THE PARLIAMENTARY STANDING COMMITTEE ON COMMUNITY DEVELOPMENT MET AT HENTY HOUSE, LAUNCESTON, ON THURSDAY 4 AUGUST 2005.

INQUIRY INTO SUICIDE PREVENTION

Mr MARTIN HARRIS, DEPARTMENT OF RURAL HEALTH, UNIVERSITY OF TASMANIA, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR (Ms Thorp) - Thanks very much for making yourself available. You would be aware of the terms of reference of the committee. The outcome of this will be a report that we hope will make sensible and useful recommendations about how the issue of suicide is dealt with in this State. I am looking forward to your contribution. If you would like to tell us what you want to say and then we will ask questions.

Mr HARRIS - I think the question and answer process might be the best way. I will give you a little bit of a background about my involvement in suicide prevention, and then some of the work that I have been doing, perhaps to declare my interests so that there is some transparency there, and then we can perhaps go to questions and answers, because I would like to be able to respond to your concerns or what you would like to know.

My background is in education principally, and I worked in education for 20 years until 1998. In 1999 I went to the university's Department of Rural Health. I was completing my Masters in counselling and education psychology, and went to do some practical work with Oak Rise, the child mental health program here in the north, and from there was asked to complete some suicide prevention work for the university, who had been asked by the Department of Health and Human Services to help them. That was the original youth suicide prevention program from the Department of Health and Ageing, and they were looking to bring to Tasmania a youth suicide prevention program. It was very much the early days of that NYSPS funding. The response to that was to look at the existing programs. In fact there had been an audit done of some of the programs that had been designed. You would be aware of the ASIST program, the Canadian program that Lifeline use -

CHAIR - Yes.

Mr HARRIS - and there are a number of other programs that had gone through this audit. Kate Blackmore, who is actually Chris Moorhouse's partner - I think you've spoken to Chris or are speaking to Chris today - did the audit of that program, and she has an interesting background not in suicide prevention particularly but in that process of the audit.

The program that we adopted for Tasmania was the Gatekeeper program which is the one I have been involved in since 1999, and my task was to adapt the Western Australian

program for Tasmanian purposes. The Western Australians, for all the reasons of geographic dislocation and distance from the east coast, seem to get on with things a little bit ahead of the rest of the country, and they certainly have that isolation mentality that if they don't do it no-one is going to do it for them, and their program is, I think, years ahead of anybody else. They also have a ministerial council for suicide prevention, and this ministerial council might actually provide a model that is worth looking at, because it draws from Justice, from Education and from Health - I think they are the principal players - and they have a range of criteria that they look at in terms of trying to address the problem of suicide prevention in the west, and there are a number of satellite models that hang around the ministerial council. There is one for research, I know. There is one for indigenous populations, another one for education and training and so on. But that model might be an interesting one for you to have a closer look at.

Mr FINCH - What is that called, Martin?

Mr HARRIS - The Ministerial Council for Suicide Prevention, so the acronym would be the MCSP. I have contact details for them if you want that, so I could provide that for you.

I had quite a close link with that ministerial council and invited them to come and look at the Tasmanian circumstance and just see how well we could adapt the Gatekeeper program for our purposes. One of the good things about the Gatekeeper program is that it is an Australian product and you are allowed to modify it for the populations to whom you deliver, which is one of the criticisms that I have of the ASIST program, which is a Canadian program. While the content of the ASIST program is excellent, they are quite firm about copyright and they are quite firm about the way in which it is adapted for any other populations. There are lots of other programs in that audit.

Another one that I looked at, but it was a very clinical program, was one called Keep Yourself Alive, which was a program developed by Professor Graeme Martin, who was at the University of Adelaide. Now he is in Brisbane at the University of Queensland. The Keep Yourself Alive program was in fact embraced by the Divisions of General Practice, and they have been on a regular basis rolling out that program for GP training, for the professional development points for general practitioners. That is a good thing, except that I think within the GP population you tend to get the same people putting their hand up. My experience of GPs is that they either have an interest in it or they don't, and when they elect for those professional development points they tend to go where their interests are, and not a lot of GPs are principally interested in suicide prevention. I think it frightens them a bit.

CHAIR - We haven't had a great deal of response from them.

Mr HARRIS - No. But, interestingly, and I am trying to think of his name - and I am jumping about, but just excuse me; I will come back to the programs - just a fortnight ago the Tasmanian representative for the National Suicide Prevention Council was appointed. Originally we were represented by Ian Webster at the national level. Ian was the chair of that committee and a terrific representative, but there was no Tasmanian representative. We were left off the map again. And then Barbara Hocking, who is currently the chair of Sane Australia, a mental health organisation, was our Tasmanian representative for 18 months. Then two weeks ago - and I am not even sure that this has been announced - but certainly I am not even sure that this has been announced, but

certainly we have a Tasmanian representative and he is a GP in New Norfolk, and his name will come back to me before we finish this interview. That will provide a good chair at the table, because until now we have only been represented in a de facto way. I think if we get the right kind of representation at the national level we are more likely to be supported in the programs that committees like yourselves and others involved in the area might promote. It also gives us an opportunity to be heard in that reverse way, that not only do we find out what is going on at the national level but we would be heard and have a seat at the table, because the de facto representation was never very satisfactory. However, when Ian Webster was doing that, because he was the chair he was determined not to disadvantage us, so we probably got a good run for our money there.

The Gatekeeper program was my original reason for being involved. I rewrote that program for Tasmania and invited the Western Australian trainers to come down and do a round of training for the Tasmanian community. We trained about 80 interested persons: most of the guidance officers and social workers from the Education department, a range of people from non-government organisations, quite a few from Health and Human Services involved in mental health. We are pretty pleased with ourselves. We had a really good turn-up and there was an eagerness to be involved. We did one in the south, one in the north and one in the north-west. We selected 22 persons to go on to train to deliver the programs.

CHAIR - Train the trainer.

Mr HARRISS - The second half of the train the trainer model, and we trained those 22 people. As happens in all walks of public life and private life, they tend to move on, they do not stay in the same position, so you train a person rather than a position and they move to other things. Of those 22, probably eight are still active in the process, about four from the Education department whom I know and they inform me and give me feedback and evaluations and so on, but they continue to do the work. Karen Gee is up here. There is a number of them who are still working in the Education department, and I support them when I can with materials. Tim Johnstone, who is on your list, is another trainer, and Tim is quite active in the training program. In fact, that is his thing, to be involved with community training, and he is probably the most active trainer. Tim varies from delivering the Gatekeeper program to delivering programs of his own design, which I think draw heavily from the Gatekeeper and from whatever that community particularly wants. Colleen Jackson is another one. She is a sister in the Sisters of Charity in Devonport, and she does a lot of work in grief and bereavement, and Colleen is an excellent resource. Are you going to the north-west?

CHAIR - We were there yesterday.

Mr HARRIS - Colleen is probably another one you should have on your list for people to consult.

CHAIR - We could do a phone interview, perhaps.

Mr HARRIS - Yes, just to get her feelings, because she has some real insights into the bereavement postvention aspects of suicide and is a really valuable resource. I continue to do the work. Anyway, there are a few.

The next stage of train the trainer - that is, training people to train the people that give the workshops - requires a Certificate IV in workplace training and assessment. Two of those particular trainers have that qualification now - myself and a chap in Hobart who was with the Department of Health and Human Services and now works for the Department of Sport and Recreation. His name is Brook Teale. Brooke and I now provide the opportunity to train up as trainers within the Gatekeeper program, to train those who deliver the training to have this model sustained in Tasmania. It has been a long, hard haul. The original funding ran out, so there was no money. The university carried me for 12 months and in that time we shifted from training the populations to getting the qualifications to deliver this sustainable model. In that interim period I also worked on some training material for the Tasmanian police force and worked with Mike Ryan, the police psychologist, and the head of the Rokeby academy. We have now taken the Gatekeeper model and moved it into the police academy training. The police had no suicide prevention training at all. In fact, when I delivered that first round of training to the police, I could not get out of the car park. The police wanted to ask question after question. In most crisis moments they are the first point of call and they really don't have very much information or understanding. In fact the commissioner came to the training and was sitting in the corner watching this to see whether it was a good idea to unleash me on his cadets. The first question I asked was to about 70 or 80 cadets was, 'How many of you have had close contact with a suicide or a completed suicide?', and about 75 put their hands up. You could see the commissioner's jaw dropping.

CHAIR - Does that include things like dealing with someone who is on the edge of the bridge?

Mr HARRIS - That sort of thing, but I didn't qualify it by saying, 'Was it family, was it friends?'.

CHAIR - No, but I mean in terms of the training?

Mr HARRIS - The training they do is very much about the police protocols and what to do in the circumstances. Their understanding of suicide was pretty thin. It is such a complex area that any glib answer, any kind of protocol for someone who is suicidal is only going to be handy at best because it's just not that easy.

That particular program hung in abeyance when the funding ran out. I continued with the police and some other NGOs who wanted to develop programs. I did have funding in that 12 months to develop an older-persons program. It was a Tasmanian program and my focus for that was the Oatlands multipurpose health centre. Working out of Oatlands we looked at older persons, particularly older rural and remote communities.

CHAIR - Did that involve the laughter therapy stuff as well?

Mr HARRIS - No, but I know about it.

The older-persons program I then gifted back to the Western Australian ministerial program. They took those two programs and amalgamated them and produced a whole-of-population program for the Gatekeeper, which, as I said, was a youth focus one. So now the Gatekeeper program has a whole-of-population target, rather than it being a

youth focus. The program has been reborn as a whole-of-population suicide prevention program.

That brings me up to the end of 2003. Last year I was fortunate to be funded for the Tele-Check program, which I know Justine and Irene have briefly mentioned. I am not sure how much you would like me to tell you about that program.

CHAIR - Well, we would like to know about it. They were going to and then when they realised we were seeing you they didn't elaborate.

Mr HARRIS - They are two of my trainees. The original concept of TeleCheck program is an Italian one. A Professor Diego de Leo, who is an esteemed colleague and a specialist suicidologist, a world-ranked researcher in the area -

Mr WILKINSON - He was the fellow in Sydney, wasn't he?

Mr HARRIS - Yes, you would have met Diego - tall, smooth-talking, dark hair. He looks like an Italian singer. He's got the look. Did I introduce you to him? I think I might have.

Mr WILKINSON - I think you did, yes.

Mr HARRIS - Diego was based in Italy, and now heads up the Australian AISRAP, the Australian Institute for Research Into Suicide Prevention. The Tele-Help model was a northern Italian model. It was not particularly a suicide prevention program but it was more about palliative care, respite care for those in rural and remote communities, because they felt that their clinical outreach to these people was inadequate. They began a proactive telephone contact with the people on their books to identify their issues, their problems, their concerns about medication or the general somatic -

CHAIR - They weren't waiting for people to ring them up?

Mr HARRIS - No, which is the Lifeline model, the crisis model. This was more about 'Hello Lin, it's Martin here. How's the medication? Did you get the script filled? Have you got firewood at the house? Who's walking the dog? Is there food in the fridge? Oh, they cut the power off, did they? Okay, we'll see what we can do about that.' It was very much addressing the environmental needs, the physical needs, the emotional needs, but the serendipity of this contact was that the suicide rates in that community dropped to just about zero.

CHAIR - Because they were taking away some of the events that would lead people to feel -

Mr HARRISS - That would take them on that trajectory. Diego seized on this and did some analyses about the process and then set in train a 10-year evaluation of this program, in particular addressing the suicidality in the region, and wrote a number of quite academic papers on that. In my contact with Diego I suggested to him that Tasmania might be a great population to invest some of this, because it is a fairly stable population, it is rural, it is remote, it is isolated. We can probably get some decent evaluations out of this.

CHAIR - We're an epidemiologist's dream really, aren't we.

Mr HARRIS - We are. He encouraged me to make an application for a grant, and that grant was successful, and then Diego helped me write the program. The irony was that the intention was to look at the Italian model and really to take the wisdom from that and to adapt that for our purposes, translate all the training into English and see what we could draw from that, and basically co-opt them into being our partners in the program. About the day after I got the funding the Tele-Check model, Tele-Help model in Italy was sold to private enterprise and is now a working model for the area around Genoa. It has gone into Austria and Switzerland and all those areas surrounding northern Italy on a pay-for-service basis. It has been so successful they now do it on a pay-for-service basis, so if you have a relative or a family member for whom you think this program might be useful, you pay your fee and then they involve that person. Their willingness to share that dried up. They said, 'No, it's ours, we paid a lot of money for it, it is going to be our little cash cow', so we were back to square one. So Diego and I and other experts began to rewrite the program, we reinvented the wheel, and the reinvented wheel looks all right.

The four areas that we addressed I alluded to earlier. There was the physical, the psychological, the environmental and -

CHAIR - Spiritual?

Mr HARRIS - It is not spiritual but it certainly comes into it, but the proactive contact with the clients was the genius behind that, looking for an opportunity beyond the clinical setting to reach out to those people who might be on that trajectory of risk. It is not a crisis response model. It is not saying, 'Here is someone that is suicidal. What are we going to do about it?' but it is saying our increased understanding of the needs of individuals who might lead them to that trajectory is pretty well understood now. It is complex and it is very much contextualised in that particular individual's moment.

CHAIR - What might be a disaster for one person will not be for another and vice versa?

Mr HARRIS - That is right. And support systems vary and the moment varies and not everybody is suicidal all the time. There is that moment where it just seems to be too much and they choose death as a logical solution to their problems which is so counter-intuitive to everybody else but for them it seems like the right thing to do but there is the dilemma: preventing someone from getting to that point is a much better way of dealing with the problem than waiting until they have been there, rescued them and then looking at some sort of repair for their already damaged psyche. But it is more complex than that also because then there are all sorts of contributing factors, not the least of which is depression and how depression is treated.

CHAIR - Is there any suggestion of reporting, from the medical fraternity, of people they are treating for severe depression. Does any of that go on that you are aware of so that people are alerted outside the GP or whoever is treating?

Mr HARRIS - I think you would fall into the area of confidentiality. The ability to share that information is quite limited and doctors are very loath to share.

CHAIR - Understandably.

Mr HARRIS - And I think in this increasingly litigious world that they would steer clear of any threat of them being accused of breaching their ethical trust with their patient.

Mr WILKINSON - Would it be a good thing? It is a bit like, I suppose, GPs if they think a person is dependent on alcohol. They often write to the Transport department and say, 'I think Joe Bloggs is dependent on alcohol. He should not have a licence therefore test him'.

Mr HARRIS - The ability of a GP to be part of a network of care for somebody is crucial. How much they share with that network I think is going to be a client decision in discussion with the GP. I will come back to the Tele-Check model because I want to describe it in a little bit more detail. The discussion with the client or the patient would be, 'I would like to involve others in your care plan. I would like to involve others in where we go from here'. It ought to be a positive thing. It ought to be a proactive thing. It ought not to be, 'I am so worried about you that I need to bring' -

CHAIR - I need to put you on 24-hour watch or something.

Mr HARRIS - The medical fraternity work from a medical model. They wait for the disease and then they treat it and that is how they are trained but the positive end of that is that if you identify the needs of somebody before they become ill then chances are you can address some of those needs and make a difference so trying to get GPs to embrace that concept of wellness or wellbeing, they might talk about it but they are still trained in the medical model. They are still trained in the disease treatment model.

Mr WILKINSON - I have sent a couple off to GPs that I know because I thought they were suicidal but it seems to me that they go to the GP, the GP has a chat to them but then they will go to either a psychiatrist, a psychologist in Hobart, down to the Rokeby clinic or places like that and, it is what you say; it is that clinical setting as opposed to some other setting which might be more productive, I don't know.

Mr HARRIS - Yes. The TeleCheck model certainly doesn't exclude the medical fraternity. In fact, they are part of the service-provider community that we need involved for it to be a workable model, but it doesn't stop with them. It is saying there are networks of care beyond the GPs' surgery that are usefully embraced. That might be people like the mental health worker, the local social worker, NGOs who are involved with home help, right down to the neighbours who are doing a care program or helping a person out. Getting the clients' permission to embrace those others in their care plan is part of the way in which the TeleCheck model will work. You are relying on those networks of care to talk to each other so that there is some plan of action. It is not a response to a critical concern; it is saying, 'Here is somebody who has all the factors that we understand to be part of the trajectory of risk towards the contemplation of suicide'. We can list them now. The research is pretty much agreed on that: things like isolation, the loss of loved ones, the change in role, the idea of moving from being valued to not being valued, and the sense of hopelessness and helplessness and contributing factors to that. There are lots and lots of them and I can give you lists of these risk factors, risk events and risk behaviours.

