHAIR - Are they both federal bodies?

Ms BARRATT - Federal bodies, yes. It is based on risk and resilience research. A few years ago was actually when we looked at issues like suicide we might have really focussed on risk factors and warning signs, whereas now a lot of the research is really looking at the flipside. Rather than just focusing on what makes young people at risk, what actually protects them? So we are really flipping the coin over and examining those protective factors that stop young people. You have two young people who come from similar sorts of backgrounds. One might be feeling suicidal and one wouldn't be. What are those factors that actually make a difference for two young people who are both going through stress? What actually protects them from harm? A lot of the research that has been done around those issues, particularly the stuff on resilience and connectiveness. They are two really key concepts used in my matters and also in our Tasmanian based curriculum. We are looking at what that actually means, what it looks like and how we can support young people to develop resilience and to feel connected and to be able to seek help.

In a nutshell that is what it is all about. I thought that I would just go through what is in the kit so you can see how it all comes together. It is like a newsletter and on the inside page you can see what all the booklets are within the kit. There are three curriculum framework documents. These are documents within the kit that give a really good understanding of the background research to my matters and the models that are used and what a whole-school approach looks like. It is not just about what goes on in a classroom; it is about encouraging schools to have a whole-school approach for wellbeing promotion.

This one has a lot of audit tools that schools can look at and ask, 'How well are we doing in relation to having policies and procedures in place to deal with things like suicide, bullying, behaviour management, and how well we are travelling with all that stuff?'. That has lots of that sort of information.

'Community Matters' recognises that schools needed a bit more information in relation to diversity. There are a whole range of young people, for a whole range of different reasons, who need extra support. It looks at issues in relation to disability, same-sex attraction, migrants, Aboriginal backgrounds. There is a whole range of what we sometimes call equity target groups, and what it would look like for them if schools are doing a good job about their needs.

'Education for Life' I think is probably the most significant in a way in relation to what you are looking at. It is a guide for schools in relation to dealing with suicide and self-harm and critical incident management. It has some really good information guidelines, advice, and evidence-based information in relation to how schools can respond in relation to suicide. The message that we give teachers with this one is that their role is not about being therapists or counsellors but about being aware of what those issues entail, being able to make clear referrals if they see that a student is in distress and needs counselling or further support.

Suicide comes into classrooms for a whole range of reasons, not just because a young person is in distress. It might come in, say, through a text that they are looking at in English that looks at suicide; there might be a visiting play or there might have been an episode of *Home and Away* on TV the night before that looked at suicide. The kids can come to school and actually talk about it even though we say you don't teach about suicide because we don't want copycat behaviour. You can still come in and ask, 'How do teachers respond when the issue arises in a whole range of ways?'. This has really clear guidelines in relation to how teachers should respond in those issues.

These five documents are what we call curriculum documents. They have classroom-based activities that teachers can do with students in order to enhance resilience, look at loss and grief, deal with bullying and understand mental illness. With the enhancing resilience one, again I think this is relevant to what your committee is looking at because it is giving teachers really sound evidence-based information and activities. They can engage young people in building their scoping skills, helping them to deal with stress and talk about what stress is and how we bounce back from stress. There is a whole range of really engaging fun activities to get the kids involved in when looking at these issues.

Loss and grief, dealing with bullying and harassment, I guess these are two issues which we can say are linked with mental health issues, that there is a link between that and feeling so stressed that you might think about suicide. It is the same with loss and grief, that can also link in there. Suicide is, I guess, something that is a background issue to a whole range of the booklet areas within Mind Matters.

CHAIR - I was thinking myself that a lot of the focus of Mind Matters was on suicide prevention, but it is not.

Ms BARRETT - Not directly. It is that one booklet, but that is really about teacher awareness raising. It is not something that we advocate. There is a bit of debate still about that, but most of the research seems to point to not putting suicide up there with your work with young people as being something. You never know who in your classroom is susceptible to suicide. You never really know what some of those young people's issues are and what they are thinking. I guess we just say that you need to be aware of those issues but not to directly teach about suicide. Particularly do not talk about means of suicide or anything like that that could romanticise or glorify suicide or put that in the minds of young people. They are very susceptible.

If the teacher was to look at the issue of suicide, it says in the Education for Life review that it needs to be done in a context in which positive health promotion is the overriding message so that suicide is just one issue in amongst how we need to look after ourselves and seek help and all those broader issues.

'Understanding Mental Illness', which is more for senior secondary students, looks specifically at five different mental illnesses - bipolar, schizophrenia, depression, anxiety and eating disorders. I guess suicide is underneath some of those mental illnesses, and that really helps young people to have a better understanding about what some of the symptoms and warning signs are with mental illness and what they could do to support a friend. That is the biggest message in that because we know that sometimes young people who don't have a significant adult that they can trust in their life might talk to a friend. There is some really good information and activities that can be done to help support friends.

CHAIR - Helen, is this information for teachers or is this something that they use in the classroom?

Ms BARRETT - Both. The three framework documents are probably more for their own information and the five curriculum documents are things that they would do in the classroom with kids.

CHAIR - How often would they do it?

Ms BARRETT - What we would like to say with Mind Matters is that it needs to be imbedded and integrated into the curriculum as far as possible. In most schools it comes into pastoral care and also the health curriculum. It could be looked at every week in some form or another.

CHAIR - Do you know that? Do you track that? Do you have an understanding of how much it is being used?

Ms BARRETT - What I can say is that at the moment 88 per cent of all Tasmanian secondary schools have sent someone along to training. A lot of those schools have sent people numerous times over that period so we have statistical data on who has come along. The training is over two days; it is quite significant training. For some of those schools that has been backed up with doing work at their school base so that those messages are consistent: 'What does it look like for us? How well are we doing in supporting the young people that we might identify as being at risk, for a whole range of reasons? What are our referral pathways? What do we do if someone is being bullied in the school?'. That is where I think the change really happens, where you are able to work with and engage with whole schools and staff in making changes at their schools.

CHAIR - What is happening at the 12 per cent of schools that don't embrace it or get involved? Is that a decision they are making?

Ms BARRETT - That is a decision they are making. When you look at what those schools are, they are quite often small schools or schools with particular religious backgrounds of their choosing.

CHAIR - They might feel they have the issues covered.

Ms BARRETT - They have the issues covered through their own curriculum or whatever.

CHAIR - Through other programs.

Mr WILKINSON - It is interesting that one of the submissions we have says that people are dying at 40, 50 and 60 from smoking but it is through a problem they picked up during their school years. It seems to me that that analogy can be transferred in some cases to suicide or attempted suicide. In other words, it is not the case that someone at the age of 40 will suddenly say, 'Yes, I am going to commit suicide'; it could be a case of the seed being sown in their earlier life and they have had problems leading right up to the last straw when they are in their 40s and 50s.

Ms BARRETT - Yes, in some ways the research says that schools in themselves are protector factors because young people are connecting on a daily basis with significant adults and peers. In a way it is after they leave school that they do not have those daily connections that are set up through a school structure, they are out in the wide world and they have to maintain those social connections themselves. That in itself can then be another risk.

I think also what you are alluding to is that for some young people who do not find school a really pleasant and safe place - that small percentage of young people who might be bullied or whatever - their unhappiness, depression and stress might start in adolescence. Depending on what happens with their life, that might continue down the track.

Mr WILKINSON - Sorry, I missed the start; did you give some evidence as to how this mindset started and how you came to get your expertise? Have you give evidence as to that?

Ms BARRETT - Not personally. My background is actually in social work; I have been a school social worker for 20 years on and off, plus I worked in health and community settings as well. Mind Matters itself came out of a national schools audit which was done in the late 1990s which identified that schools were increasingly having to deal with mental health issues, that the onset of a lot of mental illness was happening in the period of adolescence so schools needed to have that information and that schools felt that they really did not have a good resource that skilled them both in their own awareness raising and also in what they could do within the classroom curriculum.

Mr WILKINSON - So it is an Australia-wide organisation?

Ms BARRETT - Yes, Mind Matters was developed Australia-wide. It was a collaboration across quite a few universities in Melbourne and Sydney and quite a lot of very good minds got together to put it together. It has stood the test of time - five years later it is still being used quite broadly across all schools - so it was really well put together.

Mr WILKINSON - Are you making a submission to the terms of reference?

Ms BARRETT- No, my understanding is that I am providing you with information so that if other people say that we need programs in schools then you have an understanding of Mind Matters as being one of those evidenced-based programs which is being widely used in secondary schools.

If I was asked to comment on what the needs are, I guess I would say that a lot of primary schools have said that they would like to see a resource similar Mind Matters specifically developed for primary schools because those issues are being seen at a younger age.

CHAIR - With bullying and harassment, that is where a lot of the bad habits start, where kids are under the pump more.

Ms BARRETT - Absolutely. Primary teachers can and do come along to our training and they do see that it is relevant. Nationally we keep lobbying to try to get a primary-based resource so that funding could be extended. That is something that they are looking at.

Another initiative from Mind Matters is Mind Matters Plus which is really looking at young people who might be at risk and what other complementary programs there are that fit with Mind Matters. I have a little brochure there that talks about Mind Matters Plus. So what they did two years ago was offer 17 schools across Australia some extra funding to train and run those programs which are complementary to Mind Matters.

Collegiate was the Tasmanian school; you will see on there the list of schools across Australia. The programs down in the right hand corner are all the programs that they saw were evidence-based, and were consistent with Mind Matters. The schools were then able to choose which of those programs they wanted to implement and were funded to do that. They are currently being evaluated to see how well those programs fit and mesh with the needs that each school identified. So because anxiety and depression are the two most common mental illnesses that we see the onset of in adolescence, a lot of schools adopted programs such as Friends, Aussie Optimism, or Adolescents Coping

with Emotions, to see how they could have deeper supported programs that help young people develop the skills they need.

CHAIR - Those programs you just talked about, they are not in Mind Matters.

Ms BARRETT - No, they are programs that have been developed within Australia or internationally that Mind Matters have checked out to see that they are complementary and evidence-based. A lot of them actually target groups of young people. Mind Matters is universal - that is it is relevant to everybody everywhere. So if you were teaching Mind Matters in your school, you wouldn't just select certain kids and say they might be at risk. You would do it with everybody because everyone needs positive mental health promotion whereas a lot of these other programs actually extract groups of young people and say that this 10 per cent or 5 per cent of young people need extra help. Who knows who those young people are? That has really been the premise behind Mind Matters - it is actually something that everybody needs.

CHAIR - That's right. Who knows if those that are not included in that group are under threat?

Mr BEST - What areas do you think, not so much in relation to this specific program but on a strategic basis, where improvements could be made to prevent youth suicide? Just setting aside the program itself, I'm just interested in your experience and exposure to the issue of suicide. What areas do you think could be improved upon if, say, we gave you a magic wand, or something? You hate that question, I know. That's normally Jim's question - sorry about that. I didn't mean to throw the magic wand in, I don't know what happened there! Strategically, which areas could be improved upon?

Ms BARRETT - Because I work with this I'd see the value in mental health promotion. Strengthening mental health promotion in schools is just a fabulous way to work because you can capture so many more people. The other thing that we've noticed with Mind Matters is that it is also reinforcing positive mental health messages for staff because staff wellbeing is important. When we talk to staff about how to help kids bounce back, we realise that staff actually need that support as well, so that has been a really big initiative. Mind Matters have actually developed a staff matters web-based resource for teachers to be able to look at how well they are travelling.

Mr BEST - So is it fair to say that, whilst it is encompassed in the program very well, you think this issue of the promotion and understanding of mental health is important, even the broader community?

Ms BARRETT - Yes.

Mr BEST - Right. And is there anything else you would say about that, perhaps?

Ms BARRETT - I guess more money to do more of the same because my position is only funded 0.4 from National Mind Matters for the whole State across all three sectors. It really is such a drop in the ocean, and the Education department have added another 0.4, so at least I am working four days a week to make that a more reasonable coverage, but it is really quite a small -

CHAIR - So you are 0.8, are you?

Ms BARRETT - I am 0.8, yes; so 0.4 of that is national and 0.4 of that is State-funded until the end of this year.

CHAIR - When did that commence?

Ms BARRETT - In 2002.

Mr BEST - We have heard from other witnesses today about identifying people at risk, and I think you have covered that pretty well, and you have also added what you think is important. We also heard earlier on today that there is a lack of cohesion between different groups. That might not be the case with your thing because it is so broad in a sense and it is in every school, and there is not really anything you are competing with, but is that something that you are aware of?

Ms BARRETT - Philosophical?

Mr BEST - Well, philosophical but more so the cohesiveness between different groups. Do you hear anything about that in this area? Do you think that is a real issue or just a side issue?

Ms BARRETT - In relation to suicide?

Mr BEST - Yes, and the way the groups work together.

Ms BARRETT - I am not sure if I am with what you are saying, but I think that because of the way a lot of funding has come down, a lot of agencies are then forced into a very siloed approach because to meet particularly Commonwealth-funded requirements they have to fit into these boxes. Then you have young people who have to fit into their boxes. They have to be homeless or drug-dependent or at risk of HIV. There is a whole different range of risk areas. What Mind Matters is trying to do really is to say underneath all of those risk factors is a need to promote positive mental health, rather than what I was saying before about the risk and protective factors. It is really based on protective factors, so I think that kind of looking at what can bring those agencies together rather than having them siloed apart.

Mr BEST - That is fair enough.

Ms BARRETT - Our approach in the Education department has been very much about making links across program areas. Last week I did a two-day Mind Matters workshop with teachers in Launceston, and I invited in someone from the sexual health area, somebody from the drug education area and someone from the Child and Adolescent Service, so that within my workshop those other areas and links are made, and those other services are promoted, and we are all coming across with the same sort of message. Regarding our ELs curriculum within the Education department - I do not know if you have had any information about this - I have brought along a brochure about that because two of the core values that are in our new curriculum are resilience and connectedness and they are two that are being promoted through Mind Matters. I think that if teachers are fulfilling the requirements of the Essential Learnings then they would be promoting

resilience and connectedness as two of those values. Do you know what I mean, about us all talking the same language and using the same kind of approaches?

Mr WILKINSON - Can I put a scenario to you? I do not know how common it is, but it seems to be fairly common, from my information. A young girl of 15 or 16 may be a bit overweight, starts to worry about her weight, maybe gets a bit of an eating disorder, boys come onto the scene, a bit of stress of work. You are going from, let's say, grade 10 to grade 11 and matric. What's this all about? Boyfriend problems, stress problems because of work, wants to lose weight, eating problems. Does it pick those people up?