CHAIR - Most people go through it at some stage in their life, don't they, and have those events occur or find themselves in that scenario?

Mr HARRIS - Yes. Your resilience in those circumstances really depends on your frame of reference for how you are going to handle that, whether you have the resources to draw on them, your ability to access those resources -

CHAIR - Has that been researched? Why is it that some people seem to have that capacity to get themselves through and others don't?

Mr HARRIS - It is actually the focus of my PhD at the moment.

CHAIR - It is fascinating staff.

Mr WILKINSON - Is that the one to three age group that we heard about yesterday - the first three years of life?

Mr HARRIS - No, but there is some evidence to suggest that it is a very powerful basis on which other decisions are made through life.

Mr WILKINSON - In the first three years?

Mr HARRIS - I have read about it but I haven't researched it myself.

My particular focus for my research is looking at periods of geographic dislocation, the transition moments away from traditional support systems. It doesn't focus particularly on suicide but more on the idea of being able to access the resources that allow you to flourish or to allow you to behave in a way which is positive. One of the leading researchers in resilience - and it didn't fill me with confidence - described the study of resilience as the 'black hole into which ideas go and never return'.

Laughter.

CHAIR - Has any work been done with expeditioners who go down south to Antarctica?

Mr HARRIS - No, not that I am aware, although that is a really good one in terms of isolation.

CHAIR - I have a brother who, in my opinion and that of my family, has left us; he has gone quite off the planet. He had three trips south and we saw problems developing over a period of time that, in our opinion, we think are connected to the social isolation.

Mr HARRIS - It might be that they take their problems down there. A friend of mine, Neil Roberts, had two trips down there. He was an OIC for Mawson, I think. My conversations with Neil are a rich vein of gold to be tapped in terms of human behaviour and the sorts of persons who elect to go down there, with that remote, isolated, very intense wintering they have there.

CHAIR - And they do I imagine quite stringent psychological testing before they will go.

Mr HARRIS - Heaps of them, you wonder -

CHAIR - I have got a few questions, I can tell you.

Mr HARRIS - I cannot answer those. Not my area.

CHAIR - I wondered because it seems to me, and you sound like you are agreeing with me, that there is almost like a little laboratory down there.

Mr HARRIS - It would be a good one but you would be controlling for a particular contextual environment as well, so it would be highly intensified little lab.

CHAIR - How much of it you could transfer -

Mr HARRIS - Generalised for that population would be quite tricky.

The TeleCheck program was attempting to embrace those things which the Italian model had said are the keys to addressing the needs of someone who might be on that trajectory towards suicidal thinking. Doing it early, doing it in a proactive, preventive way rather than in an interventive way, everything from prevention through to postvention. People talk about suicidal prevention as if it is one thing. It is lots of things. Suicide prevention has to be at that early stage, addressing those needs. Suicide intervention or early intervention might be before the event or when someone is at that critical moment and you need to do something about it. Intervention is really when the crisis is occurring. The postvention stuff is looking at those needs after the event, not the least of which are the families and friends and close contacts of persons that have been affected by suicide because ironically therein lies another risk for suicide.

CHAIR - We met a woman yesterday whose husband suicided and subsequently two of the three children, one successfully and one not.

Mr HARRIS - Yes. And herein lies the brunt for some of the programs of suicide prevention or raising awareness. We get lots of programs that with all the best intentions. They want to get into communities and they want to raise the awareness and they particularly target the schools because it seems like a nice captive audience. These young people are already going through what we know is a fairly tumultuous period of their life in adolescence, but the work in schools awareness raising is quite alarming and I would caution you against that approach.

It is all very well to talk to teachers and to guidance officers and those that are in charge of the young population but the teenagers have this morbid attraction to suicide as a topic of interest for all sorts of reasons because -

CHAIR - Drama as much as anything else.

Mr HARRIS - Yes, and perhaps they know somebody and perhaps they really feel as though they want to get to the bottom of it because they are hurt by it for a range of reasons. The research indicates that the most informed student populations are the most at risk, so why would you go there. One of the leaders in that field is New Zealand Professor Annette Bautrais. Annette is the leader of the Canterbury Suicide Prevention Organisation in Christchurch and she is a world-ranked leader in research in that particular area and certainly she has influenced the New Zealand Government's approach

to suicide prevention and the strategies that they have used. It might be useful for you to contact Annette and she is extremely generous with her time and resources.

The TeleCheck model is poised at this point. We took the first pilot of training, of which Irene and Justine were players. There were another six trained telephone operators on the west coast and about eight of the west coast service providers who are prepared to embrace the program. That money ran out in April, but then we were re-funded until the end of June next year to take the model to the pilot stage and to begin the process of getting some evaluation out of that program. One of the difficult things with suicide prevention and the one that Treasury always looks for is where are the results, where are the benchmarks? If you have spent all this money last year, why haven't suicides dropped to zero? The lead time is extraordinarily long. You really need, I would think, an eight or 10-year span of addressing a particular strategy before you start to see some results in the community, and nobody is really prepared to fund anything for that long. Goodness me, that is three elections.

CHAIR - I know.

Mr HARRIS - So we struggle against the tide in that regard. This is my sixth year now in suicide prevention work, and increasingly I am moving towards that prevention end, because I think everything else, while necessary, does not really address the underlying problems that a community or an organisation or a group have to make a difference.

CHAIR - Would it be fair to say that by addressing the issues, as you just described them, at an early stage we could well be addressing quite a variety of social issues?

Mr HARRIS - I agree, and it is such a broad base.

CHAIR - Coming from a teaching point of view, by the time I get teenagers of 15 or 16 with issues, I have difficulty fixing that back there.

Mr HARRIS - Yes, and in my work with Oak Rise as a clinician in Mental Health I was getting very much the polarised end of these young people. They were with me at the time when the crisis was at its most alarming, and they might even have a safe 45 minutes with me where we begin to tease out what was going on, but then I send them back to a very toxic environment, and a toxic environment in which their dysfunctional coping mechanisms are all they have. So the self-harming stuff, the cutting, the burning, which seems to -

CHAIR - Substance abuse.

Mr HARRIS - Yes, it is all symptomatic of someone coping with a problem, with a pain, with a psychological issue, for which that appears to be their best solution. How crazy is that, but that is what they are doing? The cutting particularly, that self-harm, actually feels good, and it takes them away from what their greater concerns are. So the psychology of self-harming is not necessarily a trajectory to suicide but it is in the club.

CHAIR - And if you were solving those problems - I'm being simplistic, I know - then maybe a whole variety of -

Mr HARRIS - Yes, but it gets very hard, so we have to address some of those economic things that prevent someone from climbing out of the hole they are in, and being very much aware of the needs of those people, being able to identify them earlier. Some of them we know about.

CHAIR - And supporting young families so that they do not have the social and economic problems that create the environment in the home that means the young person is growing up dysfunctional.

Mr HARRIS - This is when I am usually accused of being utopian.

CHAIR - It happens to me all the time.

Mr HARRIS - People say, 'That's all very well, but that's your wish list. What can we do?' The word utopian usually creeps into the conversation about now.

CHAIR - I get pollyanna too.

Mr WILKINSON - You have to have that Utopia, don't you. What should this committee do by way of recommendations, do you think? If you were sitting here, what would you be saying?

Mr HARRIS - I would like to think about it, because I know you are going to have to make some specific recommendations, and that will involve probably a range of strategies. I have been thinking about it since my invitation to appear before you, and it is a complex issue, and I know your terms of reference, I am very familiar with them, and I think some of the industry-based stuff is a good place to start. I think there are some good things happening there that might actually begin that process of the Aus-Help program. Jim, you were at the suicide prevention community forum. I think that is a good place to start as a recommendation, that we encourage them to become part of the Tasmanian profile. But that is a particular program and I liked the program. In terms of a general thrust of recommendations or a raft of recommendations, I would like to think about it and put pen to paper and give you a written recommendation.

Regarding the suicide prevention steering committee, the one that Wendy Quinn chairs, over a number of years now she has brought to that table some interested parties across a range of departments and non-government organisations. I think that program needs to be supported and listened to because I think Wendy brings a very rational hand to those ideas. Regarding the suicide prevention strategy officer, who currently sits with Mental Health Services, I think we need someone in that capacity to steer the programs. I would like to see more attention paid to the things that you have alluded to, Lin, where we are looking at being able to identify those things at an early stage that might assist families, young people, those in particular risk groups to identify their needs at an earlier stage and begin to address those needs in a focused way rather than just a random way, to say, 'This is going to help in this trajectory', but this is going to help all those other things.

Mr WILKINSON - How would we do that? We would have to, I suppose, recommend that there should be funding for a study into that.

Mr HARRIS - I think probably the work is done. Some sort of literature review about the merits of such an approach might be a useful thing to do. The standing committee, I think, is probably an appropriate thing to do. I think getting various public service representation from the likes of Health, Justice and Education - they sit on that suicide prevention steering committee. We have representatives from those departments and the Coroner. It is seductive to be drawn to the intervention end of things because that seems to be where the hot spots are. It is much harder to address those preventative sides of things because it is so amorphous. Where do you start? I think there are strategies to do just that. I think there are ways to do it.

CHAIR - In the education model we have seen more and more the managing difficult behaviours idea drifting down earlier and earlier through the primary school. It is really trying to work on the individual so they fit in better at school rather than addressing the reasons that child might be -

Mr HARRIS - I think the MindMatters program is a good one.

CHAIR - Kids in Mind?

Mr HARRIS - No. MindMatters is a whole raft of programs for schools that comes under the health and wellbeing program within the Education department, which is the umbrella marketing program for a number of programs that have come out of Canberra all at once. There was a sex education one, a drug one and the MindMatters one was addressing things like bullying, self-esteem and those sorts of things, and suicide was one of those. There was some real concern about giving it to schools and it ends up on the phys ed teacher's desk for a rainy Tuesday afternoon. With the Tasmanian model we said, 'Let's filter these programs as they go out to schools. Get out to schools and make sure that they're ready for the programs. Give them the appropriate training within the staff so that they can embrace the program and do something with it'. That has been a terrific model. In fact the other States are quite envious of our approach to that. Graeme Cooksey and I designed that filter.

CHAIR - He has been involved for years in health education.

Mr HARRIS - Yes, Graeme is really good in that regard.

With programs like MindMatters, when the school is ready for the program, the trainer goes out to the school, trains up the staff, gives them the real heads-up on how to use the program and then the program goes out. The MindMatters one is a good one and that is rolling out to schools in Tasmania. I am not sure how far it has gone out now. I have lost touch with it.

Those kinds of programs are addressing those early needs because they are giving young people an understanding, through the staff training, not the kids training, to say, 'Here are things that you can do; here at the things that many of you will experience in a common way'. We cannot press the pause button because there is more coming through all the time. They are just growing through these difficult times but interestingly the youth suicide statistics have begun to plateau. Now, whether that is a cohort moving through or whether it is the good work that is being done in youth suicide, or a range of different contributing factors, we do not know.

Mr WILKINSON - Because they talk, do they not, about that - the age group 30 to 39 specifically.

Mr HARRIS - Men.

Mr WILKINSON - Men, yes. Has that moved through as well?

Mr HARRIS - Seems to be. They were 20 and 29 a decade ago and they were 13 to 19 -

CHAIR - So when were they born? About 1980?

Mr HARRIS - They are in their mid-30s now.

CHAIR - About 1970.

Mr HARRIS - And there is statistical evidence now to suggest that there is a cohort factor in that. Ten years from now we wonder if the ones 40 to 49 will be doing the same thing. The spike seems to be moving through.

Mr WILKINSON - Is there any reason they can identify with that?

Mr HARRIS - No.

CHAIR - They missed out on the hippie era.

Mr WILKINSON - On the 60s.

Mr HARRIS - They call them generation something.

CHAIR - Generation X.

Mr HARRIS - But I think that is ripe for some more investigation.

CHAIR - I reckon it might be that move from altruism to self. Then all your sense of self-worth is based on your own place in the -

Mr HARRIS - I think there is an aspect of that.

CHAIR - We baby-boomers are all right.

Mr HARRIS - It is probably a bit more complicated than that but it seems to be that. There were a number of papers presented at the last SPAR conference that addressed the correlations, not the causal factors, between economic climate change, political change, social programs. There are all these really strange correlations. There are much higher suicide rates for periods of Liberal Government at the Federal level.

CHAIR - It comes as absolutely no surprise to me. I am sorry, that was facetious.

Mr HARRIS - But no-one knows why and there are lots of correlations with war. Rates go down during war time.

CHAIR - Sense of social cohesion.

Mr HARRIS - These things have an impact, that sense of cohesiveness. I am asked quite often to do community workshops. It is a bit of a *Womens Weekly* approach to suicide prevention but the tenents are the same: something to believe in, something to do, something to look forward to, someone to love, someone to love you, that sense of connectiveness, of being valued, of having an onward purpose in live, the sense of having a group around you who are supportive and embracing you and so on. Something to believe in does not need to be a god; just a spiritual dimension to you. If you have got two of those going for you, you would probably be all right but if all five fall away then you have some real problems.

CHAIR - Sometimes these quite simplistic things have got the curve of truth in them.

Mr HARRIS - They are distilled from the research but if they want something to remember then they are the five things to think about. You can draw it like a hand. You think, 'Someone to love, someone to love me, something to do, something to look forward to and something to believe in'. That will keep you going. It's something to think about anyway.

CHAIR - I am mindful of the time. I appreciate it is a big area. It would be really useful for the committee if you can afford the time -

Mr HARRIS - I will put some things on paper and I will address the particular terms of reference. I think that is the easiest way to do it because you are going to have to report against those anyway.

CHAIR - Yes. And that always becomes the difficulty, trying to get down all the information we receive.

Mr HARRISS - I would encourage you to get the evaluation of that strategy, to really look at the evaluation strategies and performance indicators for what you want to get out of it and address those early so that people are aware that this is why you are going there and this is how you are going to assess the success of that, but not put too much of a time line on it. There are good things that will come out of it that can be measured in lots of different ways.

Mr WILKINSON - Martin, you say that Western Australia has probably the best program to look at as far as we are concerned.

Mr HARRIS - I think they are, because they mirror us in so many ways in terms of outreach programs and the sense of isolation. They have I think a slightly bigger population, but there are similarities that actually annul the difference in the size of the State. There are similarities that they have addressed in particular, and there are good people on board over there from a range of different areas. Sven Silbern or Silburn is a leader over there and is one that would be usefully contacted.

Mr WILKINSON - And where is he from?

Mr HARRIS - He is Australian now, but I think from somewhere in Scandinavia.

Mr WILKINSON - But is he with the department of -

Mr HARRIS - He is a psychiatrist and he works, I think, with one of the universities and has a clinical dimension to him as well. He is very intuitive, very bright, and he understands how the system works. He has a really clear view of how the ministerial council works. The leader of the ministerial council, Bronwyn Williams - you would have met Bron at the conference - has just moved on to work for the Department of Health in WA. There is a new lady heading up the ministerial council. I don't know her very well at all, but certainly the council has a working relationship with the Tasmanian program because we have borrowed so much from them already. They are really on song with us and quite happy to help us and would be more than pleased to join with us in any investigation or to give us the wisdom of their experience.

Mr WILKINSON - And Diego, would he be willing -

Mr HARRIS - Diego is certainly, a very, very sad story. Both of Diego's sons were killed in a car accident. A typical adolescent scene with five kids in a car, wet road, fast car, young driver -

CHAIR - How do you come back from that.

Mr HARRIS - He is just coming back from that. That was just after Christmas. He is based in Brisbane. So Diego will be on and will help and is a fantastic resource, but I think we have to understand that he is coming back from a severe blow. I had a note from him the other day just thanking me for my concern and so on, so he is back and he is working, but just how functional he will be for the next little while I don't know. I don't know how you recover from something like that, if you do at all. You can only imagine what it would be like.

Mr WILKINSON - Ian Webster?

Mr HARRIS - Ian Webster is a very bright man, and is still the chair of the national committee. He has a passion for the Tasmanian position and now has, I guess, an independent role. He is kind of the elder statesman of suicide prevention, and is certainly contactable and certainly one who would have lots of ideas about directions forward. Yes, Ian would be, I am sure, very good to get on board.

Mr WILKINSON - Would they be the best, do you think, that we could gain some assistance from?