Ms BARRETT - What you would hope to see, I guess, is that some of those issues might be explored on a classroom basis generally. We would all acknowledge that everyone has tough stuff in their life, and there would be discussions about how you bounce back from tough stuff in your life or what are some healthy and unhealthy ways. There is one activity where you look at a whole range of different ways in which people cope with stress and how you choose which ways you respond in different scenarios, so helping her to see a bit more broadly what some of those possibilities might be. She might be in a classroom where they have actually used the Understanding Mental Illness booklet so that there would be some consideration of the myths and facts about eating disorders. Perhaps her friends might be a bit more supportive and her own awareness might be greater by actually seeing some of that information. There is also some stuff in there about help seeking and not being afraid to seek help. What are some of the barriers that get in the way of our seeking help and talking to other people about how we really feel? We know that often with eating disorders people get these mixed messages in their head and what you see on the outside isn't always what is going on in the inside.

Then I guess, apart from what goes on in the classroom, you would hope that the school would, through working with Mind Matters, be more aware of what they needed to do in making appropriate referrals for her and also engaging the family in that conversation.

Mr WILKINSON - So your Mind Matters would cover that type of problem?

Ms BARRETT - Yes, the discussion goes on across the whole curriculum but it is also about putting in structures and processes within the school so that alarm bells ring in teachers' heads if they are concerned about a young person and that they actually take action. They are not coming from a position of being in fear or not knowing what to do but actually having information there so that they know what to do and are able to put that into action.

Another initiative which I didn't mention before is Families Matter. What they have done nationally is say that parents need these messages as well, so they have developed a side initiative to Mind Matters which is about what resilience looks like for parents and how that message can be got out there to parents so that they are hearing the same things and they are able to also discuss what they are worried about in relation to their young people and stress. So a Families Matter initiative has been developed with Mind Matters and the Australian parent bodies and schools are now starting to pick that up. They can send parents along for free training - all the training is free, it is all covered by Mind Matters funding. Parents can have forums and teach each other about how we build our kids' resilience.

Mr WILKINSON - I know it is a matter of funding but in November Kerry and I went to a SPAR conference up in Sydney, and I went to a talk about suicide out at Laetare Gardens last week. I hadn't heard of Mind Matters before - and that is probably my ignorance - but it doesn't seem to be out there. From what you say it seems to be terrific and I just wonder what you need for it to be more out there so that people know what is going on and where to access it.

Ms BARRETT - I don't know, it is a different perspective. Because I am working with it, I see it all the time and am just amazed how many schools are using it, even schools that sent someone along to training three years ago - who's got the kit, where's the kit, how's it being used and you will find that it is being used. It is not something that is just gathering dust on school bookshelves, when a lot of materials that are rolled out are, which is really great. The Mind Matters web site is kept up to date and there is lots of really good information. There are school stories on there if you want to have a look at how schools are using Mind Matters right across Australia.

Mr WILKINSON - What I am saying is the community should know about it because -

Ms BARRETT - The community should know about it and we could do a lot more to promote it and make it strong in the community. How that happens, I don't know. I guess my position is the only position in the State but if we had a team of people working across the State we could do a lot more.

CHAIR - Mind Matters is more about mental health, the big picture, rather than a specific focus on suicide and suicide prevention which was what our conference was really all about. Just cognisant of the time, Helen, we need to conclude now. Is there anything more you would like to say to us?

Ms BARRETT - Not really, no, except Mind Matters have also had some partnerships with Kids Help Line and Lifeline and made a lot of posters and information for schools to display in order to make that connection and get that help-seeking message across so that if young people are in distress that they will call Kids Help Line. That has been a really strong national message.

CHAIR - Was that throughout all schools right through the system?

Ms BARRETT - Yes. Well, posters are available for schools to put up and there is information that partnerships have been made. Again, as you were saying, how much of that is actually known is really limited by how much we are able to do. I feel we have done a lot with such limited funding, but more could be done.

CHAIR - But it's a great kit, though, isn't it, to work with?

Ms BARRETT - Yes, it is.

Mr MORRIS - I would like to make a couple of brief comments. A real issue would seem to be how you keep the material up there. This stuff has to go on forever. It is one thing to put a poster up; it might last a year or two years but you have a continuous flow of kids coming through and that information needs to be always there.

Ms BARRETT - Yes. To have it embedded as deeply as possibly is the key so that teachers live it, breathe it, do it, and they even forget that it comes from Mind Matters. It is really about their promoting wellbeing. What we are talking about with Mind Matters is not just what you teach but how you teach. It is also putting the emphasis on staff/student relationships, helping them to build student relationships, to be aware when kids are in distress and to put good pathways in place to help them to get help.

Mr MORRIS - I am really pleased that this sort of stuff is in the ELs these days as a part of the core curriculum and it is probably enough to keep it in touch. I thought Mr Wilkinson was promoting the Mind Matters stuff - he has the colours on.

Laughter.

Mr WILKINSON - I knew you were coming today.

CHAIR - Helen, thank you very much for your time. If you think there is something you should have submitted, feel free to come back to us, through Kira. I like the idea, too, of your extension of this back down to the primary school level, so if you have some more thoughts on that you might care to put that in writing.

Ms BARRETT - It would be good to have that lobbied at a Commonwealth level because I know that that is a big drive. It is a lot of money and it would be boked at as a Commonwealth initiative.

CHAIR - Thank you.

THE WITNESS WITHDREW.

Mr LES WHITTLE, COUNSELLOR, ANGLICARE; AND **Ms ANGELA LUTZ**, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - Angela and Les, thanks very much for joining us today. I am assuming you will both be presenting. We are gathering information and working to our terms of reference, which I am assuming you have seen.

Mr WHITTLE - Yes.

CHAIR - If you would like to present your side of the story about the work of Anglicare, as you wish, then the members here will ask questions as you go along.

Ms LUTZ - Today, we don't represent Anglicare but rather one particular program, the Tools for Men program.

Mr WHITTLE - The Tools for Men program grew out of an Office of the Status of Women initiative in Canberra. The Office of the Status of Women some years ago had some input into the Federal Parliament to set up some programs that help men to deal with issues rather than allowing, particularly in the area of domestic violence, for their only to be reactive programs. Let us do something which is a bit more preventive. One of the problems that we have found in the Tools for Men program is that men don't come forward to say, 'I think I might have a problem in a week's time or in a year's time'. Men tend to become more reactive rather than proactive in their own handling of their wellbeing. So we have endeavoured to be as proactive as we can and we do that through a number of program styles. We recognise that men do not always turn up for counselling and again in some of my counselling experience I could say to a man, 'When has she left you or when is she is going to leave you?' and they will say, 'How do you know that?' because men only tend to turn up at the point of crisis.

So we still respond to those sorts of experiences that men might be having but we also try to do something which is raising the issue saying that is okay to talk about things before they get out of hand. We run workshops, we downgrade, move away from the strict counselling model which is that men will only go to a counsellor when it is a last resort and we all know that counsellors break up marriages because people who go to counselling normally separate. We try to do something that is a little bit different and we have called part of the Tools for Men program 'A Chance to Chat'. A guy might ring through to us and say, 'I have some issues. I need to talk to someone but I do not necessarily want to talk to a counsellor'.

We change hats which you can do in Tasmania fairly easily and instead of being counsellors we say, 'We can talk about what counselling options are available' and we call that A Chance to Chat. I will put it to guys that if they come in, I will make them a coffee and I will raid the biscuit barrel or something like that and we will have a chat about what the issues are. Most men will then come in, have a chat and after either half an hour with me or after some time with any of us they will start to disclose what the issues are anyway. That is a quick outline of at least some of the work.

Ms LUTZ - I think the main change to the general counselling service is that we change the jargon so we really avoid the term 'counselling'. We just call it having a chat to get back

on track because, as mentioned, the word 'counselling' is often associated with family court counselling and many men have had bad experiences with that counselling service, going through the family court. They often found out about the separation when it was too late. They did not read the warning signs.

CHAIR - Is your service statewide, Les? Can you give us some sort of picture?

Mr WHITTLE - When we put in for the funding we asked for the Rolls-Royce model and we got the second-hand Mini.

CHAIR - It could have been a push bike.

Laughter.

Mr WHITTLE - We were looking for statewide funding and we got enough to cover one region which is me two-and-a-half days a week and Angela one day a week.

Ms LUTZ - Not even that. My position is the senior counsellor in the south so I am responsible for overseeing a range of counselling for them but initially Les and I worked together on the program development and also I fill in in case the client wanted to see a female counsellor rather than a male counsellor.

Mr WILKINSON - So one of the recommendations is there should be more funding, you would think?

Mr WHITTLE - Yes.

Ms RITCHIE - Are you just doing the southern region?

Mr WHITTLE - The southern region. Another thing that we were a bit reckless about is that when the initial submission was going in we ticked the box that said 'Socioeconomically disadvataged' which is pretty much on par with Anglicare but we also ticked the box that said 'People who have some contact with the criminal justice system', so for some length of time I did a little bit of work at Risdon. I tried to get into Hayes. I found it really hard to get into Hayes. Some people find it easy to get in there.

Mr WILKINSON - Some people find it easier to get out.

Laughter.

Mr WHITTLE - I found it hard to get in. But I have done in Bridgewater and in Hobart a number of ongoing weekly workshops with people doing community service orders, and that is fantastic. They are conscripted to be there. They know if they are not they are going to be in breach of a court order so they have to be there. It is better than painting rocks just to sit down with Les for an hour or so, and I will raise issues about men's health, about our wellbeing. It might be the football and somewhere in that hour of talking about football or cars I will ask a question such as, 'Who is a good role model? Who is your star footballer? What things do they do well that you would like to emulate?' so we are starting to do something of an analysis of who we are. If we're talking about cars, at some stage I'll say, 'Were you born in a car, because you know so

much about them? How did you learn to do this?', so they will again relate to someone who has mentored them and helped them. When we think of the area of suicide, one of the features is that people do not have a network and they do not have role models whom they could lean on, or they haven't recognised them as healthy role models. So we'd be trying to fine tune that to polish that up so that they can see the role models and recognise them for what they are and continue to use them.

The other thing is to recognise whom they are role models for. For a lot of men, the issue is around fathering, around being a parent. This year I've had a couple of people who have been suicidal, and there have been the warning signs in A Chance to Chat, the counselling component of the work. The issue of parenting is significant: 'I thought I had the means, I had the mechanism and I was thinking of it, but I didn't because I thought of what it would do to my family and to my children'. So parenting is a really good key for us guys.

Mr WILKINSON - At this meeting last week there was talk about a lack of coordination between the number of groups out there that can offer assistance. Already today we've had Lifeline, Youth Network of Tasmania, and we are having TasCOSS at a later stage - and there's Anglicare. Do you all work together to assist each other or are you really working, say, just with Anglicare and somebody else is working with the Youth Network?

Mr WHITTLE - A worker with Relationships Australia who actually did his student placement with us and he is now working with RA. We've run joint groups, many groups, so he might have taken the initiative as RA tend to be good at doing group stuff. We have combined and together we're doing that.

Ms LUTZ - It is a family and community services family relationships program.

Mr WHITTLE - We have run a few groups in conjunction with them. Last year there was a national men's forum in Sydney and I put my hand up to share some of the principles at the national forum that inform our work. Again, Denis from RA was able to come with me. We ran our material past several groups down here. One of the local schools has a fathers' mentoring class every Friday or second Friday at Sacred Heart, so we ran our program past the men who were doing the mentoring. We didn't want to just go in isolation to Sydney saying this is a really good program. We wanted to keep trialing it.

One of the things that I found in working with men is not to say, 'I've got something here which is really good'. I will say, 'I've got this but I've got some doubts about it. Would you like to look through it and tell me what you think is wrong?' People will say, 'Yes, I'm glad I'm a peer with you', and they will read through and give an assessment, and at the same time they're actually taking in and digesting the material.

Mr WILKINSON - You've read that book *What Makes Juries Listen*; that's the way they deal with it as well.

Ms LUTZ - But we work together with the other community services, and we certainly get referred through Lifeline.

Mr WILKINSON - Say I came to you and said, 'Who do I go to? I'm contemplating suicide. I've had some problems at work', or something like that, or problems at home.

Ms RITCHIE - You voted for the Labor Party.

Laughter.

Mr WHITTLE - I'd say there's no hope, then.

Mr WILKINSON - We'll have a chat later on.

I come to Anglicare, and do you say to me, 'We can assist you', or do you say to me, 'I think you're probably better off with Relationships Australia, or you're better off with TasCOSS'? If I trot off to them, do you then keep in contact and say, 'Did Jim Wilkinson come and see you? He was having problems.' - that type of thing. Is that the way it works, or is that the way it should work?

Mr WHITTLE - We are a counselling program and we do some skills development, but if someone came in and gave evidence of being suicidal - they have slashed or they might disclose that they're suicidal or there might be other warning signs - then we have done some professional training around this area and we would go through a series of steps to ensure, firstly, they are still alive tomorrow morning.

Ms LUTZ - It is a risk assessment.

Mr WHITTLE - And that might be who are the people they trust' who is one person who they would like to know. We won't let them necessarily out of our sight. I have even walked down to the hospital with someone to make sure they arrived safely because on the way down they said 'I might duck off, I really feel that much at risk at the moment'. I'm not a counsellor, but there's still someone here, and we have a fairly good framework by which we could respond to the crisis.

Ms LUTZ - We have policies and procedures in place basically and we do a risk assessment. At first we probably want to check if the client is suicidal but, as you say, in your example, yes, the client is suicidal, so we would do a risk assessment and then would do a no-harm contract. It could be a verbal contract and then, documenting the state of mind, it could be a written contract, basically looking for self-help strategies - who could be contacted if the client felt like that again, giving out Lifeline's number, or even, as a last resort, accompanying the client to the Royal Hobart Hospital.

Mr WILKINSON - I am really trying to understand whether there is any conversation or contact between the other agency groups. Let us say you told me to come back in a week's time to see how things were going and I did not turn up in a week's time. I might then have gone to TasCOSS a week later, and therefore TasCOSS will have done exactly the same thing perhaps that you have done, going through the risk assessment. That person may then have gone to Youth Network the following week. If they knew that you have already gone through that process on the first occasion, it might save duplication on the second, third or fourth. I just wonder if there is that contact between you all to see whether that is the case or not.