Mr HARRIS - You've named some pretty good ones there, Jim. If you get Diego, Sven and Ian on board, I cannot think of anybody who is better than those three. That is the cream.

CHAIR - Great. Thank you very much, and we look forward to hearing you again.

Mr HARRIS - Yes. I will have a go at writing some ideas down that address the terms of reference, specifically about this issue. If you have anything that you would like me to address or respond to, get in touch.

CHAIR - That would be great, thank you very much.

Mr FINCH - Is that police work ongoing?

Mr HARRIS - Yes. I am very happy to note that they took it. Malcolm Direen, who is the social welfare sergeant for the police, has taken on responsibility for that training. They videotaped me during the whole of the first day and I suspect -

Mr WILKINSON - The police love doing that.

Laughter.

CHAIR - Where is the copyright on that?

Mr HARRIS - I don't think I have one. I suspect when they come to the suicide training they give out the books and they say, 'Watch this'.

CHAIR - Nice to meet you, thank you very much.

THE WITNESS WITHDREW.

Mr PETER O'SULLIVAN, SUICIDE AWARENESS AND PREVENTION CO-ORDINATOR, **Ms JAN MURPHY**, PRESIDENT, AND **Mr LUIGI ROMANELLI**, VICE PRESIDENT AND PUBLICITY OFFICER, LIFELINK SAMARITANS, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR (Ms Thorp) - Thank you very much for taking the time to speak to us. You would be aware of what we are trying to do and have seen our terms of reference. Perhaps if you could introduce yourselves and your interest in the area and then give us the information you would like us to have and then if you could then let us have an opportunity to quiz you a bit later, that would be wonderful.

Ms MURPHY - I am Jan Murphy and I am the President of Lifelink Samaritans, which is an organisation that has been in this town for the last 37 years. We have some information here for you.

CHAIR - Any information you have can go to Charles.

Mr ROMANELLI - My name is Luigi Romanelli and I am one of the vice-presidents of the organisation. I also have the portfolio of being publicity officer. It has been my responsibility to make the organisation more well known in the greater Tasmanian community and the services we provide to Tasmanians free of charge.

Mr O'SULLIVAN - My name is Peter O'Sullivan. I have been with the organisation for about 25 years. I am involved in the coordination of suicide awareness and prevention and I am on the committee as well.

Mr FINCH - Did you say 35 years, Jan?

Ms MURPHY - Thirty-seven.

Mr O'SULLIVAN - I will start, and these two will interrupt me, particularly if I say anything that is incorrect. The most important thing about Lifelink Samaritans is - and I want to get that in the context of Australia and Tasmania, where we fit, where we are and what we are - we are all volunteers. The philosophy of Lifelink Samaritans, which follows the philosophy of the Samaritans in the United Kingdom, which was started heavens' knows when -

Ms MURPHY - In 1955.

Mr O'SULLIVAN - We have followed on that philosophy. We are an associate of their organisation. In Australia the Samaritans exist in Perth and Albany, Western Australia. I am not too sure whether they still exist in the Blue Mountains. Here in Tasmania there is three and they are in New Zealand. They are right through South-East Asia, America and particularly in the United Kingdom. If you watch *The Bill*, you hear the Samaritans being talked about all the time.

CHAIR - Oh yes, I knew there was a reason I watch that show.

Laughter.

Mr FINCH - Are they all known as Lifelink Samaritans?

Mr O'SULLIVAN - No. I will go back and give you a bit of history about how it started up. Lifelink was started by a concerned group of Launceston citizens who got together in the mid-1960s when there was a spate of suicides in Launceston. The conveners of that group were a number of community people, one of whom was Dr Eric Ratcliff, a psychiatrist here in Launceston. He is still our patron to this day and still does part of our training program for us. He has more or less been our mentor. At that stage they knew that some sort of telephone befriending service needed to be established. There was nothing in Tasmania at that stage and only three or four on the mainland, which were Lifeline centres. They looked at all the models around the world and decided that it was better to go with a pure volunteer model and a non-religious model. That is how we started and that is how we exist. I think Lifeline are gradually going to that model as well, even though they are based and started through the Uniting Church. Quite a few Lifeline centres in Australia are very much working on the same model as us. We don't have any paid staff. The whole philosophy of the organisation is being volunteers. We don't pay any honorariums so therefore our running costs are fairly minimal. It does require a large commitment from the volunteers.

CHAIR - Maintaining a volunteer base is hard work in itself, isn't it?

Ms MURPHY - We are fairly lucky.

Mr O'SULLIVAN - All the people on the committee do telephone work, so when the committee makes decisions about what the volunteers do or don't do it is reflecting on them; they have to do it themselves. I often make the joke - and I am sure Madam President won't mind me saying this - that even the president has to do duties and even the cleaner has to do duties, and in this case the cleaner is the president.

Laughter.

Mr O'SULLIVAN - We have been long established in the Launceston community.

Ms MURPHY - I think that is our secret: we are community based. We are not counsellors, we are not professionals, we belong to the community and they support us.

Mr ROMANELLI - In Launceston once our processes were well established we then went on and developed a 1300 number, which people anywhere in the State can utilise 24 hours a day. We are still based in Launceston and our volunteers come from the greater Launceston area. However, it is important to remember that we do take calls from all parts of Tasmania.

Mr O'SULLIVAN - Increasingly so, and we are getting a lot more calls. Our call rate varies between 6 000 to 8 000 per year and that averages at 20 to 25 per day - don't test me on the maths for that one, but I think it is about that number. Some of the calls can be from someone who hangs up or changes their mind as soon as we answer the phone, to people who stay on the phone for anything up to two hours. A number of those people are regular callers to our service.

Mr WILKINSON - Any special time? Do things get worse at night time?

Mr ROMANELLI - There is no real logic to it.

Mr O'SULLIVAN - Sometimes there may be more intensity at night perhaps, because that is when people are lonely and cannot sleep.

CHAIR - Seasonal peaks, with Christmas?

Mr O'SULLIVAN - It can be. For some people, Christmas and Easter can remind them of people who are not around so they become lonely.

Mr WILKINSON - More in winter than summer?

Mr O'SULLIVAN - I do not think so.

CHAIR - It sounds pretty broad.

Ms MURPHY - It does not make any sense. You can do a night shift - we all do night shifts, this particular trio - and you can have a night shift with two calls and a night shift with 10 calls. Just a different week; no reason at all.

Mr O'SULLIVAN - I think the important thing that Jan mentioned is that we are volunteers and we do not pretend to be professionals. We call ourselves befrienders, not counsellors, because we believe that counsellors are somebody who is more directive and has some training behind them. I think that is important. That is of great assistance to us when we are dealing with other professional groups because sometimes professional groups can get very jealous of where they are sitting and what they do, and they do not want to be threatened by volunteers. We therefore let people know exactly what our training is and they know exactly what we do in that we befriend people, we do not counsel them. Therefore they are very keen to refer people to us.

One of the beauties of this organisation, and Lifeline as well, is that most of the professional services are available 9 to 5, Monday to Friday. What happens on Friday at five o'clock, what happens over the weekend, what happens between 5 p.m. and nine o'clock the next day? There are very few services around and a lot of professionals and a lot of counsellors suggest to people that if you have problems and you are alone and you are feeling anxious and you need somebody to talk to, ring Lifelink Samaritans. That can be a stopgap for people.

Also our organisation is quite often the first step for people. Imagine somebody who is very desperate, lonely, anxious and has suicidal thoughts. Sometimes it is very threatening to actually see someone face to face and it is a lot easier to ring somebody who is anonymous, non-religious, confidential, and they are a lot more confident in doing that. That is why it is so important in our organisation that we keep our volunteers reasonably confidential. Lifelinkers do not put their hand up and say, 'I'm a lifelinker', because invariably there might be somebody around the corner who knows them. They might say, 'If I ring Lifelink, I bet I get Jan or I'll get Luigi'. So there are only a few of us who have a public profile.

Mr WILKINSON - Do you give your names when you answer the phone?

Mr O'SULLIVAN - We give a name but it is not ours.

Ms MURPHY - That is part of our training of stepping back from the caller, of not being involved - in there boots and alls. It is a strategy we use to say, 'Okay, I'm here for you, but I'm not going to be involved in this'.

The other thing I would like to add to what Peter said is that over the years we have, because we are community-based and well-known in this area, established protocols with people like Laurel House and psychiatrists and doctors. They know that we know the boundaries, we do not step into their area, we just fill the gap that is there while the client is waiting for another appointment or whatever.

CHAIR - I imagine the longevity of the organisation means that there has been a reputation developed in the community so people can feel quite confident.

Mr O'SULLIVAN - Very much so.

Ms MURPHY - The professionals do, as Peter said, suggest that their clients ring us. We are non-threatening to them. We have made it very clear where we stand.

Mr FINCH - Those three points you made about being non-religious - and there were two others, Peter -

Mr O'SULLIVAN - Confidential and anonymous.

Mr FINCH - Do you promote that?

Mr O'SULLIVAN - Yes.

Mr FINCH - If people saw that in the newspaper that would be encouraging to them, wouldn't it.

Mr O'SULLIVAN - Yes.

Mr FINCH - Lifeline, do they have a paid workers?

Ms MURPHY - Yes.

Mr FINCH - Okay.

Mr O'SULLIVAN - I think it is very minimal.

Ms MURPHY - Yes. We are lucky with our training; when our presenters come in from the community we do not have to pay them so our costs are less. Lifeline, because they are counsellors at the end of their course, obviously have to have paid presenters, so there is a difference.

Mr FINCH - Because they have built up those skills.

Ms MURPHY - Yes.

Mr FINCH - And trained.

Ms MURPHY - They still do the same job.

Mr O'SULLIVAN - Examples of our presenters are Eric Ratcliffe, and John Morris from the Clifford Craig Research - he has been with us nearly since day one - and Molly Campbell-Smith. They still presented our training program but we run the rest basically ourselves. We get other people in from the community and other professionals in to talk about their expertise. Other groups like AA come along and talk to us and so on. We have been a referral number for them for some years.

In saying that we are just befrienders I do not want you to underestimate the power of an organisation like ours and the difference that we can make. We have a philosophy that we believe that everybody that rings Lifelink has the power to help themselves. The training that we give through active listening and talking people is to get them to realise what they should do in their own lives.

CHAIR - You are not there telling them what to do.

Mr O'SULLIVAN - We do not give advice and we do not tell them what to do. We emphathise, we get in contact with their feelings. Sometimes people need to talk about it. Men are the obvious ones who do not do it enough. People need to talk through their issues. We get them to talk about what they need to do or what is happening with them and maybe what they need to do. This might take a number of times for them to ring us, and from then on, sometimes later than that, they might keep ringing us for whatever reason because they are lonely and whatever.

CHAIR - How do you maintain the connectiveness, then? If someone rings and gets one person and then they ring back the next week -

Mr O'SULLIVAN - The caller knows that they are not going to get the same person. Some of them assume that we do know but sometimes there is a volunteer and you say, 'I am sorry but you might have to tell me that again'. They go through it and they do not have a problem. Actually sometimes it is a little like therapy to keep telling their story over and over again. They actually like that but for those who do shifts regularly, which is most of us, you get to know the regulars by their voice and quite often most of them are happy for you to recognise their name. They say who they are quite often.

Mr FINCH - You do not keep a file on the call?

Mr O'SULLIVAN - We would only keep aggregate statistics such as male or female and length of call.

CHAIR - And issues raised?

Mr FINCH - You do not make notes on what they are actually saying?

Mr O'SULLIVAN - It is amazing how many people ask, 'Is this being recorded?' 'Are you writing this down?' and that is what they do not want to know. They want to be confident that it is absolutely anonymous, that they cannot be traced. We keep that faith with the caller and we do not record that information.

Mr FINCH - And you do not make calls back the other way?

Mr O'SULLIVAN - No.

Ms MURPHY - The only time we do that, and it is on a very selective basis, is in our face-to-face service here in Launceston, where every six weeks a caller can come and talk to somebody. We get so many calls from outside Launceston now; we often get calls from the east coast, or the west coast where someone is desperately in need of a face-to-face referral. We cannot give it, so for six weeks, at a designated time, we might ring that fisherman or whatever and give him comfort and work through whatever he is going to do next. We do not do it very often but we do offer that. We do not offer it in Hobart or on the north-west coast because Lifeline are there and they have face-to-face.

CHAIR - Do you have mandatory reporting requirements. If you are told about something that is severe like a child abuse issue or a criminal issue?

Ms MURPHY - We have above us a panel of people - Dr Eric and a doctor and we did have a representative from the police, a lawyer - who advise us on certain things but it is really hard to notify anybody because if they do not give you their name and where they are we cannot do that.

CHAIR - That must be distressing.

Ms MURPHY - It is very distressing for the volunteer when you here people bragging about what they have done and you cannot do anything about it.

Mr FINCH - Why is that? There is something there -

Ms MURPHY - There is a need for them to tell you exactly what they do to children and stuff like that.

Mr FINCH - Why is that?

Ms MURPHY - There is a need for them to tell you exactly what they do to children, stuff like that.

Mr FINCH - Well, it must be pretty confronting when you are trying to deal with a call like that.

CHAIR - And you're trying to help this person.

Ms MURPHY - We are dealing with the caller. The way we do that is to take away what has happened and then just deal with the caller.

CHAIR - And what about debriefing for yourselves if you have been through a particularly harrowing call?

Ms MURPHY - We have a support system in LifeLink. There are always two people on each month, and they are there 24 hours a day for our befrienders. So if we have a bad call we debrief with the person who is coming on after us, or if it comes back to us we ring these support teams.

CHAIR - You would need that.

Mr O'SULLIVAN - The encouragement is there. You do your shifts at the centre and the issues that come up at the centre we like to see stay there at the centre. In other words you deal with them at the centre and don't take them home to your family. Invariably as human beings you do that from time to time; you can't help that. Sometimes you scan the papers when you have talked to somebody who was desperate the night before wondering whether so and so who has died was such and such who was on the phone the other night. Invariably people who take the problems home with them, and do not get other debriefing as we encourage them to do, don't usually stay that long with the organisation. They find it too hard.

CHAIR - It burns them out.

Mr O'SULLIVAN - For some people it is a little bit removed, too, to do this work, because a lot of people like to jump on their horse and go out and be the white knight and go and save people, and we don't do that. That is not what we are about.

CHAIR - So they are not getting that gratification.

Mr O'SULLIVAN - Yes, and you need to sort of finish it off. When our volunteers go on the phones for the first time the desire to jump through the phone and help them or hop into the car and go and pick them up and take them and do whatever they want is enormous.

CHAIR - It is human nature, I guess.

Mr O'SULLIVAN - They know you cannot do that because, as we say to them, if you do that, what are they going to do next time they are in trouble? They are going to ring again and ask for the same sort of service, and that is not helping them to grow as individuals. Our aim is to get people to grow, to get people to make their own decisions, to move on so that they don't become a burden either on us or on society, that they are able to get through this trauma, this emotional time they are going through, to move on and become valuable people in society.

Mr FINCH - Do you have difficulty getting the right type of volunteers, who fit your philosophy?

Ms MURPHY - No. Our training weeds out the ones that aren't. We always say during our training that there are no failures, but that it is our right to choose the people to go on the phones, because we know the sort of calls we get. With some people, as you work with them over 16 weeks, you get to know them and whether they are the knight in shining

armour who is going to put those three children and their bereft mother in their spare room, or whether they are able to stay away from it and just help that caller. So there is a selection process.

Mr O'SULLIVAN - It is the nature, I suppose. We say to them whether they are suitable or not suitable, and some people are not suited to it. Some people are better off going and working at the library or in a community house or a shelter or Red Cross or something like that -

Ms MURPHY - Yes, where they can actually physically do it.

Mr O'SULLIVAN - that is more hands-on help.

Mr FINCH - How do you do your recruiting?

Mr O'SULLIVAN - We advertise.

Mr ROMANELLI - I have been interviewed twice in the past month on ABC Radio to raise awareness that the training was taking place. It is important to know that we do have a significant number of our original members. We have a membership base of people in their low 20s. Our most senior member is 80 and a month. They all come in from different walks of life, different educational backgrounds. The thing that unifies them is their readiness to give their time freely without fanfare to anybody and everybody who needs help. We don't filter calls. We have the attitude that you go to the centre and you are just there. Most people take a book with them to read, or the ladies take their knitting.

CHAIR - Oh, okay. It is not to your home?

Mr ROMANELLI - No, we have on purpose a centre so that it is separate from us, and so that our hats are different from -

CHAIR - I was assuming that you would be on roster at home and the phone would come through or something like that.