Mr WHITTLE - I think when it is a really serious suicide risk, the chances of going from one agency to another are minimal, and we would do the networking on that person's behalf. If they are suicidal they are reclusive, they are in isolation, they are not wanting to talk to someone else, and if they have guts enough to tell us, the risk is they might not want to tell someone else immediately. I have had people on the phone and I have mentioned Lifeline and said, 'Look, if this person rang you, would that be okay?' 'Yes, it would be'. Or Men's Line would be another one, giving them some other options. For our part, we would be in contact with them either the following day or within a few days, and we would not be waiting a week. If they were that much at risk, we would either be saying, 'I feel really concerned for you. If it is okay I want to be able to ring you tomorrow. How can I ring you? Is that okay? Would that embarrass you?' 'No.' 'Will you be alive tomorrow, you will still be breathing? What things will help you to keep breathing until then?'

Mr WILKINSON - So your experience is, as I understand it, there is not the necessity to ring the others to see whether they have been there, because you believe that by them coming to you, telling you in the first place, experience has shown that they won't go to the others, they will still rely upon you.

Mr WHITTLE - They haven't been to the others. I think the chances of duplication are fairly small. We would actually be making the phone calls once they have come to us anyway. 'Do you mind if we ring your mother or your family?'

Ms LUTZ - Unless it is an after-hours service, because we only operate between 9 a.m. and 5 p.m. Some person might contact Lifeline after hours.

CHAIR - I just wanted to get onto that if I could, Angela, how do you get your clients? How do they come to Anglicare?

Mr WHITTLE - Jim mentioned before about lack of funding and lack of resources. We do not advertise, because we are already flat out. One of the things about our program is that there is a waiting list, and I am concerned that if someone rings up today it might be two or three weeks before they can get to see us. Once the contact is made, if someone has been in once they can drop off the radar for some length of time, but they will come back. But if they haven't got in the first time, we don't know what risks there would have been.

CHAIR - Who else would they go to? Who else is out there for them doing the same work that you do?

Mr WHITTLE - There are very few men's programs around, or programs that are supportive of men in some sort of way, so Tassie Male at Relationships Australia -

Ms LUTZ - But they provide a different approach. It is a group session, group support, rather than one-on-one counselling.

Mr WILKINSON - I know there is Women Tasmania, which is focused on problems that women had. The problem now is perceived to be that males in the age group between 25 and 44 are the major problem. Should there be a major focus from government like Men Tasmania, which is the same as Women Tasmania?

Mr WHITTLE - I think where there are issues that are particular to men they need to be addressed and they need to be addressed structurally, by including government departments or community support. Not just the mirror of OSW but something which addresses the issues that allow men to be more fully functioning members of the community and to have support and access to good services.

Mr BEST - A couple of issues that we have had raised include the early detection of mental illness and the awareness of that, and promotion of mental health and acceptance of that. I'm not pitching these against each other, but the primary one, from your experience, would be this issue of something for men?

Mr WHITTLE - There are probably several aspects to it. One would be having something available for men which is attractive and seen as male approachable, but there are other triggers that seem to occur and they are around a very complex set of factors: isolation, family breakdown, family court matters, employment, the view that we have of men as being the providers. That still carries a lot of weight; 'I think I should be the provider for my family. Oh, I haven't got a job or I've been made redundant. How do I cope with being a house dad instead of being out there working'.

Ms LUTZ - Economic failure.

Mr BEST - Do you see a link between work and suicide? Are these issues on an equal basis?

Mr WHITTLE - They are very complex and sometimes it is like having a bowl of spaghetti and pulling out one thread but there are a lot of other threads that are caught up with it as well.

Mr BEST - What then would you say, though, about the whole-of-community approach to suicide?

Mr WHITTLE - One of the dilemmas is that if we had a look at actual suicides and drew it as a pyramid, you would have a pyramid which is relatively small. If you then put in the base of attempted suicide, the bottom of the pyramid stretches out. If you then put in suicide ideation, it increases somewhat more. If you put in the rest of the population, it is a very big rest of the population, so to target the whole of the population isn't probably a good use of resources. So targeting the issues around mental health, family court, employment et cetera, if we put little triggers in there that help to support men at those times, I think we will address the issues, rather than an all-community approach.

Mr BEST - We also heard earlier on about the cohesiveness, I suppose, between different groups out there assisting people with suicide issues or prevention. Do you think there is a problem there with cohesiveness between groups or do you think that's not an issue?

Mr WHITTLE - It is, and on occasions it is a frightful issue. That is partly because some people like us might be coming from one particular understanding, others come from a medical understanding, others come from a psychiatric/mental illness understanding and others come from drug and alcohol, but the poor person might not have any of those.

There is sometimes some dispute over, 'Oh, they're not suicidal', or 'We can't respond. We only work office hours'.

Ms LUTZ - In the process of implementing a new counselling model it is best if the framework is on evidence-based framework. We try to utilise an integrated service approach where we really want to work closely with other families or significant others affected by the issue, and with other services that are involved. We want to have discussions and really work closely together with the other services to find out the real issue here, what we can offer, what the others offer.

CHAIR - Just coming back to your funding, is it State funding that you get?

Mr WHITTLE - No.

Ms LUTZ - It is Commonwealth government funding, Family and Community Services, and it is through the Family Relationships Services Programs Branch.

CHAIR - What is the likelihood of that being increased for you? Will you be holding your breath in this Budget tonight?

Mr WHITTLE - It might be someone voting for the Labor Party.

Laughter.

CHAIR - What about the State Government, have you looked for more support in this area?

Ms LUTZ - We will be looking for the continuation of the program because it started off as a pilot and now it is integrated in the counselling service provision. But in relation to other services, Lifeline obviously as you know is pretty understaffed and there is Men's Line. Is that at the national level.

Mr WHITTLE - Men's Line is national.

Ms LUTZ - My sense is that Men's Line is pretty well utilised by callers.

Ms RITCHIE - I think that the whole male perspective is interesting. I know there has been a lot of talk about men not being particularly motivated in terms of personal maintenance, what to use and not to use - like a car. Women tend to network with each other; we are more likely to go and speak to our friends or doctors more often than men would do, so I think in terms of our overall tuning of ourselves personally we are probably more attuned to that. I wonder what comments you would make in relation to perhaps cultural issues that maybe need to occur so that men - I am not saying women always get it right - can start to look at addressing their own ongoing maintenance in a better fashion.

Mr WHITTLE - I sometimes ask the question, particularly in mixed groups, what is good about being a man, what is good about being a woman, what is not good about being a man, and usually people will come up with relative responses. They will say, 'The good thing about being a man is that you don't have to have babies', so it is seen as relative rather than what are the things that people could do for their self care, regardless of

whether they are male or female, and that is probably one of the big hassles that occur in the issue around men's care. Are we responding from a traditional feminist model and saying men need to do something because they have done a whole lot of stuff that perpetuates the patriarchy or are men copping it hard because look at the Family Court, it takes such bias against men and it always goes in favour of women? There is still a big debate that men are wrestling with or the men's collective movement is wrestling with about that, about whether it is a feminist model that we should be using or a men's liberation model, and I do not think people have quite got the words or the jargon right.

Ms RITCHIE - I guess I more specifically meant, though, in terms of their capacity to go and access a doctor more often or in terms of their capacity to not perhaps see the word 'counsellor' as something -

Mr WHITTLE - Ought to do something other than -

Ms RITCHIE - Aside from any debate they might have about family courts and all those sort of things, I am just wondering more about their own personal care.

Mr WHITTLE - So if we highlight when - I have forgotten his name - the Queensland player from a few years ago missed the semi final or the qualifying final because his wife was having a baby and we wrote a letter to the paper congratulating him for that as a role model. It is sad for Collingwood, but Mick Malthouse was in tears at the end of the grand final. When I am talking with the CSO guys it is good to be able to say, 'Yes, to be able to express emotion'. I know it is only football and it is only Collingwood but it is good that a guy can actually do that, to be in tears in public like that - to make that cultural shift. It might take a thousand years but we want to be part of that shift.

Ms LUTZ - It is about challenging assumptions.

Ms RITCHIE - I just wondered how important you saw that in the overall drive regarding men, and of course in terms of prevention strategies for suicide overall. I would think that giving people improved access to understanding services and a willingness to participate in them is a large part of the battle, particularly for male groups.

Mr WILKINSON - There was a men's health unit of government, though, and they obviously did quite a bit of work on those same issues. What's happened to that, do you know?

Mr WHITTLE - That was predominantly policy based rather than service delivery. They looked at the impact of particular health policies on men, and the Government would be seeking advice from the policy worker while actually giving a lot of very inventive and constructive work. They really weren't a service delivery agent. They weren't in a position to do other than give support - they couldn't actually get involved in service delivery.

Mr WILKINSON - So the work that they did is not really, let's say, beneficial to -

Mr WHITTLE - Not in a concrete, tangible service delivery way.

CHAIR - We are going to need to finish up now. Do you have any closing comments that you'd like to put forward before we finish? Keep in mind, Les, and Angela, if you leave and you think of something that you perhaps should have submitted to us, or you want to get to us, let Kyra and Charles know. Are you submitting anything to the reference group?

Mr WHITTLE - Only in terms of that document which is a history of the programs, some of the difficulties that we've faced, some of the trends and some of the marketing tools that have helped us in our understanding of marketing our program - some of those dilemmas.

CHAIR - And if there's anything more that you feel you'd like to add, feel free to do that, won't you.

Mr WHITTLE - Thank you, yes.

CHAIR - Okay. Thanks very much for your time today, we appreciate that.

THE WITNESSES WITHDREW.

Mr MATT ROWELL, CHIEF EXECUTIVE OFFICER, TASMANIAN COUNCIL OF SOCIAL SERVICE INC WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - Matt, thanks very much for joining us. We are gathering information now pertaining to the terms of reference that we've set for the Community Development Committee, and if you'd care to make your presentation to us, then we will jump in with questions from time to time.

Mr ROWELL - When Charles phoned, I told him that we probably wouldn't have a lot of information at this early stage because we want to do some consultations with our members. But I've got quite a lot of material which will essentially form our written submission which we'll get in by the closing date in a formal written form.

It is probably important just to remind people that TasCOSS is the peak industry body for the community welfare sector, so that whilst we don't specifically engage in service delivery with clients on the ground, we represent the non-government community services industry in this State, which in Tasmania is made up of about 250 organisations that are funded by a mixture of the Department of Health and Human Services and other mostly Commonwealth government agencies.

As I said, given the short lead up to this particular day, we have just done some initial consultations with our member organisations who do work with clients or consumers of services on the ground. We have some initial findings. The primary area of concern for us is the role of non-government organisations in the prevention and intervention of suicide, and suicide strategies. Under the Tasmanian suicide prevention strategy there are a number of non-government community organisations that are funded specifically to deliver suicide prevention or suicide intervention programs. There is a much greater role for non-government organisations in suicide prevention in this State. The extent of the role of those 250-odd organisations across the State is much greater than just that handful of 10 or 15 organisations that receive the funding specifically for that particular purpose.

Mr WILKINSON - So, Matt, there are 250 organisations around the State that you believe could tap into this type of thing?

Mr ROWELL - Well, there are 250 non-government community service organisations that provide a range of services to disadvantaged or vulnerable Tasmanians - everything from Les and Angela's counselling service, Anglicare, through to providing community housing for people, through to family violence services. As I said, whilst many don't have specifically funded suicide prevention programs, most report to us that on a daily basis they are seeing clients who present, for whatever reason, to their agency who have either attempted suicide, are thinking of attempting suicide or have been touched by someone who has completed a suicide. As I said, it occurs across homelessness and housing services, alcohol and drug services, emergency relief and financial assistance services, and generic family support and youth services as well. This is further complicated in our sector by the fact that the complexity of clients presenting to our services has increased in the last number of years.

The Industrial Commission ruled that the community services award for our sector was out of date last year in that the complexity of clients presenting to each of those services and the expectations of the staff in those organisations and the level of skill and expertise those staff are now required to have in dealing with those clients is at a much higher level because we are seeing a greater incidence of clients coming through the door, not just because they're homeless, not just because they have a drug or alcohol addiction, but because they are homeless and have suffered family breakdown or have been a victim of violence and also have a drug and alcohol issue. As I said, clients no longer present to those organisations with just one issue.

Separating alcohol and drug issues from mental health issues or homelessness from family violence issues is really quite difficult. The duality and complexity of the issues that people present with and being able to, as an organisation, just attend to one particular issue is really quite difficult. We are finding that organisations really need to be looking at ways of attending to the multitude of issues before they can get to the root cause of why they are walking through the door. So if someone presents and is homeless and they express that they are feeling suicidal, then of course they are not going to be able to attempt to look for affordable housing until you have dealt with that initial mental health issue or emotional issue. As I said, as a result of the increasing complexity of client issues, services are seeing more people who are literally frustrated with not being able to get a service or with the multitude of issues that they present with more people are verbalising to the staff in those organisations that they are feeling suicidal as a result of that.

The other major issue for the non-government sector is the notion at the moment in this State that mental health services are at full capacity. Lots of non-government organisations would have referred people off to either the community-based services - when I say 'community based' I mean the government-run community-based outreach mental health services or the crisis teams or to the residential psychiatric facilities - but it is harder to get people referred to the government-run organisations because they are full, because they are at capacity. We know that mental health services have a major backlog and I guess that we applaud government's commitment to addressing that through Bridging the Gap and through funding the initiatives in that over the next four years. I think that by implementing that particular program of reform, in the coming years that will make a real difference to the non-government sector and should reduce some of the pressure that has built up on generic, non-government community service organisations.

Disability Services also are experiencing an increase in the number of people with dual diagnosis. Historically when we have talked about dual diagnosis in health care we have talked about people who have alcohol and drug and mental health issues, but we are now seeing a greater incidence of people with disabilities, particularly intellectual and physical disabilities, who are also being diagnosed with mental health issues. So it is the Disability Services sector that is also experiencing an increase in the number of people who are also experiencing suicidal ideation. It is important to note that two-thirds of the disability sector is delivered by the community services sector so it is by non-government organisations. In the mental health sector more and more of those services are being contracted out to non-government organisations. In fact 70 per cent of the Bridging the Gap reforms will go to the non-government sector on a recurrent basis rather than to government-run agencies.