Mr ROMANELLI - We just take whatever comes through, be it someone discussing loneliness, suicidal tendencies, their gripes with government agencies, whatever. On the phone we don't have a button that shows us that it is to do with suicide.

Mr WILKINSON - Our first term of reference is the role of non-government organisations and other community and business partners in progressing suicide prevention in Tasmania. What happens if I ring up but I don't say that I am going to commit suicide but you can glean that I'm a candidate for it? What do you do? Do you talk them through it or do you have a chat with them and say, 'If I was in your position, I'd be contacting such-and-such'? Do you put them on to another non-government organisation?

Mr ROMANELLI - The first thing we do is speak with them, reassure them that it is okay to talk to me about suicidal thoughts, that we can handle it, it is not a taboo subject. We

would encourage them to talk about what is going on, what is causing them to think of this particular scenario.

Mr WILKINSON - Do you bring it up with them?

Mr ROMANELLI - We have a motto: if in doubt, check it out. Some people need permission to be told, 'It is okay. I'm not going to freak out if you start talking about suicide'.

Mr O'SULLIVAN - One of two things is going to happen if you mention it. You don't mention it upfront, but after talking to someone for a little while you get a feel for where they are coming from. If deep, strong thoughts are being expressed you would say, 'Have you been feeling as though you want to end it all? Are you feeling like you want to take your own life? Have you thought of suicide?'. One of two things will happen: either they will say, 'No, I'm not that bad yet' and dismiss it or they will say, 'Yes, I am'. That is permission for them to talk about it. Sometimes it is an absolute watershed because the word has been mentioned. It does not incline them to want to take their life. As Luigi said, out motto is 'when in doubt, check it out'. We treat every call as a potential suicide call; everybody who rings Lifelink is a potential suicide call, until we can discount it.

Mr WILKINSON - And when do you discount it?

Mr O'SULLIVAN - After you have been talking to someone for a while you get a feel for where they are coming from and what is happening in their life and, because of the skills we have, we get them to talk about it. The ultimate call is where we say nothing as a volunteer and they say everything. Sometimes at the end of a call people will turn around and say, 'Thanks very much for being there for me', and we think, 'What did I do?'. For most people, when they talk about their problems - and we do it in our everyday life - we get advice. Someone has always been there, done that and someone wants to tell them what to do. 'If I was you, Jim, I would do such and such'. People don't want to hear that. What we do is give them permission to talk and we don't judge them. Just talking about it can sometimes give them a clear indication of where they need to go or what they need to do. If at the end of a call they haven't made up their mind or they are unclear or they are still foggy about the issues or where they could go and get some help, we have a 300 referral service at our fingertips. What we would do is say to them, 'There is this and this you could do. Would you like to choose one?' Ideally, we like to get them to make their own decisions so that when they get off the phone it is their ownership. They have made the decision to go and do something about it; they are empowered by it. That can be an awakening for some of them; it can also be a growth issue. Sometimes the problems they have they feel are unsurmountable. What we will try to do is help break it down for them and maybe just take one step at a time: 'Let us think about something you could do that might help' - not maybe the big issue but maybe small things one at a time. Once they can achieve one they can go onto the next one. We do have an extension referral service of professional organisations that we might suggest are out there, but we won't suggest that you go to this one or that one. We will say, 'You can make a choice'. They then have to get on the phone or they have to make an appointment and take the next step. We don't do that for them.

Mr FINCH - What you are talking about and the way you go about it, is that a Samaritans program? Would they be doing the same thing in other areas - in England - dealing with issues and the process in the same way?

Mr O'SULLIVAN - Absolutely. We have a strong relationships with the Samaritans. We have a twin centre in Northampton in England. They come and visit us and we go and visit them; we have people are travelling backwards and forwards overseas. We are part of the Samaritans worldwide network and we also have a strong relationship with Western Australia. So we keep that professional connection up. The skills we are talking about, Lifeline does exactly the same thing. It is just a different operating philosophy, that is all.

Mr FINCH - I am thinking how interesting it is for people who come in as volunteers from the community, looking to make a contribution. It must be a terrific learning process for them, too, if they embrace the program and are suited and then come into the operation.

Mr O'SULLIVAN - It is a huge thing in your own life.

Mr FINCH - Yes, that is what I was thinking.

Mr O'SULLIVAN - The skills you learn in life you can use at home.

CHAIR - And a sense of contributing.

Mr O'SULLIVAN - Yes, although my wife thinks that I leave the skills in the centre.

Laughter.

CHAIR - There is a research study there.

Mr WILKINSON - It sounds like a normal family.

Could I go to term of reference 2 - and tell me if you are not able to answer any of the terms of reference -

Mr O'SULLIVAN - We do have some things here because we have looked at the terms of reference.

Mr WILKINSON - Okay. 'Investigating strategies to address the needs of the high-risk group'. You have probably heard before the high-risk group was 25 to 44. It is down now to the 30 to 39-year-old males.

Ms MURPHY - But I think it is quite interesting that in our core rate the men at risk are the much older group and who have all the means to do it. They have the tablets there. Their spouse has gone, their dog has died and there is very little we can latch onto to say, 'Please stay here'. They have lived their life, their friends are all gone and they just want to end their lives. That is part of euthanasia, I suppose, when you think about it. They are a high suicide risk.

Mr WILKINSON - And some say, 'I've had enough', don't they?

Ms MURPHY - Yes, they do.

Mr WILKINSON - What do you do there?

Ms MURPHY - Just keep them talking, and contract with them, 'Ring us again when you feel like this'.

CHAIR - Usually living alone?

Ms MURPHY - Yes, usually living alone, usually sold the farm, into town, knows nobody, that sort of scenario.

Mr O'SULLIVAN - There is a difference between befriending somebody who is lonely and having traumas or problems in their lives and befriending somebody who is having a strong idea of suicide. When it gets to that stage we change our mode of befriending to become more directive. If somebody's life is in danger, we try to find out where they are and get help to them, and help is usually ambulance, police -

CHAIR - Like 'I've taken pills' - call for help stuff?

Mr O'SULLIVAN - Yes, and we try to find out where they are. Sometimes people will tell us. On a couple of occasions I have had the ambulance and police being able to go to places to save people. Of course if they have taken pills, it takes a long time for something to happen.

We also have to become more directive in getting them to face up to the enormity of what they doing. Somebody who has decided on suicide has a huge tunnel vision and they are ambivalent about everything around them. They can just see something in front of them.

Sometimes we talk about people who have died through suicide and we think, 'How could they have done it?'. The only thing that sometimes we can take away with us is that they thought that they were doing the right thing. They were wrong, but they thought they were doing the right thing. So our role at Lifelink is that if somebody has strong ideas of suicide, we will be more directive with them and we will try to get them to face up to what they are leaving behind.

CHAIR - The consequences.

Mr O'SULLIVAN - Whether it is family, pets, who is going to find them - what is it going to be like for them - all those sorts of things. And they cannot keep this ideation up for too long because it is physically impossible and sometimes they will come out of it. So the longer we can keep them on the phone talking to them and get them to face up to the enormity of what they are intending to do and what the aftermath is likely to be like, the more chance we have of maybe getting them through this period. Quite often when they do think about what it is going to be like for children, wives or husbands, or pets or family friends, they do come to the realisation that people are going to be distressed and the stigma of that is going to be around forever.

One of our trainers said to us once - it is something that I have never ever forgotten - when somebody dies through suicide, for the person who commits suicide the death happens once, but for the person who is left behind, it happens over and over again. Those people left behind then become an at-risk group and suicide can become an option for them as well.

CHAIR - Because it has been demonstrated to be an option.

Mr O'SULLIVAN - Yes.

Mr ROMANELLI - We heard lots of anecdotes about that at our stall at Agfest this year. Three was one lady who had a horrendous tale: her brother-in-law suicided, the family did not have any idea of what to do about it and did not know who to talk to. Her husband then was under financial pressures and he thought, 'It was okay for my brother to opt out so I'll do it', so he suicided. The family again still had grieving and unresolved issues and then another couple of people in the family died of suicide within a spate of three years. She was absolutely devastated, and it is not that uncommon. If there is someone in the family who has suicided unless there is intervention other people will consider suicide as an option.

CHAIR - That is human nature, isn't it? You are likely to consider those things that you have had experience of.

Mr ROMANELLI - Yes.

Ms MURPHY - And everybody seems to get on with their lives so it is not going to be a big issue.

Mr O'SULLIVAN - Getting back, Jim, to your point about the investigation of strategies, there are two areas where we see that we can be of assistance and also some thoughts that Jan has on the gaps in the service and one is making the community a lot more aware of our organisation. Fortunately or unfortunately the nature of the people who join Lifelink is that they are not necessarily good at promoting themselves, which is why they become good befrienders. I think we are getting a little bit better, thanks to Luigi. We are not that good at promoting ourselves and there is no sense in us having a service there that people do not know exists. I am a member of the Launceston Safer Community Partnership. I went to a meeting this morning and there is a lot of kids out there who do not have access to phones or mobiles or do not even read to know about services like ours. The other area that Jan was talking about is that some people do not want to go to 1E and they do not want to go to A and E. Jan, you have some thoughts on that.

Ms MURPHY - I think there is a huge gap there in suicide prevention because we can talk to them on the phone or we can talk to family members of a suicidal person and the family members will always say to us, 'Where can I take him? I know he has the gun and I know he is there and I cannot watch him 24 hours a day but he has told me he will kill himself'. There is a gap there because there is not anywhere, apart from ringing us or Lifeline, and the person who is suicidal may not want to do that. The family members have nowhere, apart from probably the church minister, if they have one, or their family doctor. A lot of people do not have family doctors so there is not anywhere. They do

not want to commit them. They have no right to do that. They have certainly got mental health issues.

CHAIR - That is our Mental Health Service in the State really, isn't it?

Ms MURPHY - It just needs more funding somewhere, some sort of service that is there for support, and it needs to take the stigma away from actually having to go to the hospital. It is huge money and it is huge resources in people to man all this. It has never been done and people are still suiciding.

Mr FINCH - Jan, do you think the police are not the appropriate agency?

Ms MURPHY - There is a very good program on the north-west coast, isn't there, with the police.

Mr FINCH - I do not know but if there was an understanding by people that the police had those skills - we have heard from Martin that they have been trained now, we heard stories yesterday that some police officers did not have skills in the past -

Ms MURPHY - I think that is relatively new and on the north-west coast they work with the Burnie hospital - the police talk them off the cliffs and then they have different corridors they can go down, depending on what the suicidal person wants. The police coordinate that and I know that was going a couple of years ago or last year.

Mr FINCH - I am just wondering whether that is the sort of thing that might be the measure, that might fill that gap that you think is there, if people have an understanding that if they call police officers they know that they are trained to not only deal with the dangerous situation of somebody with a firearm but they also have the ability to counsel, to coerce, to draw that person back from the brink.

Ms MURPHY - That would be fantastic for us, an organisation like us, if we knew that was out there and I think the police are in the perfect position to do that.

Mr O'SULLIVAN - I think the best person to talk to in Tasmania Police is Scott Tilyard. He is an assistant commissioner. He was commander up here and he was going to come and speak to our group.

CHAIR - Isn't he still up here? Has he moved again? He was up here as commander, was he?

Mr O'SULLIVAN - Yes. He has a lot of experience and background in suicide issues in relation to police so he would be the perfect person to talk to, I would have thought.

Mr WILKINSON - Mike Ryan, do you think?

Mr O'SULLIVAN - I don't know him.

Mr WILKINSON - Mike is the psychiatrist.

Mr O'SULLIVAN - In relation to the statistics, that is a difficult area for us in terms of confidentiality. The information that we release in our annual report is just aggregate information about the ratio of males and females and the number of calls. I was interested before when Martin was talking about benchmarks. As a public servant, you get that thrown at you all the time. Well, police know about benchmarks. I do the suicide prevention awareness training in our training program and someone challenged me a few years ago and said, 'You provide this service. How do you know you are successful? How do you know you are making a difference?', which is pretty fundamental to the reasons why we are there. I said, 'Of course we're useful'.

Laughter.

Mr O'SULLIVAN - It is very difficult to talk in benchmarks about our organisation, as Jan said earlier. Unfortunately a lot of people - and it would be nice if they did - when they move on don't ring us back up and say, 'Thanks for that person who was on duty the other night'. It happens occasionally, which is fantastic.

Mr WILKINSON - The success is based on the fact that you have approximately 8 000 calls a year. That is obviously the answer, it would seem to me.

Mr O'SULLIVAN - That certainly is one benchmark. The other thing is that you can have somebody who rings up and they are extremely distressed. At the end of it you can be having a normal conversation with them, like you would be with a friend, so you are able to get them through that period and get them to talk about it. I would not like to put a percentage on it, but for the majority of people just being able to talk to somebody who doesn't have any judgment or who is going to look at them in any particular way is what the majority of people want.

CHAIR - I suppose if someone like Martin, for example, looked at the way you collect your data and said, 'If you are able to provide this for me' - whether it be to tick a box or whatever - 'could I use that information?' It would be feasible, wouldn't it?

Mr O'SULLIVAN - We would look at anything like that provided that, as a committee, it was inside our guidelines. We give certain information. We categorise our calls into groupings of why they rang and we release that.

Mr WILKINSON - Such as?

Mr O'SULLIVAN - Loneliness, accommodation, medical, financial, gambling, suicide, drugs.

Mr FINCH - I am sure that is useful information, too.

Mr O'SULLIVAN - Yes.

CHAIR - I am sure the gambling statistics could be very telling.

Ms MURPHY - We usually get the calls from the distraught wife or husband who has just found out there is no money left and things like that. The calls are very rarely from the gambler themselves.

Mr WILKINSON - And that's what happens, isn't it? People just don't the extent that the other party is involved in gambling.

Mr O'SULLIVAN - I had an older person who was concerned about the fact that she hadn't left any money for her family. She had blown the inheritance and was extremely distressed.

Mr ROMANELLI - It is also important to note that we get quite a few calls from people who have been referred to us by other people who have used our service in the past.

CHAIR - That is an important statistic to keep.

Mr ROMANELLI - It is hard because we feel it is not appropriate to ask people, 'How did you find out about is?'

CHAIR - But if it came up.

Mr ROMANELLI - They often do drop it in, though sometimes they are so caught up in their concerns or their emotional turmoil that they are not quite sure exactly who they have phoned: is it Lifelink Samaritans, is it the Crisis Intervention line, is it Centrelink?

Mr WILKINSON - There are a number of NGOs around who obviously are doing some terrific work. Do you think there are too many? I say that because if a person who is having problems says, 'Gosh, there are 15 of these and I don't know who to ring'. That is another problem in itself, deciding which one to ring because there are so many

Mr O'SULLIVAN - I personally think that that is a real issue. I get really concerned about the number of support groups out there that have got really very well meaning people as part of them but they are not trained correctly. When they are faced with crisis when people ring, have they got the skills to handle it. Ours is a 16-week training course. That is every Tuesday night and two full Saturdays before they go on the phones. Then when they are on the phones they have to do it with somebody else for the first four or five sessions on the phones, and then we are always monitoring how they are going and have meetings etcetera.

Mr WILKINSON - Should that be a recommendation let us say under the last point, any other relevant matters, that people who are in the area should receive 16 weeks training or a proper training curriculum.

Mr O'SULLIVAN - Absolutely.

CHAIR - Because the danger is in the rescue model.

Mr O'SULLIVAN - Yes, the rescue risk is huge. The other thing is that some of the people who get involved in helping groups, support groups, are probably people that have been through -

CHAIR - Your co-dependency issues?

Mr O'SULLIVAN - And they believe that the only people who can be supportive are those that have been through the same thing that they have been through. We have had that in a suicide clinic. The only people able to provide good suicide prevention are those that have actually been suicidal themselves. People say that to me.

Mel MacIsaac, whom we are a bit of a fan of - he was probably Australia's foremost expert on grief - said, 'If you have somebody that has been through it and has dealt with it and moved on and they have got the skills, they are probably the perfect person, but certainly if they have gone through it and have not dealt with it, they can be the worst people to be involved in a support group'. So training is important. As Jan said earlier, in our 16-week training program we might have 10 in a group and we have three group leaders for each 10 people. In that training program, because we go through some self-analysis and skills and so on, we get to find out about people and we know whether they are suitable at the end to go on the phone.

CHAIR - Self-awareness or self-analysis would be vital, would it not?

Ms MURPHY - And accepting that you are judgmental. You can be as judgmental as you like so long as you are aware of it and it does not come across on the phone. That is part of the training, recognising what happens to you. We are all human beings; none of us up there are Lifelink are perfect, but being able to cover that and being aware is part of the training.

Mr WILKINSON - At the SPAR conference Kerry and I went to last year, people were saying, 'We really do not know what the cause is. It is too hard. We have got to do something so we are doing something. We do not know whether in the end it is going to be worthwhile but we think it is, that is why we are doing it'. That type of conversation was taking place. Do you believe that with proper data and a proper basis of data collection, people would, in the end, have a better idea as to risk factors?

Ms MURPHY - Our training teaches you to recognise the risk factors but we always say at the end of it that you can know that a family member, for instance, is showing all these but it is the one little tiny thing that tips them over the edge. That can be absolutely anything and we have no idea what that trigger is. The trigger is always there in a suicide because they can be seen to be coping quite okay and then the next thing you know they have jumped off the bridge so it is that trigger that you cannot find.

Mr WILKINSON - I see. For a person like Martin, who is doing a study into it at the moment, it would be ideal if all this data could be collected, thrown at Martin to see what he can make out of all this.

Ms MURPHY - I still think we will never really know. No matter how much data you collect it is not going to make an eyeful of difference at the end of the day if somebody wants to take their own life. Stats are all very well but it is just dealing with what has already happened.

CHAIR - It is 'after the fact'.

Ms MURPHY - Yes. It is getting in there and being aware. That one that Nadia was talking about that they do in Canberra, the workplace thing, I think is fantastic. They just go in,

sit with the organisation, and they are there as a support team. I guess that is what it is all about, supporting people. Literally what we do is support people and what we need is to be out there a bit more so that people know we are there.

Mr WILKINSON - Even though I hear what you say that nobody can really tell what the trigger is, and I can understand that, what I am trying to explore is whether you believe that it is appropriate, for there to be a data collection base, for all the data to be placed in an area so people could properly study and research it?

Ms MURPHY - It is information, isn't it, so yes it is relevant to say, 'We're peaking here', or 'We're not peaking there'.

Mr WILKINSON - Does it happen now? Is there any of this data research?

Mr O'SULLIVAN - Only the coroner's information, I guess.

Ms MURPHY - Yes, I think that is the only bit that happens.

Mr WILKINSON - Obviously you would have to get the okay of the board to do it, but if you were doing it, I understand the type of data would be the number of calls, male or female, areas of suicide, loneliness - that type of thing.

Mr O'SULLIVAN - We give that to the department each year anyway through our annual report. Whether they look at it is another thing; I have no idea.

Mr WILKINSON - Is there any other data that you believe would be appropriate?

CHAIR - Or research?

Mr O'SULLIVAN - I would hate to say how much money has been spent on research on suicide prevention in the last 10 years, it is just frightening.

CHAIR - The thing that interests me is the causal stuff, going way back to why it is that some people see that as an option.

Mr O'SULLIVAN - I do not know whether any of you saw a program on *Four Corners* some years ago on teenage drinking. I am involved in the liquor and gaming side of things, and recently under-age drinking has become a big focus for governments as well. When you get 13-year-olds and 14-year-olds and they are binge drinking, it is a lost cause; there is not much you can do about it. You really have to get kids at primary school. I can remember at the end of this *Four Corners* program they had a teacher and a class of kindergarten-age children. The teacher said, 'Can you tell me who's the most important person in your life?' Some of them said, 'Mum', 'Dad' and 'God'. The teacher said, 'No, come up here and I'll show you who the most important person in your life is'. There was a mirror, and the kids looked at themselves. What that is basically saying is that it is a matter of self-esteem and building inner skills with people is important and what we have to start. That is parenting, it is all those sorts of big issues.

CHAIR - And why do parents go wrong? What are the pressures on them?

Mr O'SULLIVAN - Yes. It starts really early. Suicide prevention starts when the baby is born. It is all about looking after and supporting people and being aware. I think that is the way we see suicide prevention because prevention of suicide is everybody's responsibility - all parts of society. It is checking out our friends and our mates and the people we work with. If there is a change in behaviour, 'Is everything all right? Are things going okay?'

Mr WILKINSON - When you speak with the person - let us say they are working as a boilermaker/welder - you would be saying to them, 'Do you have a number of other employees?', 'Yes', 'Is there any promotion of wellness or suicide prevention or things like that within the workplace?'. Do you go into it that far?

Mr O'SULLIVAN - It is difficult to ask questions. We do not use that process because they can then feel that you are being inquisitive and interrogative. They are two words that we try to avoid like the plague because you have to get people into your confidence to ask questions. That in some circumstances may be possible once you have established that rapport and they trust you and you can get some information. It would be fantastic if someone rings up and you say, 'Before we start, can I have your name, address and phone number'.

Laughter.

Mr O'SULLIVAN - It would be fabulous, but we can't because as soon as you start asking questions they hang up. So to get that sort of information would be very difficult.

CHAIR - Perhaps not your role.

Mr O'SULLIVAN - No, not our role. It is such a tenuous connection. Having somebody ring on the phone can be a bit removed because you do not have someone face to face but on the other hand when you just have voices, it can be an extremely intimate communication.

CHAIR - You only have to look at the classifieds in a movie to work that out.

Mr O'SULLIVAN - I am not talking about those, although they did take some calls away from us.

Laughter.

Mr O'SULLIVAN - When they became big our call rate actually dropped. We won't go into that. We do get those people calling us. I can see you are interested.

Laughter.

Ms MURPHY - They are doing fairly good research on this issue.

Mr WILKINSON - What type of recommendations do you believe we should make?

Mr O'SULLIVAN - I would like to see our organisation as an NGO get more recognition. We want more recognition from the department, because the department are really bad at

it, and I am not putting too fine a point on this. We have virtually no connection with the department other than that they give us $8 500 a year. That is the Department of Health and Human Services. I would like to think that they would set up some liaison role. In the early days when we used to get our funding from them they used to come and see us every 12 months, which we used to like, because they came and checked us out to see what we were doing. We really have to badger them. It is little things like when there is a tragedy or trauma that is public, and there might be an article in the newspaper, and on the bottom they put Lifeline. They don't put LifeLink Samaritans, when we have constantly told them that we are out there too. We take Lifeline calls and Lifeline take our calls, so we are all out there. There is enough business for both organisations, unfortunately, and we are both badly needed, and the department should use us more. The department could also help us in terms of how we promote our service so that they are actively involved in letting people out there in the community -

CHAIR - You mean with the publications and brochures and -

Mr O'SULLIVAN - Yes, and help us get that sort of thing. We run around applying for funding from the community service levy and the Tasmanian Community Fund and all those sorts of things, and thankfully those have come along because in the last five or six years they have been a real help to us to get the standard of documentation which we now have, because we have good documentation. Also we are the only service in the State that actually puts ads on television, and we are just about to release another one, but that is with the good grace of the Community Fund which is going to fund part of it, and the fact that Southern Cross are using it as part of their community service commitment. So I would like to see the department liaise more closely with us, and also I would like to see them give us more assistance in terms of promotion and awareness and our publications so that it is well known that we exist, that everybody knows, so that, if there is an issue after five o'clock during the week or on a weekend when other helping services are not around or are not available, the professional services, they ring us and they ring Lifeline.

Mr WILKINSON - So more recognition. Make sure that people who are involved in Lifelink and Lifeline and people like that are properly trained before they are able to work alone, I suppose. Anything else?

Mr ROMANELLI - It would not hurt if we had more assistance also with funding of our telephone service. At the moment we are a 1300 number for people in all of the State, and it costs people a local call. We have to bear the difference.

CHAIR - Have you been in touch with Telstra about this?

Mr ROMANELLI - We have in the past, and because we are small fry, basically, and they have had a working relationship with Lifeline, they feel that they are doing their bit.

CHAIR - Have you spoken to Margaret O'Rourke? She's a fabulous woman. I would really recommend you do.

Mr WILKINSON - How much does that cost you?

Mr ROMANELLI - Anywhere up to $15 000. I think it is between $13 000 and $15 000, for which we have to fundraise. We have a brilliant group of fundraisers and without them we would not be able to offer the services we offer because at the moment we get minimal funding from the State Government, and if we were to be incorporated into a government agency it would cost a small fortune.

Mr O'SULLIVAN - When you think about it, we are fabulous value for government. You have 120 volunteers, people who have given their time, offering a service 24 hours a day seven days a week and we have been doing it for 38 years, and the only funding we get from government is $8 500.

Mr WILKINSON - You are not going to ask for any back pay, are you?

Laughter.

Mr O'SULLIVAN - No. In saying that, it has also been our philosophy not to ask for too much either, because we feel that to keep an independence and to keep our philosophy of the way we operate we don't want to become too dependent on government funding either, because we think that is important.

CHAIR - Have you briefed the minister?

Mr ROMANELLI - We have continually tried to get an awareness from the minister. I send letters to the minister. The minister sends letters back through the department, and we are not getting anywhere.

CHAIR - Okay. Do you have a card? We have a State conference on this weekend.

Mr O'SULLIVAN - He knows about us. Sue Napier asked a few questions in Parliament, too.

Mr FINCH - I am just wondering if that is the confusion.

Mr O'SULLIVAN - It is.

Mr FINCH - You have organisations with similar names: Lifeline, Lifelink. Which is which? Has Lifeline changed its name?

Mr O'SULLIVAN - That is an issue for us.

Mr FINCH - The other point, too, with the newspaper; if the newspaper does the story and if they ran down the list of services and phone numbers, they are not doing themselves a service. They want to go to just one.

Mr O'SULLIVAN - Quite often Lifeline aren't put in either and they should be.

Mr FINCH - I hear what you say, that there should be more recognition in that respect.

Mr ROMANELLI - We were the first telephone befriending service in Tasmania and we are the fourth oldest in the country. We are totally a Tasmanian organisation. It is important

that we work with Lifeline but it is also important that we get recognition for the service that we have continually offered since 1968.

CHAIR - If I make the suggestion that you would like an opportunity to brief the minister about the organisation and don't mention funding in my comments, if you choose to raise it -

Mr ROMANELLI - Which we have with the minister on three occasions.

Mr O'SULLIVAN - We have invited him to come and attend our seminar, as we would invite all of you. I think Kerry has been up.

Mr JOHNSTONE - Can I add to what you are saying? I am from P.O.S.I.T.I.V.E, who do the suicide prevention training. All my training brochures have on the back, 'If in need, contact Lifeline and Lifelink'. But following that proforma of having the two contact numbers, is that just a personal bias of mine, although it is? It is also following the national guidelines as set out as being the correct way of referring people if they want further help. Any media in Australia which does not put, 'If you need help, contact Lifeline or Lifelink' and give the telephone numbers are not following the national guidelines of media reporting about suicide and suicide prevention. They have to do it in order to follow the suggested guidelines given out. They can be reprimanded for not doing it but they have to do it in order to be politically correct in reporting anything about suicide and suicide prevention.

CHAIR - So a direct approach to the editor of each of the main newspapers?

Mr JOHNSTONE - Absolutely. The *Mercury* has been absolutely atrocious in the last two years because they have been disregarding a lot of those guidelines and sometimes forgetting to put Lifeline or Lifelink, one or the other or both. I thought I would mention that there are guidelines out there that absolutely every media outlet in Australia has, and they have to mention that.

CHAIR - What are they called, do you know?

Mr JOHNSTONE - Not offhand, but it is the media guidelines as set out. Whenever I have *Advocate* or the *Examiner* or someone else ring me up, the first question I ask them is, 'Are you familiar with the reporting guidelines of suicide and suicide prevention given out by the media?'. If they say yes I say, 'Let's talk about it. I will give you a refresher about what you can say and what you are not allowed to say and after that go and refer to the book so you make sure you get it right'. If you don't follow it, let us have it on record that you are breaking all the guidelines. I thought I would mention that because if Lifelink and Lifeline are not mentioned they are actually not abiding by the correct rules and regulations.

CHAIR - Thank you for that.

Mr JOHNSTONE - Sometimes people say, 'Let's make Lifeline bigger and forget about Lifelink', or 'Let's make Lifelink bigger and forget and Lifeline'. Why do you need two? Think about the person who has had a very unsatisfactory response from one or the other, maybe not the fault of that organisation or maybe it is. If it is that they are in great

need and they feel they need to shop around and there is only one organisation in Australia for them to contact, they have nowhere else to go. It is very important for them to go to the other mob - so-called, in our opinion, the opposition; it doesn't matter which way it goes - and say, 'I have had a really bad response from the other people'. Then Lifelink or Lifeline can say, 'What was your problem?' and they can use that to see if they can get deeper into the problem and hopefully solve it. So it is really important to have two very strong choices for people to contact.

Mr FINCH - Tim, would you like to draw a chair up to the table.

Laughter.

Mr JOHNSTONE - Sorry, I hope you don't mind me cutting in but I think it needs to be seen from somebody independent.

Mr O'SULLIVAN - That referral happens a lot, from one to the other, and I think that is healthy.

Mr FINCH - You mentioned the face-to-face counselling that you do -

Mr O'SULLIVAN - Befriending.

Mr FINCH - Is that what you call it?

Mr O'SULLIVAN - Yes.

Mr FINCH - Do your people who answer your calls do that?

Ms MURPHY - No, we have specially trained people to do that.

Mr O'SULLIVAN - But they do befriending on phones as well. They do both.

CHAIR - But you need extra training to do face-to-face.

Mr O'SULLIVAN - Yes.

Mr FINCH - Okay. So your befrienders can go on to get those more advanced skills?

Ms MURPHY - If they wish to.

Mr FINCH - And they do a course that is run by you?

Ms MURPHY - Yes.

Mr FINCH - Okay. And the other thing was Agfest; I wanted to ask a little bit about your involvement there and how the general public deal with you when you are at Agfest?

Mr ROMANELLI - We had a site this year at Agfest -

Mr FINCH - First time?

Mr ROMANELLI - This is the second time. I believe in the first one or two years of Agfest there was a site at Agfest but we decided this year that we would go there. One of the reasons was because there had been so much in the media about Lifeline and Telstra and some people were not sure exactly who were Lifelink Samaritans, where have you come from and what do you do. We thought it would be an excellent opportunity to touch base with at least 70 000 people from all over Tasmania from all different backgrounds. We prepared information packs that we gave out freely to anyone who stopped by and wanted to talk about what we did, where we came from, where are we going as an organisation.

We also gave out our youth cards. There should be one in the info pack that we put together with assistance from other agencies, including government agencies, which we give out to students. It is important that we try to get out to the community as well, although we find it difficult because of our volunteer base. A lot of our volunteers work and so it is difficult to expect them to give up their paid time to do our work. Also, some of our members not really wanting everyone to know that they are a Lifelinker. It is also difficult sometimes to get through the red tape to go to schools and go to some organisations. Because we are volunteers it is difficult to get through all that process to do that, so something like Agfest is great because you get people in their civilian clothes and you can actually talk to principals. I spoke with at least three principals and it was great to remind them that we exist, that we do produce booklets about suicide and that we are available 24 hours a day for themselves as well as their communities.

Mr FINCH - So it was successful?

Mr ROMANELLI - It was extremely successful and we look forward to 2006.

Mr O'SULLIVAN - If I can add one other thing as far as an outreach. We talked about face-to-face befriending but we also provide training for other organisations - nurses, teachers, all sorts of groups - in terms of active listening. We also provide the training - Kerry, I think you are aware - for the Time-Out Project. I think Liz Gee is going to come and talk to you today.

CHAIR - Yes.

Mr O'SULLIVAN - We have been doing their training since they started and we are very actively and closely associated with the Time-Out Project, so we train their volunteers in the same manner as we train our own volunteers.

CHAIR - That is great. Thank you.

THE WITNESSES WITHDREW.

<u>MR TIM JOHNSTONE</u>, PROJECT POSITIVE, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - Thank you very much for making yourself available to us. You will be well aware of what our terms of reference are so perhaps if you could just give us some understanding of where you are coming from and then perhaps we can start quizzing you, if that suits.

Mr JOHNSTONE - The organisation I come from is the POSITIVE project. You are probably already familiar with it but I will give you a brochure each anyway. POSITIVE is Prevention of Suicide Involving Tasmanians in Vital Education. That is the acronym for what they do. So in a nutshell that sums it up. I have done training for the Lifelink workers. I do training of suicide prevention in pretty well all sectors of the community. If there is a sector of the community that I believe is important to have access to, I find a way to access them and find out what the message should be and how to execute the message for them. That is what I see as my specialty.