Mr MORRIS - On that point, do you have any understanding why we have a situation where the government mental health services are at capacity? They have been at capacity for a long, long time. Is it because of increasing expectations or is there a real increase in the number of people presenting with their more complex needs and is there any clue as to why that is? Especially in the last few years we have supposedly an increasing number of jobs, the lowering of unemployment, and if employment is one of the key issues in people's wellbeing then we should have started to see the pressure back off but instead we seem to be somehow seeing a greater demand. Have you any insights into that?

Mr ROWELL - I think, Tim, it is all of those things and I think that you would have heard from a range of people who know more about suicide specifically than we do as the generic peak body but I think that now we have this historical thing about mental illness being seen as something that is swept under the carpet and not having a public profile, so as the stigma around mental illness has reduced in some ways then more people are accessing services. Probably growth in services hasn't kept up with the need. We have seen the impact of deinstitutionalisation with the Royal Derwent and Willow Court being closed down and probably not the appropriate amount of community resources being put in, because we weren't sure how that would play out, to support people and to prevent them from ending up in dire straits, I suppose.

But I also do believe that whilst, yes, in the last two years we have had a reduction in unemployment - and I will talk about unemployment as a key factor in suicide in a minute - what we are now left with, if you think about it, is that if Tasmania has an unemployment rate of 5.6 per cent, those 5.6 per cent of people are the ones with multiple barriers to work so they are not the ones who are on the fringes of the labour market and coming in and out of the labour market because they have some skills or have been made redundant or the company have downsized or whatever, it is generally and genuinely those people who have the most barriers to being able to get jobs so we are talking about intergenerational poverty. We are talking about people whose family have never known work. We are talking about people who do not go past year 9 and 10. We have people with profound disabilities and people with profound psychiatric illness, so what we are essentially left with in terms of what is available for the labour market, particularly with those long-term unemployed, is a concentrated melting pot of people with a complexity of issues. So in terms of how the labour market changes impact on people with regard to suicide, yes, the more jobs there are the more people are feeling okay about their lives, are able to manage their money and are able to pull themselves out of that kind cycle probably but we still have this quite a large number of people in Tasmania who have been unemployed for a long time and have barriers. As I said, in the community services industry over the last five years there has been a remarkable, notable increase in the number of people presenting with more than one issue and I think that that has been a major factor.

Mr WILKINSON - Is that because of the way the questions are asked now as opposed to the way they were previously? For example, if I came to you and said, 'I have an issue of schizophrenia' but really I had a number of other issues but because, let us say, you were not as well trained as you are now, you just focused on that one issue as opposed to delving deeper to see whether there were any other issues, or a bit of both?

Mr ROWELL - I think it is a bit of both, Jim, but I think there has been an upskilling of the community sector so I think that as client complexity has increased so has the need for

staff in that industry to be smarter, more skilled and experienced in how they do assessments for clients. There are some parts of the community sector that now have really thorough assessment guidelines so that we have people in homes and services who do assessments about what kind of barriers you have to maintaining a tendency. So it is not just about making a referral for public housing and getting someone a house; it is about if we do that are we going to be able to maintain that tenancy? If you make a referral to a private landlord are you going to be able to sustain that tenancy if a person has a psychiatric illness that we know is episodic and may not pay his rent for two weeks out of every three months because he is having an episode? I think that staff in our industry are much more skilled now at picking up on some of the indicators of other potential issues that may impact on those sorts of things.

CHAIR - Do they look after their own policies and protocols in dealing with people with the sorts of issues that we are talking about? Do they have their own or does TasCOSS have instructions that go out?

Mr ROWELL - Sorry, the organisations have their own, do you mean?

CHAIR - Yes.

Mr ROWELL - Individual organisations do have their own assessment and you heard Angela talk about their assessment procedures. Each organisation has their own and I guess, depending on where your funding comes from, there are often guidelines attached to those procedures. So if you have a family relationship support service that is funded by the Commonwealth, there will probably be a set of guidelines attached to the work that you have to do in that particular area. The Supported Accommodation Assistance program, which is the national response to high-risk assessment, is providing support services and shelters for people who are homeless or at risk of homelessness. There is a set of guidelines that is attached to assessments and the work that those organisations do. Most organisations have their own guidelines, often driven by their funding contracts.

Non-government organisations are also experiencing record numbers of what we call 'turnaways', people who are only able to receive a service when they present because there are not enough staff on the ground and because there are more people coming through the door seeking services than they are able to provide assistance to. You would be familiar with some of the publicity around Lifeline, and Angela and Les talked about that. There are times where Lifeline is only able to take one in every four phone calls. Lifeline is considered to be an essential service. It is one of our only 24-hour services and it is the one that most community organisations that work between nine and five refer clients to after hours to pick up that support. Because of their funding situation they are not able to take all the calls that they receive, so there are some real concerns about how those 24-hour services are resourced.

CHAIR - Is Lifelink Samaritans on the radar in the south of the State?

Mr ROWELL - I don't think they operate in the south; I think they operate in the north.

CHAIR - They are statewide.

Mr ROWELL - Are they?

CHAIR - Yes.

Mr ROWELL - I wasn't aware of that.

CHAIR - You can access them by phone. Today we have heard Lifeline, but Lifelink Samaritans do have their 24-hour service.

Mr MORRIS - Matt, the one position that you are probably privileged to be in is the chance to have an overview of each of your members and the types of services that they provide. Do you keep databases on the services that are provided by each of your members so that you can see if, say, there are three providing one particular service statewide or whether there is one doing it twice in the south and not in the north - this very issue that we are talking about? Do you have an idea of what is going on there? Obviously one of the issues must be, if there is a shortage of services in one area, is there a corresponding oversupply of services in another area. Maybe recommendations might be made that at least even this out so that if there is a shortage it may be statewide.

Mr ROWELL - I don't think that anyone in the non-government industry would say there is an oversupply of services

Mr MORRIS - I am not just thinking of the non-government, but perhaps the government and the non-government when thrown together.

Mr ROWELL - We don't keep that data as well as we could. We have a database that is based on all the funded organisations, where they are and briefly what services they provide. One of the things we want to do this year is to do a community-sector census that gives us a much greater indication of what is happening on the ground in every community in the State. We don't do it as well as we could but we plan to.

Mr MORRIS - Right, we had better talk to you next year. I think that is really good to know that that stuff is being dealt with. Assuming that there is not going to be an ever-increasing amount of extra resources that can be thrown in, we also have to maximise the value out of the resources that we are getting and try to target those and make them as efficient as possible.

Mr ROWELL - We have a reasonable sense of what services are available in different parts of the State. It is not hard to find out. As a peak body we still get community members finding us and wanting to know where to go for support around particular issues. We are always to provide them at least with the organisation's name in Smithton or wherever it might be. It is such a small sector by interstate comparisons, so we know who the main players are. There are a number of statewide organisations that deliver services right across the State. The Salvation Army and Anglicare, for example, have services in most communities around the State.