I have been doing it for seven years. The reason why the National Suicide Prevention Strategy funding still keeps on giving me the money to do it is because I am always throwing myself out there and tackling the hardest issues, trying to find the magic formula to see if we can tap into that community. That is really it in a nutshell. So seven years ago the communities I was tapping into, no-one else had ever tapped into no-one else had ever tapped into and now other people can, but I was tapping into them then, and I am always breaking new ground. A month ago I spent a week on Cape Barren Island working one-on-one with people who called me into their homes. I did not tell them I was available to call into their homes. I just said I was on the island and I was doing something on suicide prevention. They didn't even know what I was going to do. That is because I didn't know myself. I made myself available - it was my third visit - but this time instead of going over there for the day I went over for a week. I found from previous experience you cannot really communicate with anyone unless you are actually in the area where they all hang around, which happens to be the no-smoking zone outside the hall, so I took two packets of cigarettes and smoked like a chimney for a week.

CHAIR - Why is it that so much community work involves smoking?

Mr JOHNSTONE - I don't know, but I gave half a packet of cigarettes back to the community nurse as I was catching the plane, and he said, 'What are you doing that for?' and I said it was part of the trade. I've finished'.

Laughter.

Mr JOHNSTONE - So that was a really big sector in itself, so my report to NSPS was that when you work in communities that fall into a certain slot like that the only way to network them is if you are in a smoking area, you smoke. All the hazards and everything else have got to come into it. Don't do it if you don't like it, but that's what you do. I took over everything including food to feed the whole island if need be. One of the things I did do was I called it the secret men's business lunch. They have had secret women's business things in other parts of Australia with Aboriginal communities, and so I put on a barbecue, soft drink only, no alcohol, and cooked the food for them, and they

all stood around. We only have 60-something people on the whole island, 50-something permanent, so I had 10 men, which is more than half the full population of men on the island there. They stood around with their sausages and were ready to hear. They were really wanting to listen to me, and it was very much a two-way thing. It was quite remarkable, the two-way communication that we had, and I had a full audience. It was absolutely brilliant. And beyond that I did a special workshop for the kids of the island. There are only six high-school age kids and I did something for them in their classroom situation and an out-of-classroom situation on the streets, because they are on the streets all the time, and then one-on-one with everyone else.

The morning I arrived on the island I had a hidden agenda, and that was to access the community the best way that was appropriate, and how I was going to do that was by listening to the community, and that is my secret. That is how I manage to enter into other communities. So as to how I access communities, it is always completely different, but that is just an example of that.

CHAIR - In turn, once you have accessed the community, whether it be through the kids on the street or the blokes around the barbecue, what are you trying to do?

Mr JOHNSTONE - In that particular case, when I was called to someone's home, they just wanted to talk to me, and in all the cases it wasn't them saying they were suicidal. In other words, it was a counselling thing like Lifelink people do. My role - and I obviously clearly got across to them - was that I was there to teach people about suicide.

CHAIR - What it is, and -

Mr JOHNSTONE - Yes, and in every case people who wanted to talk to me one-on-one talked to me about their relative who had killed themselves. One guy was demonstrating substantial grieving behaviour 15 years after losing a brother, and he is still going through a lot of self-abuse problems because of that level of grief. In the short time that I spent time with him I ran through to him the dynamics of bringing someone to suicide, and made it very clear to him, because there is a sense of incredible guilt, 'It must have been something I said' type of thing. We were going through it saying there is a whole pile of things that bring someone to that point, so it is impossible for you to be the main reason for it. And by going through the whole thing, he was saying, 'Oh yes, that was the case, yes' and he was actually throwing it back at me, and by the end of it he had a pretty good grasp of how his brother got to that point. If it is that at the end of things like that people have more of an understanding of something they should have been told 15 years ago, then the after-effects of someone losing someone close to them is not as bad. That is just a side effect of people learning about suicide.

CHAIR - So your brief, in a sense, is that you identify areas that probably aren't receiving services and you tackle them?

Mr JOHNSTONE - Yes. Last year I did, for example, quite a few workshops with indigenous communities, and now I have my foot in the door they all want me, so that is great. I did a workshop fairly recently at Smithton and there was a woman there who is indigenous who had been to another workshop of mine - it was her second workshop with me. She now wants me to go back and speak to a group of 30 indigenous people of Smithton.

CHAIR - Excuse my ignorance but are our indigenous communities statistically more at risk?

Mr JOHNSTONE - Statistically in Australia, indigenous males are the highest risk factor. The second point is the indigenous community of Australia, and no exceptions for Tasmania, are at the highest risk of self-harm through alcoholism and high-risk taking behaviour, so that being the case it is a high-risk group. I also worked last year, for example, with migrant communities working with the Migrant Resource Centre. I worked with a co-worker and trained her up to know how to teach it, how to go and network with the communities the way that I normally do, so she organised the workshops and I turned up and did my song and dance. As well as that I do normal workshops in normal communities, both professional and non-professional.

CHAIR - I suppose the Migrant Resource Centre would be with newly arrived refugees with trauma.

Mr JOHNSTONE - That person who I trained up to do that work is now working with newly arrived refugees but last year what I was doing with her was not working with those because their needs bases are too raw at this stage. It is more into - which is still suicide prevention stuff - meeting their very basic needs, teaching them how to live in Australia. She is doing that now but last year I was working with migrants who have been here for a lot longer.

CHAIR - I had experienced only in the last few years with the Bosnian community at Clarendon Vale who were having real problems. They were not newly arrived but had been here for a while and it was not working out and then I imagine there is also the much older migrant whose sense of social isolation would grow with old age. Is that right?

Mr JOHNSTONE - I did an absolutely inspiring workshop for the Italian club at the casino at Prospect. There were about 60-odd there, I reckon, just the most phenomenal group. Basically I got them to talk about life in a family in Australia as an Italian family compared to an Italian family in Italy and they were saying there was no suicide in Italy. I said, 'Why is there no suicide in Italy?' When they were saying that, there is suicide but not the suicide that they are referring to. If you are in a family you do not kill yourself but it happens in Australia. I said, 'What is the difference?' and they talked about the dynamics of family in Australia compared to the dynamics in Italy. I then said to them, 'However, and statistically speaking, Italian families still have a lower suicide rate than other migrant communities'.

CHAIR - Because of the strength of their links?

Mr JOHNSTONE - And I wanted to make it very clear to them that that is a very important thing that they can call on and in this case a reaffirmation of their standards as a family, to strengthen those bonds even further and an affirmation - you were on the right track.

CHAIR - Yes.

Mr JOHNSTONE - And tell your young people that this guy said that. He is not Italian but he is standing back and looking at it and saying this and reinforce them to be involved with it. At the same time talk to them about cultural clash within their families, the expectations of their children, of the younger generations. Pull back from it, be loving. Be that loving Italian grandmother without having too high expectations about toeing the line because that is when they pull away and make it really gruesome.

CHAIR - Can you extrapolate that out to Greeks, Spanish people, others?

Mr JOHNSTONE - A little bit to Greeks. The Dutch community in my opinion is probably the most difficult one because you have a religious clash coming into it through the Dutch Reform Church. The Dutch bond has loosened substantially in my opinion. Talking to Dutch people and talking to other migrant communities it is my experience that their culture is seen to be lost a lot quicker. I am not sure really how to describe it but there seems to be a higher risk factor in other communities.

CHAIR - What about workplaces?

Mr JOHNSTONE - With workplaces, Kerry and Jim will also know who I am talking about here as far as the boys in Canberra - I am calling them boys - I forget the organisation at the moment. At the moment they are doing work with apprentices and they really want to work with bosses as well. It is very worthwhile. I do workplace stuff but not to the level of where that is, and I believe that is where things are going to have to go to.

CHAIR - And you're into the workplace. Are you coming in through the workers representatives or through the management?

Mr JOHNSTONE - For example, I have done a lot of work with fire brigades and I have worked with teachers and nurses, in all three cases through professional development built into the system. Once you go into other professions or other types of workplaces then it becomes a lot more removed if there is not a set formula for professional development.

CHAIR - Where it's not built in.

Mr JOHNSTONE - That's right. What I hope in the future is that it will be built in.

CHAIR - As a part of duty of care?

Mr JOHNSTONE - Yes. What I would like to believe is that you would be able to go into a factory and see posters up - which weren't around when I was a boy - saying, 'You must wear earmuffs and goggles'. There would be another one there saying something like, 'You must talk to a mate if you feel like crap'. Those posters are all together. If we talked about the importance of eyesight and ears you would say, 'But the factories wouldn't have put those posters up if we said that 20 years ago'. We expect to see them; I expect to see something like that down the track.

CHAIR - Have you had any conversations with Unions Tas on this sort of thing?

Mr JOHNSTONE - No, I haven't, because the boys in Canberra have really got their finger on the pulse as far as coming up with the angle of how it could be handled. I see myself as a plug, that I can go into the Education department and plug into them so I can do their education for their teachers - which I have done in 40 or 50 schools in Tasmania. I can plug into the migrant community through other ways, plug into the indigenous communities through different ways, plug into the unions that I don't have the time and resources to do or the conduit to do it.

CHAIR - I can just see so many opportunities there. For example, I have friends involved in the ETU and they go out and visit Aurora workshops and Australia Post workshops when they have shift changes and they get 50 or 60 people there.

Mr JOHNSTONE - That's fantastic. One of my problems is that the training modules I have don't scratch where people are itching, and the guys in Canberra have that message. One of the problems you have is that the population now increasing in age are the ones who are the higher risk; we are now looking at the men of the 1930s and 1940s. Twenty years ago they were the youth suicide risk factor. They are growing older. In a lot of cases those people are at higher risk, not just because of the divorce rate and expectations on them as fathers, husbands and all the rest of it; there are also some skills that they have lost that they could have learnt at a younger age. There was a gap there in our history and I believe what has happened is that during the time when they could have learned those skills they did not learn them because of how the system was at that time.

CHAIR - Can you clarify that?

Mr JOHNSTONE - I will give you an example. Thirty years ago an apprentice would learn his apprenticeship of, say, motor mechanics with the fully qualified mechanic. He would learn all the good and the bad habits; he would learn how to drink, how to socialise - absolutely bad and good - but he gets the story. At the same time he also learns how to clean his clothes and all those things because it is all done in a mentor type of situation. What has happened is that, once again bad or good, you learn the skills. Down the track it has got divorced from that where the mentor system wasn't as strong. They may not have had dad at home to mentor off; they may not have had a healthy father-son relationship to mentor off, so consequently they stumble through and later on they don't have the abilities for coping when stresses happen because they have not seen it mentored through. The way they were taught through their education, the way they were trained up is slightly more removed with the TAFE situation where you have the teacher upfront and 30 students in a class learning a skill. It's slightly different from a one-on-one mentor. Nurses; my wife when she nursed was nursing straight into the hospital situation. She was hands on. Now there is training at university and they are taking them for six-week batches where they have a steep learning curve to learn their skills. They make terrible mistakes, lose a lot of confidence but they are still not learning the culture of nursing because they are not there from day one.

CHAIR - Because people are not being, if I am understanding you correctly on those, given a context so that they know where they fit, who is above them and who is below them in terms of the rank or hierarchy if you like and the expectations that are there.

Mr JOHNSTONE - Let me give you an illustration I use to different groups according to their understanding. I can actually do this with a children's group or I can do it with

Aboriginals. It is an illustration of scales. And when I was in Cape Barren I literally had an old paling and a couple of buckets and sand and it was balancing across my eski full of soft drink, so that is how it raw it was when I did it but I can do it in PowerPoint or on a whiteboard. Imagine we have a fulcrum and some scales. On this side is a bucket and this bucket is the needs and pains of someone. Remember at the top I have a heading and when I put the heading I am going to say, 'The significant definition of a suicidal person is someone who is needful'. Needful is real important because if you meet someone's needs they are going to be less needful. You are talking about the new migrants in Hobart. I was talking about new migrants arriving and saying that what MRC are doing is suicide prevention because they are meeting the needs of the newly arrived. That is the sort of thing I am talking about. That is subtle suicide preventing because you are meeting people's needs. This bucket by the way has a hole in it so some can get out. That is a time thing. A little bit goes in there and in time it can sort itself out beautifully if the hole can just get some of it. Some of the rocks and things that go in that bucket will not ever get through that hole. They have got to be dealt with by other ways. When that stuff goes in there, if it goes in there really quickly you have a lot of traumas in your life happening all at once. What goes in the other bucket is your copings. You cannot go to the shop and buy half a dozen copings. Copings are what you need to cope with. You have two different sorts. You have resources and you have skills. Resources are the things you call on - Lifelink. So you look up the phone number and you ring them up. They are a resource to help you cope. The skill is the ability to pick up the telephone and make the phone call. Now, with skills and resources where are you going to learn them from? You are going to learn them at school, from family, from the workplace, from your mates. The best way to learn the skill is through example, through a mentor.

I have gone and said the same thing but all back around again. The overall picture as far as I am concerned is why is it we have a suicide rise in certain groups? And you go right through the groups and you come up with the same answers. Why was it that suicide in older men was quite substantial in the early part of the century? The older men wore worries back from the wars that were not dealt with properly.

CHAIR - Dislocated.

Mr JOHNSTONE - Exactly. Secondly, they were not dealt with in their level of pain from prostate cancer or whatever the case may be. In other words, men's health was really quite basic. They would have the pains et cetera but they did not have the copings to balance it up. They were at high risk. You go through absolutely every stage and you say everyone has pain. Everyone has horrible things happen to them, some more than others, but why do some so often cope better than others - because they have coping. Why do they cope? Because they have enough resources and enough skills. Giving someone a resource like Lifeline and Lifelink is very important, but unless you give them the skill such that if you feel crappy then see someone about it, then they are not going to deal with it.

CHAIR - And that would reflect back on parenting skills and everything, I would imagine.

Mr JOHNSTONE - Absolutely. Someone in the workplace sees someone cope in a mechanical context. A customer comes in and the customer is angry and they see the boss handling the customer. Be it appropriate or inappropriate, he is still seeing the boss

coping with that situation and that apprentice can make a decision whether that was appropriate or not appropriate, but at least he can make a decision. At least he has some way of actually formulating how he deals with that situation, and that is all part of the process of coping.

CHAIR - I suppose sport would play a role in there too. You guys were talking about football.

Mr JOHNSTONE - Yes, these are resources again. The skill is the self-taught ability to gain the help et cetera, the resources are who it is you can turn to.

CHAIR - And self-awareness, I guess, and recognising symptoms.

Mr JOHNSTONE - So when I see resources like Lifelink and Lifeline, I think this is fantastic because this is offering a resource. Now all you have to do is offer the skill to make people contact them. Let's get the skill improved from Lifeline and Lifelink so when someone does ring it is going to be pretty slick. That's good.

Mr WILKINSON - Do you think there has to be appropriate training before people can be with Lifeline and Lifelink, or do you think it is not that important?

Mr JOHNSTONE - It is really important to have good training. I do not actually have a firm opinion as to whether they are or not. I do not actually have enough feedback from the public saying they were lousy, so I would say that is good. I believe they know their limitations too, because I hear people saying to me, 'Oh yeah, I rang up Lifeline. They were hopeless because they wouldn't tell me this, wouldn't tell me that'. I have to say to them that this is exactly what they are supposed to do, and I am personally very pleased to hear that.

Mr FINCH - Just talking about those skills that people have, and your bucket over here with resources, there is a word that we have been hearing over the last couple of days that I would like to hear your thoughts on, and that is resilience. It seems to be something that, particularly in the education system, they are talking about a lot more. It think it might be coming through with Essential Learnings that resilience is a key to a person's character in respect of dealing with issues and with life.

Mr JOHNSTONE - Has Martin Harris come in before me?

CHAIR - Yes, he has been in.

Mr JOHNSTONE - Did he talk about resilience?

CHAIR - Yes.

Mr FINCH - He mentioned it.

CHAIR - Not to a great extent.