Mr WILKINSON - Do you have any idea about the amount of assistance which is occurring, like neighbourly assistance? Say you live down the road from an elderly lady or fellow and that person has had suicidal ideations, maybe because of the death of somebody who was their partner for 40 years or they aren't as mobile as they used to be. You have that community assistance from the neighbour down the road who goes and

has a cup of tea with them and helps chop the wood, mow the laws and that type of thing. That happens a lot in the community. Do you have any idea how often that occurs?

Mr ROWELL - We hear that it doesn't happen as much as it used to in Australia. Communities have become much more disconnected and less supportive of each other. What we hear now from that kind of concentrated group of people who have, for example, multiple barriers to employment, is that they are also are the same people who have a lack of family and community support networks. We do hear some examples of particular isolated rural and regional communities that do band together and come up with their own strategies. There is one in particular - Tandara in the north-west - which was about driving the community to take responsibility for their high level of suicide, but I think that is not the norm. What we hear from individuals who come through our doors is that they do not have the support that they used to have. There is probably also a reluctance to reach out for that support in some groups.

Ms RITCHIE - In order to try to deliver services to the best of our capabilities, do you think that the problems at the moment - and you have talked about people being turned away and so on - simply come down to the need for more funds to be injected, or do you think that it is perhaps a combination of a need for more funds and also for restructuring the different organisations across the board? Can you make some comment about that?

Mr ROWELL - I think that the community sector is pretty disconnected and I think that is probably a product of the way that funding has been rolled out to the sector over the years. There is a multitude of funding programs in the State, with a multitude of organisations out there all vying for similar funding. We have some organisations that receive funding from 15 or 20 different line agencies in different State and Federal government departments. In the past that has essentially meant that State and Commonwealth agencies have not talked to each other about planning services. One of the things we have talked about whenever we have sat at this table is the need for government departments within and across the State and Commonwealth to plan for where they can best direct their efforts. I think it is really important that we continue to sell that point - that there is no point in just putting services into places where there may already be services doing the same thing without communicating with each other. There is absolutely a need in some areas, such as housing and mental health, to look at generic family support, for example, and do some solid planning where the need is greatest.

Ms RITCHIE - But perhaps if governments did decide to look at the way they were going to roll out their funds, some of the 250 NGOs themselves might have to restructure and others might end up not existing at all. Is that something that non-government organisations discuss between themselves?

Mr ROWELL - I don't know that they would discuss that directly. I think there are some good examples of NGO networks working well - for example, emergency relief providers who give assistance to people in financial hardship. They have strong networks set up in each region about sharing client information and making sure they provide assistance to people who are most eligible. I also know that there are more NGOs out there engaging in partnerships with each other to deliver services. We are looking at innovative partnerships between organisations to deliver services in regions where perhaps one of those agencies may not have been before but another one does

have that capacity. They are acknowledging that each organisation brings a different set of skills and experiences around particular services.

Ms RITCHIE - Do you think that the State or Federal governments, or whoever is funding a particular program, actually follow up appropriately and regularly enough to ensure that they are getting the best value for their dollar in terms of the delivery by the organisation they have funded?

Mr ROWELL - Again it depends on which funding stream it is and which government department, whether it is State or Commonwealth. Some State contracts that provide services for homeless people, for example, have very few requirements in terms of reporting or evaluation, while there are some Federal government contracts that are really rigorous about self-evaluation and employing external evaluators in their program. But then there are situations such as the Stronger Families and Community Strategy, which the Feds rolled out four years ago, developed community capacity across the country and then ripped most of those programs out at the end of that cycle and left communities with expectations of receiving support services but didn't fund them anymore. As I said, it depends on which funding stream it comes from and which government agency.

Ms RITCHIE - More broadly, I was wondering whether you feel that the relevant government agencies make sure that the taxpayer is getting appropriate -

Mr ROWELL - I think more and more NGOs are being required to provide a greater level of accountability, so we are getting smarter at that stuff.

Mr BEST - We have talked a little with other witnesses about the cohesiveness between groups - it fits with what we are talking about. In some ways, I suppose, it can be a positive thing to have some sensible competition but in other ways it is counterproductive. I think you made the comment that you do not want to have two organisations in the same area, one providing a service and one trying to provide the same service. Do you think there could be greater cohesiveness if there was a bit more policy on this issue, or do you think that, in the overall scheme of things, that is not a big issue? On a scale of, say, one to 10, there are probably bigger issues out there.

Mr ROWELL - I don't think it's a huge issue in relation to suicide and mental health. Competitive tendering has really fractured our sector over the years and we now do hear reports of organisations, particularly smaller ones, that don't put the time into putting submissions for funding programs that get rolled out in their communities because they don't believe they will be successful against some of the larger organisations.

Mr BEST - Because the competitiveness has gone too far, it has lost sight of -

Mr ROWELL - I don't know how you roll it back, but certainly it has resulted in some fractures in our sector. We advocate continually that Tasmania needs a robust and diverse community sector, if for nothing else than the fact that communities need a variety of service models to meet their needs or models that fit their community best, given that 60 per cent of Tasmanian communities are regionalised. We have a whole range of communities with specific needs and therefore need services that meet those needs best. Clients should also have, in an ideal world, a choice about what services they want to go to. If they want to go to a Christian agency, they can do that; if they don't

want to go to a Christian agency, they don't have to do that. Given that, if those organisations are all stretched in that capacity, then most clients don't have a choice; it's about whatever region you are in, then you go to that particular agency for that reason.

Mr BEST - Given that you cross a lot of different groups, what would be your key opinion about suicide prevention?

Mr ROWELL - It is such a huge question, there are a whole range of things. It is about community education, it is about support services on the ground, it is about service integration between government and non-government services, between non-government services themselves, between different levels of funding bodies.

Mr BEST - It is a networking thing - is that how you see it?

Mr ROWELL - I think it is about smooth integration. One of the examples I had from a youth service for this material today was about young people who, with borderline personality disorders, were admitted to one of the hospital's psychiatric units and then discharged onto the street with nowhere to go. There is something wrong when the clinical part of the system can't liaise with the non-government part of the system about trying to find emergency accommodation. So what happens to a young person who may have been in hospital for a week? Their illness is being managed, they have stopped having suicidal ideations, but they go back out into a cold night in Hobart. What is that going to do about how they are feeling about themselves and the world?

CHAIR - Matt, being cognisant of the time, is there something else you would like to present to us?

Mr ROWELL - I am really happy not to present the whole lot because it will come in the submission and then if you take further evidence we will flesh that out further.

The one point I really wanted to make is the importance with the unemployment as the key driver of poverty and the key driver of some of the issues of the age group we are talking about, particularly the 25-44 male age group. Sixty per cent of all Tasmanian men who are in receipt of unemployment benefits are in that age group, 40 per cent of all men on disability support pension are in that age group. So we have particular issues about that age group and if TasCOSS could assist both governments to deal with employment and have a zero unemployment rate, then the poverty work would almost be done, as would some of the pressure on people who experience social isolation, a lack of support around them and are unable to provide financially for their families so they get themselves into states of despair. It would reduce financial pressure on families so there would be less financial breakdown. So I think the issue that has been discussed a bit this afternoon about employment being one of the key factors in not just poverty but also in social isolation and therefore suicide can't be stressed hard enough.

CHAIR - Matt, thanks very much for your time.

Mr ROWELL - You are welcome.

CHAIR - We will look forward to that submission when it comes through.

THE WITNESS WITHDREW.