Mr JOHNSTONE - Okay. Martin and I banter about issues of suicide because we are contemporaries and we fight for the same issues, and we are really a very good support

to each other. Martin said in a throw-away statement to me something about resilience being probably one of the hardest things to define. It is very important but really hard to define. I am really sort of paraphrasing what he was saying, so he will probably be upset by my quoting him, but he made me really think about it. Resilience is very, very important, but it is kind of like the label on the box, but what is in the box. It is too hard to define because there are things rattling around in that box, then let's go and find out what those things are and break it up from there. So we can put a title on it, 'Let's improve resilience', but let's move from there. What does that really mean? And then it actually branches back out to all these other things. That is why I like using my scales thing. I mentioned to Martin the other week that it is actually a modification on different stuff that you can get from any training programs - they all like to use it - but mine has actually improved on it because I can talk about the different ways it works. What I like about this illustration is that resilience is 'bouncing back from the crap'. When this stuff over here happens, it still comes back to balancing up, and that is resilience. The person who has poor resilience or is lower in resilience is the person who does not have the resources to call on.

CHAIR - And would those be things like the capacity to be optimistic, to see a light at the end of the tunnel?

Mr JOHNSTONE - That is a skill, yes.

CHAIR - Capacity to call on supports, whether it be family, friends?

Mr JOHNSTONE - Yes, those are resources; yes, that is the sort of thing.

Mr WILKINSON - A definition of resilience could be ability to cope, couldn't it, which is the same as your coping strategy.

Mr JOHNSTONE - Yes, ability to cope, but you hear people say, 'Oh, I just don't cope when something happens'. I actually quiz them on it and say, 'Okay, what do you mean by "you don't cope"?' What they do then is that they can actually redefine what they mean by 'don't cope'.

CHAIR - It upsets them, or they cry.

Mr JOHNSTONE - Yes, and sometimes they can actually belittle their own ability for coping. Let me give you an example: a young girl, poorly educated because she just did not attend school very much, a low achiever, she gets pregnant when she is 13. She stays at home and has the baby. She seems to cope really well. You see her on the street all the time and she seems to be fine. Why is it that that 13-year-old girl is coping really well and then you have a 25-year-old mother who is in a happy marital relationship with a baby the same age and she is falling over in absolute distress because she is not coping. Is it intelligence? No. What is it? Is it expectations? Maybe. But do you know what it really is, when you really go and peel off the layers? The 25-year-old mother, who has a good relationship and all the rest of it, may not have the ability to call on the resources that she needs to cope with. The 13-year-old girl living at home goes out in the backyard and has a cigarette while mum is inside looking after the baby. Take this 25-year-old mother and give her more resources to cope better - self-confidence et cetera - and she will be fine. Take this 13-year-old out of her mum's home and put her in an absolutely

brilliant $2 million flat somewhere on her own and she will fall over very quickly. So it is not cultural; it is whether that person has gained the skills and has access to the resources. It is all within the context of the person.

Cape Barren Island is a perfect example. One of the guys at lunchtime said he had to go to Hobart and was down there for a week. He finished up in the mental health hospital because he just freaked out. He couldn't cope; the big smoke of Hobart was too much for him. They had to get him onto a plane and get him back over to Cape Barren where he was content. He said that in front of the group; he was not afraid to tell how he felt and what happened to him. I said to him, 'You've got your resources on Cape Barren but you didn't have them in Hobart. That's not your weakness; it is just a statement about you'. You get someone from Hobart and put them on Cape Barren Island for a week and see how they cope. That is the difference. We are talking about tapping in on the resources that a person has available to them. Going back to resilience, we support school education systems that we have going now that are very good with improving resilience in our students. Mentoring programs that the councils have are very good. I support all those and do all the education work, the suicide prevention stuff for all mentor programs in the State. They are absolutely brilliant because they are providing mentor that a young person may not normally get. That is helping in giving them coping resources. Teaching the teachers and working with the parents I see as being broad-stroke stuff. I do not come in with a magic formula - well, I do. The magic formula is the suicidal person's need for an individual. They see killing themselves as a way of coping or escaping from their situation. That is not my definition; that is the definition. After that, you say, 'Let's have that person's needs met. What has happened to them? They are needful because they don't have access to resources and skills. How do we tap in on that?

CHAIR - So it doesn't really fit well with treating everything through a medical model, does it?

Mr JOHNSTONE - I believe the medical model is just a fix. It is not the fix; it is a fix. If it is that someone is suffering from a mental illness then sometimes a medical model is the only thing that is going to fix that. But in the seven years I have done this and at all the national and international conferences I have ever been to they have all said you have to look at it from the broad-stroke point of view. Whenever you see a cohort in the population that has a higher risk it is usually because there are things happening to that particular age group which has an imbalance between the amount of needs and pains they have compared to the amount of resources and skills. I make it really simple and I leave it up to everyone else to make it complicated. You can say, 'Yes, but what does that mean now?', that is the complication.

CHAIR - You were talking about it with the fellow from Cape Barren going to Hobart; that geographical shift created an imbalance, to use your analogy. I imagine that could also could occur through life if life events change, whether it be simply the process of ageing et cetera. At different times in your life you can be more or less isolated, with a young family, whether or not you are at work.

Mr JOHNSTONE - Social isolation, physical isolation, they are equals so far as risk factors. The same thing applies.

CHAIR - How do you see the role of the media in all this?

Mr JOHNSTONE - I mentioned before when I rudely butted in, the media do have guidelines so they do exist and the role of the media is that they have to be a lot more responsible. One of the media outlets in Tasmania - and I am not picking on it because I have a personal bias; I am stating a fact - have been causing strife because they have been out of order. I have done other work with other media outlets and, as I said before, I have made it very clear that there are guidelines that you must follow, are you aware of them, before you print this so you do not get into trouble, check them out. So the media can play a very good role and can play a very bad role.

Mr WILKINSON - Tim, you have answered a lot of the questions that we are focusing on in the terms of reference but it would just seem to me - I think I know your answer - that the role of non-government organisations and other community business partners is progressing suicide prevention in Tasmania. What would you say to that?

Mr JOHNSTONE - As I am one of those, obviously it would be mad to say otherwise than that it is really important. But let us go beyond that. The reason we believe it is important is that the non-government organisations can be supported by the Feds or State, or whatever the case may be, to venture out to do the work that they simply cannot do in the government situation because they can step out of the usual guidelines that they have to follow in government.

CHAIR - Are you talking about being more flexible and responsive?

Mr JOHNSTONE - Yes. I do not have to worry about red tape to go to Cape Barren Island. I make a phone call and do it and then I tell the Federal Government afterwards what I have done. I have been giving myself a lot of freedom but I can do it. Talking to my contemporaries who are in government, they cannot do that. They have to go through such nonsense to be able to do it and they are all restricted as to how they can handle things. Too restricted. Why do I say too restricted? Too restricted to be effective in some circumstances but the restriction is there for a purpose so I am not going to say they should have it lifted but when it comes to NGOs - we were talking about Lifeline care - how many volunteers did they say they have got?

Mr FINCH - 120.

Mr JOHNSTONE - Okay. The value of that goes without saying. I donate my office space and a lot of my time because my income that I get from NSPS is nowhere near to fund what I do so I have a business that I run at the same time in tandem which supports me to do suicide prevention stuff, so the Government gets incredibly good value for money. So NGOs is one - incredibly good value for money. Secondly, they have the independence and the quality of the product to be able to get out there and do it. They can also then, by a legality of me getting the money, get feedback that they can then use to spread the mission elsewhere.

I did some workshops down the west coast a couple of years ago and I found it totally mentally and physically draining the way that I did it. In my opinion it was a total disaster for Tim Johnstone so in my report I made it very clear that if someone else wants to do it this way, do not let them because these are the reasons it is a disaster. They

loved that information. Instead of just hearing that Tim Johnstone is great because Tim Johnstone has done this and that, they love to hear feedback that he is going off the other side of the coin. That information is very important for NGOs. So voluntary work, value for money, freedom to get out and do the work and also the flavour. There is a flavour that comes with it which is different from what a government organisation can do.

Mr WILKINSON - What about the second one: investigate strategies to address the needs of the highest risk group? When you are endeavouring to word terms of reference it is always a bit difficult to get the correct ones at the start of the investigation -

CHAIR - That is why we always have 'and any other relevant matters'.

Mr WILKINSON - as opposed to the end. You should be putting them at the end. The second one is: Investigate strategies to address the need of the highest risk group in Tasmania, men aged 25 to 44.

Mr JOHNSTONE - Everything I do is two things, investigative as well as proactive.

Mr WILKINSON - What should be our recommendation about that?

Mr JOHNSTONE - As far as NGOs doing it or as far as anything happens?

CHAIR - Anything.

Mr JOHNSTONE - Read the question again.

Mr WILKINSON - I suppose I should go from the start. I will give you a copy. That is probably a bit easier.

Mr JOHNSTONE - Investigate strategies to address the needs of the high risk groups in Tasmania. These are your terms of reference?

CHAIR - Yes, so we are looking at strategies.

Mr JOHNSTONE - That's an investigation for you as well?

CHAIR - Yes.

Mr JOHNSTONE - You can read into what I have said as being part of your investigation. Allowing the Tim Johnstones that have the ability to safely investigate these things and then come back to you guys to give the information. Every good practitioner, be it a nurse, a doctor, teacher, minister of religion, will tell you very clearly if you want to be effective with your message to the person you want to get the message across to find out how you can get that message across most appropriately with your methodology and your words. The skill is there is no standard message. When I do a workshop for a small village on the north-west coast, the far north-east coast or the west coast it is a different message than in suburban Launceston. When I do a message for a committee like yourselves it is a different message from talking to someone from Cape Barren Island. If

it is exactly the same message, the same wording and the same approach, it is a miserable failure.

CHAIR - That comes down to the skills of the worker.

Mr JOHNSTONE - Absolutely. If it comes down to the skills of the worker, perhaps one of the recommendations, if you believe that that is important, is to see if you get other people skilled up to be able to do it. At the moment, to my knowledge, there is only one Tim Johnstone in Tasmania. There is a guy in Western Australia that a psychologist got us to meet - you guys would have met him at the national conference last year. We got on really well together. He works in Western Australia and he and I are like little clones but we invented ourselves in other parts of Australia, so there's not many of us around.

Mr WILKINSON - So how do you get more of you?

Mr JOHNSTONE - Allow cloning to be legal.

Laughter.

Mr JOHNSTONE - That is an issue.

CHAIR - They are born too, I think.

Mr JOHNSTONE - I think that is possibly it; that is part of the problem. But at the same time, it can be an acquired skill.

CHAIR - But you have to have the opportunity to have the experiences and exposure to situations to realise what you can do, don't you?

Mr JOHNSTONE - Yes. Let me give you an example. I drove out towards Scottsdale to visit some of the small villages of the north-east and I picked up a hitchhiker just outside Launceston. I could tell before pulling up that we were looking at a high-needs young person, by his clothes and his whole demeanour. I have a policy of picking up hitchhikers only if I have no family members in the car. I picked him up hoping he would be valuable for work; five minutes down the track he was absolutely brilliant for work. He had just come out of gaol. He came from Ravenswood, he got kicked out of home and he was heading back over to stay with his grandmother in a very small, isolated community in the north-east. He started splurting to me about all the stuff in his town. I had to call into Scottsdale to see the council and then continue on my way. I said to him - and this is cutting a conversation between here and Scottsdale - in a nutshell, I made a deal with him: I would take him to Scottsdale, he could go and have a smoke or a pie while I went to see the council. He could leave his gear in the car. When I finished he could come with me and if he gave me a lot of information about his community I would drop him off at his doorstep. He was rapt because to get to his doorstep would have been a really difficult task because he had to hitchhike to get to a fairly isolated community. By the time I got to his doorstep I learned about who lived in what houses in all the different towns we drove through, about different dynamics, about who were the most significant contact people in those places. As I soon as I dropped him off I got out the notebook and wrote everything down I possibly could. Once I knew that, I went into the local store and bought a cup of coffee. While drinking the cup of

coffee I talked to the storekeeper. When I told her I had just dropped off so-and-so down the road she said, 'Oh, did you' - but I got the inroads. When I said what I wanted to do they told me then who was the best person in the town to contact, and I knew that was right because of what he said, who were good and who were not good. I said, 'How can I get hold of these people?' She rang for me and handed me the telephone. They organised for me to go and talk to the manager right away. As a result I organised to do a workshop, went up and did a workshop, filled up the Town Hall choc-a-block. I said 'I'm not even going to give you a poster, it has to be word of mouth', because I usually give out posters. I said 'If you want it to work then it is up to you to spread the word around', and the place was choc-a-block. Seventy-five per cent of the local population turned up at a workshop, and it was an absolute scream of a workshop. It was fantastic. What happens? You pick up a hitch-hiker, you buy a cup of coffee.

CHAIR - I don't think you could do a course on that, Tim, quite frankly.

Mr JOHNSTONE - Exactly right, it's seat of your pants stuff, but once it happens I am happy to go around and say this is how you work with these communities because I have bought cups of coffee and given people lifts in cars and taken up cigarette smoking for a week at a time.

CHAIR - But quite often you will be a catalyst then to make sure that others in the community pick up on -

Mr JOHNSTONE - Pick up on it. That is fine. I am happy to lead the way and then let other people know how to do it. That is fine. And that is what NSPS like to get back from you, how the message is appropriate.

Mr FINCH - Those creative skills, though, not everybody's got them.

Mr WILKINSON - They are unique, really. Do you think there are enough data collection resources? What should we do to get more? What type of data should we get?

Mr JOHNSTONE - We cannot get attempts at suicide unless you do a specific closed study, and it is not going to be very effective. Risk-taking behaviour can be found out through other ways but is still not very clear. It is all anecdotal. We can only get suicides or death by misadventure and it is all going to come through the coroner's office if the coroner says that it is a death, and we all know it is going to be higher than that. We will never ever determine deliberate car crashes.

CHAIR - Single vehicles, particularly.

Mr JOHNSTONE - I think we can only be aware of the fact that the figures here are actually worse than is printed because of the situation.

Mr WILKINSON - Should there be an overarching body that gets all the data? You might say the coroner's office does, but I don't think it would probably get the data that it should get from Lifeline, Lifelink, Samaritans, maybe from a number of other NGOs. If they fed their data to this umbrella body, would that help at all?

Mr JOHNSTONE - I never thought about, to be quite frank with you. I don't know if I can give a very good answer to it, but it is probably a good idea. That is without giving it thought. Off the top of my head it is probably a good idea as long as confidentiality was sorted. The last thing you would want to have is if you rang up Lifelink and you became a name et cetera, then you really would not ring in the first place.

Mr WILKINSON - What type of data would be required, the best data that you could get?

Mr JOHNSTONE - I would say there would be combinations of the amount of different people who ring and the percentage of the main problems. You might be able to get a very good social pattern going. For example, you might get a high percentage of young people ringing up and saying they cannot support themselves because they have dropped the dole, or the dole is harder to get and therefore they are going to kill themselves. If that information could get back through then some decisions may be made as a result.

CHAIR - Causal factor stuff.

Mr JOHNSTONE - Yes. Also, how many times the same person goes back to the organisation. The trouble is that Lifeline and Lifelink would have to come together to actually do it, but it is a not a very good idea because confidentiality is going to be a problem.

Mr WILKINSON - Area of living or environment, or where they live, north-east coast, south, north, north-west, west?

Mr JOHNSTONE - The problem with that, Jim, is that actual statistics in suicide get screwed up by where someone kills themselves.

CHAIR - Because you may choose to leave home to do it.

Mr JOHNSTONE - Exactly.

CHAIR - Or it is because you are away from home that you are feeling that way.

Mr JOHNSTONE - There is some anecdotal stuff to say that the north-west coast suicide rate has increased as a result of putting my *Spirits* on, because people who are running away from a problem in Melbourne or Sydney are coming to Tasmania and then killing themselves just outside Devonport. A lot of non-Tasmanians killed themselves down the north-west coast not far from the ferry. Now that is just anecdotal, but that gives you a good answer. Hobart will have a higher ratio because people are sent down there for mental health issues and mental health issues are not adequately dealt with, but that doesn't mean Hobart is going to have a higher suicide rate than the north; it just means they are down there.

Mr FINCH - It might be interesting to know that, particularly about the *Spirit*, because there could be a poster up that might swing them around.

Mr JOHNSTONE - That's right.

Mr FINCH - It might have a message that might get through to them while they are on that trip. It might say, 'Hey, think about this. Are you dealing with things? Here's a number to call.'

CHAIR - We put everything else in the toilets, don't we. Even bowel cancer ones I have been noticing lately.

Mr JOHNSTONE - That is right. Lifeline put out this poster - and excuse the French in this one here, but this is what it says - of a person with a seagull flying overhead and a big splotch running down, and obviously the bird has just crapped on his head. And then it has S and then things to hide the rest of the word, and the T at the end, so 'S H I T happens'. Very clever, and it has Lifeline with the telephone number on it. Stuff like that.

Mr FINCH - So a message like that on a TT-Line trip, and I am probably thinking TT-Line would be used for all sorts of various things, but that might be a message. If that sort of thing is occurring, if that statistic were understood, there might be some leverage there to get a strategy like that in place.

CHAIR - I suppose the other half would be using the media, too - we were talking about responsible media earlier - but also using the media to get good messages out. That could be a television ad, couldn't it.

Mr JOHNSTONE - An organisation that is not Tasmanian had a media campaign in Tasmania a couple of years ago, and I just -

CHAIR - Was it bad?

Mr JOHNSTONE - Yes.

CHAIR - Some of them are shocking, aren't they.

Mr JOHNSTONE - This was really politically unbelievable. I just made so much of a noise about it, and so did a few other people, but I was totally offended by it. It was a week before Christmas and there were two or three different ads. My children brought my attention to it, because it was always put on during *Home and Away* and *Neighbours*. It was a coffin being lowered down into the grave, and it said, 'This could be your child if you don't support -' and it said the name of the organisation.

CHAIR - The latest drug ads are like that.

Mr JOHNSTONE - It doesn't work. Suicide and suicide prevention need to be handled differently from drugs or anything else. I am speaking tomorrow night. I don't normally speak to young people under the age of 18, but I am going to tomorrow night because I have got the people from a youth group to send letters to the parents warning them, if they have any problems, to ring them, so I am going along to speak to the group. But in saying that I am not even going to mention suicide, okay, so you've got to do suicide prevention without mentioning suicide.

CHAIR - The S**T Happens ad is not mentioning suicide.

Mr JOHNSTONE - Absolutely. Now I will be doing it tomorrow night. I will be still using those scales and I will be doing all those things and I will be talking about normal coping mechanisms. I will be talking about resilience without having even to use the word resilience. Drugs can have a little bit more shock value, a little bit but not as much as you are talking about, but suicide just does not work. I am saying this because I would really like to have it on the record. It is very dangerous if any organisation says to you guys, or if you ever get the notion in your head, that suicide prevention and education has to happen to under 18s by really pushing home to them how they have to help their mates if they are suicidal. It is just so dangerous.

Mr WILKINSON - We have been told that already, earlier on today.

Mr JOHNSTONE - Have you? From Martin? Good, because if Martin comes across someone who is slipping past those rules, he screams out to me and I do to him, because we are both aggressively strong about it. There are some organisations who believe that is nonsense and that you can shock kids into making themselves available to assist their friends if they are suicidal. They are not emotionally ready for it. It is just dangerous.

Mr FINCH - That's a Canadian organisation, is it, the yellow -

Mr JOHNSTONE - Yes. It is dangerous. It should be banned. If there is ever a possibility to just wipe them off the social calendar of Australia, that has to be done. It is just so dangerous.

CHAIR - And who likes them? Where are they getting these opportunities?

Mr JOHNSTONE - Ill-informed principals of schools who don't realise. They think it would be really good for the kids to be involved. They can quite easily slip into the school and take over the school's environment before you know it. You have kids going around the school with a badge saying they are the assigned student, and any other students who have a problem can come and talk to them about it. So we are talking about a pimply-faced 15-year old boy or girl who are going to have people coming to them saying 'Mum's raping me' or 'Dad's raping me'. What can I say, because that is what their ability is supposed to be? It is just not on, so it goes without saying -

Mr FINCH - Because if something happens, then of course that student then bears that scar, that damage.

CHAIR - Of course.

Mr JOHNSTONE - They are just not emotionally mature. Looking down here: role of Tasmanian media in suicide prevention. Have I answered that?

CHAIR - Yes.

Mr FINCH - Just something I wanted to say to you about the media. You mentioned an organisation that has remained nameless, but didn't that same nameless organisation win an award at the SPAR conference for the way that they are dealing with -

Mr JOHNSTONE - No, they didn't. It is a different organisation.

Mr FINCH - So I can quite freely mention that the *Mercury* really are embracing the protocols?

Mr JOHNSTONE - No. The *Mercury* have in the past. Sorry, now I am with you with what you are talking about when you mentioned the organisation. I am not sure how much to say in these circumstances, but that reporter got the award because he did the right thing. He is no longer able to take on suicide. He still works for the *Mercury*. Anything about suicide is being written by somebody else, who is a real pain in the butt. The *Mercury* is not following the guidelines as well as they should. That reporter won an award at SPAR for good suicide prevention reporting as an individual. He is no longer determined by the *Mercury* as being the person that should be allowed to do suicide prevention stories. Because I am a member of the State committee, the TSPSCSP, you know what I am talking about, we have talked about it a fair bit in that meeting about that, and it is a thorn in our sides.

CHAIR - Can I ask a favour of you as we tie up? If you have an opportunity in the next few weeks to scribble down some points for us under each of those headings, or the ones that you -

Mr WILKINSON - It makes our job easier, you see, Tim.

CHAIR - If you have the chance.

Mr JOHNSTONE - If I get a chance.

Mr FINCH - Martin is going to get his head around it, so it might be a comparison when you are aggressively meeting with Martin and discussing things.

Mr WILKINSON - You remember those nutshell books, you know, *Hamlet in a Nutshell*, that's the type of thing we want.

Mr JOHNSTONE - I have handled this sort of forum with a scatter gun. That is deliberate, because I could come in here and be very specific, but I do not believe it is the information that I -

CHAIR - We need to get our heads around the whole culture.

Mr JOHNSTONE - Yes, so I am using a scatter gun. Now I wonder then whether that is the information that you require and how much of that is actually something you believe you would like to have written down.

CHAIR - It gets our thinking in the right area to be able to tackle it, but we are required at the end to actually make recommendations, and that is the hard part.

Mr JOHNSTONE - That I know and, I tell you what, I am glad you are sitting that side of the table.

Mr WILKINSON - What happens, in all honesty, is that in the end we get so many submissions. You read the submissions, you read all the evidence - because it is transcribed, you have folders of it - from people who we believe know a lot about the subject. What we like to do if we can is to go to those people and say these are their views in relation to this, and then you can milk off that what you get from your scatter-gun approach as well. You are obviously an expert in the area and a person who has worked in it for a long time, a person who is well respected, and it would be terrific to have some points so we can say that Tim said this, this and this in relation to that. We are not experts. We are listening to all the experts and therefore it is going to be extremely helpful if you can.

Mr JOHNSTONE - The magic formula, in my opinion, if there is a magic formula for your guys, is to view the aim of reduction of suicide under a broad banner and say that there are specific areas that have to be addressed in order to do it. For example, there has to be public education, and the public education sub-headings will be the following things, including media correctness and the Tim Johnstone posters. Then you are going to be looking at mentoring, improving that sort of process, so we are looking at improving the ability to gain access to good quality resources in order to cope with circumstances. Some of this may be just simply recognising existing structures that are in place and have them recognised as being very valuable in the subject of suicide prevention. There is so much very valuable stuff out there that is very effective in suicide prevention. I have mentioned two or three today, but you could go on for ever about it. That is very valuable but it does not necessarily get recognised as being important in that field. Sometimes it does not have to be, but I think at other times it might be worthwhile, and it helps give legitimacy to some of those tasks as well.

I will use the example straight downstairs, Service Tasmania, because I am up here and I thought of them when I came through the door then. For various reasons I often go into Service Tasmania. There are some workers down there who are absolutely brilliant to be with and they have a sense of humour. Some others are horrors. They are all getting paid the same amount of money, I assume. They are all doing the same task. So if I was involved with Service Tasmania I would find out who the horrors are and see if I could improve them, and I would find out who the wonderful people are and find out how they can teach the horrors. That is suicide prevention. So it gets to the point where -

Mr WILKINSON - Pat the good people on the back as well and say, 'Look, you're doing a good job', because it doesn't usually happen.

Mr JOHNSTONE - Absolutely.

CHAIR - It's not part of the job description, either.

Mr JOHNSTONE - It's not part of their job description and they are not valued for it.

CHAIR - We could argue the same thing about teachers, nurses, pretty well anyone really.

Mr JOHNSTONE - Absolutely, and I think there are a lot of things like that which really do play an important part.

CHAIR - Thank you very much, Tim, and if you do get an opportunity to put something on paper we would appreciate it. It was great to meet you. Keep up the good work.

Mr JOHNSTONE - Thank you.

THE WITNESS WITHDREW

Dr CHRIS MOORHOUSE, EXECUTIVE OFFICER, MEANDER VALLEY ENTERPRISE CENTRE AND RURAL AND COMMUNITY DEVELOPMENT SERVICES WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR (Ms Thorp) - Thank you for making yourself available to the committee; we do appreciate it. If it suits you, you could give us an address on where you are coming from and if you're happy with it we would like to ask you some questions later.

Dr MOORHOUSE - I am pleased to be here but for all of us it would be much better if we didn't need to be here. The fact that we need to be here at all is for the State and for this nation a tragedy; the necessity to consider matters in relation to suicide of any description, the tragic circumstances for the individual and obviously for the families. My particular interest today in making some comment is in respect of communities because communities are affected in particular ways where a suicide has occurred within that community. There are many aspects of attention that have been given in evidence that you will have heard in respect of medical, psychological, psychiatric matters and various other aspects.

My particular interest, although I have some background and interest in those matters also, the reason I am here today is in respect of community matters and the impact and effect on communities, and in particular the things that communities can do in the longer term to have an impact on suicide reduction. The impact of suicide on Australian communities has been particularly strong in rural areas of Australia. That effects Tasmania particularly, not because of its rurality but because of the decentralisation of the population in this State. The particular tragedy in respect of suicide occurs because of the increasing trend towards younger persons suiciding. So I am making some comments today with particular reference to suicide amongst young people.

I am aware that you have had people testifying - in fact, Martin Harris earlier today - who have particular expertise in that area. My comments today will not come from any point of particular expertise, although I have background experience and qualifications in health care, higher education, and more recently my work has been principally in community development and it is from that point of view that I want to comment mainly.

I think the terms of reference are a credit to the committee that put them together and attached them because they are sufficiently broad and the breadth of the terms of reference comprising the six elements covers what I would assess to be the principal elements that should indeed be considered. The two that I am particularly interested in today are the first and the fifth. Firstly, the role of non-government organisations and other community and business organisations and partners and the second is the fifth one, the opportunities for the workplace to promote wellness and suicide prevention.

I see then a brief two-page summary of the kind of position that I wanted to have on the record today. I have had first-hand experience from the professional standpoint of suicide and in particular in Tasmania - I have been in Tasmania for about eight years. I came to a position at the University of Tasmania. My work with the Tasmanian Community Foundation derives from my particular interest in and commitment to

contributing to community development and the sort of interest that I have in suicide and health-related matters stems from my background in health care and in education.

Working many years ago now, well over a quarter of a century ago, in the mental health settings I had my first experiences of people with depression and people who were recovering from suicidal attempts. Although I had no direct first-hand experience of suicide, many of the people that I work with as colleagues and also in the professional and counselling context had considered themselves, or were dealing with the impact of suicide among family members.

In terms of my interest now in communities and their responses to social problems and community problems such as suicide, it is increasingly evident to me in areas of Tasmania, particularly rural sectors that I have spent time in and worked in, but also in drought-affected parts of Tasmania where my own family own sheep and cattle stations, for instance in South Australia and New South Wales, and it has been relayed to me from time to time stories of people that they know and people that they have had working with them and for them and near them who have either attempted suicide, successfully committed suicide or in various other ways have been affected by suicidal ideation.

Those kinds of things can be dealt with as chicken-and-egg stuff, as horse-and-cart stuff, and my particular interest here is the upstream. I think it is particularly important for hearings such as this to give, as I am sure you have already, considerable attention not only to the treatment end of the spectrum, the secondary and tertiary levels of treatment, but also to the primary sources of the problem, to what, in the health-care setting, we call the primary health care aspects of dealing with suicide.

As all members are aware, a massive amount of time, attention and Australian government money has been put in in recent years, by which I mean about the last decade, into dealing with the increasing problem and regrettably it remains an increasing problem Australia-wide. There seems to have been a poor correlation between the amount of money that all of us as taxpayers have put in to dealing with the issue of the problems of suicide and its reduction. You may have had some evidence before you, but my understanding is that there is little evidence that the rates of suicide and in particular rural suicide, farmer suicide and young people suicide, are in fact reducing in spite of the amount of the amount of time, attention and financial commitment that has been given to addressing those problems.

It becomes therefore in my opinion quite important that we address suicide, not only at that end of the spectrum where clearly we must but that we address it much more at the end of the spectrum where we have not, namely at the upstream end where suicidal ideation may first appear in the minds of people; that we begin to think much more about the cause, not only of the suicidal act itself but of the kind of mindset, of the kind of ideation, that leads to the initial thoughts of suicide as a resolution to the kinds of difficulties, complexities, challenges and various other sociological, psychological, psychiatric factors that individuals are dealing with.

Suicide among young people in particular - and it is that that I will be referring to to some extent - is sometimes an impulse-of-life decision. Generally, however, it is not; generally people who commit suicide or attempt suicide have considered doing so for quite some time. It would therefore be a mistake for us to put in place social and

community programs and mechanisms that do not address some of these quite early stages of life and experience where people begin to hatch the possibility of suicide as one of the ways of addressing the problems that they may see themselves as having. People often believe that suicide is a selfish act. It is an act that people perform out of desperation, through having nowhere else to go and no other options or avenues of information and support and all the things that you have already heard about and know about from your work in general. The complexity for young people, the challenge with respect to young people, is that they often have very well-developed patterns of suicidal ideation before they ever come to the attention of the authorities. Unless they have well-developed social support mechanisms within families, communities, schools and so on, the initial suicidal ideation can become quite oppressive and onerous to the extent that even if it goes on for a number of years, in my understanding of the incidence and the sociodemography of successful suicide, they will ultimately become successful. There are a whole lot of reasons such as that why we ought to be looking at the very early causes of suicidal ideation among people. We ought to be looking not only at families and individuals but at communities as a whole. Community members generally, through the various agencies of schools, community groups and so on can have a role in identifying potential suicidal thought patterns but also, and more importantly, in putting in place programs that can lead to much more fulfilling lives and senses of the future and the possibilities of life in the next year or the next decade.

CHAIR - Do you think that there has been sufficient research into the area of the early causal factors?

Dr MOORHOUSE - I am aware of a great deal of research that has been done. A great deal of my career has been in health-related research. I haven't done any of it myself but I am aware of a lot that has been done and the answer is yes, a great deal has been done and it has been of very good quality. It has been done from various standpoints and various theoretical perspectives. All sorts of recommendations have arisen from that, not that you necessarily expect consistency across recommendations of dealing with major social problems but the diversity of recommendation and opinion about what is to be done about it is a reflection itself of the complexity of the problem.

CHAIR - You mentioned the early identification. If someone goes through with a suicide and has a successful suicide attempt, for want of a better expression, what are those early signs, from your experience, that people could identify and perhaps intervene?

Dr MOORHOUSE - I think part of the problem is that they are so difficult to identify and yet there are so many people who have had direct first-hand experience of suicide who say, 'I didn't see it coming. I should have. Why didn't I recognise it?'. But retrospective identification of these kinds of the problems and their intensity is worthless, is useless.

CHAIR - Retrospectively.

Mr MOORHOUSE - Yes. Retrospective identification of these kinds of problems and their intensity is worthless, is useless, and so one of the major problems in this respect is how to get better patterns of identification, early patterns of thought along those lines. I think therefore that we ought to be looking much earlier in a young person's life than we currently are.

I expect the psychologists and the psychiatrists will be able to give us fairly clear indications of the kind of things that become evidence in a young person's thought patterns that may later translate to, or beget in some ways, a successful suicide. How one can systematically identify that, I have no idea. That is exactly the sort of thing that we ought to be looking quite specifically. You have had some advice along those lines.

Mr WILKINSON - What things do you think we should be looking at, or do you think the experts should be looking at, to try to identify at a young age people at risk?

Dr MOORHOUSE - I think that people who have attempted suicide could give a great deal of insight into what their thought and life experience patterns as young people were.

CHAIR - It is almost a case study model?

Dr MOORHOUSE - Yes, a cumulative case study model. The trouble is there are lots and lots of case studies in respect of successful suicide, but how the thought patterns arose and what the individual's experiences were are much more difficult things to aggregate. It is my understanding and my belief that, although a great deal of research has been and is being done from around about late teen years when the problem becomes quite severe, I think that there has been relatively little attention to those childhood years of thought and behaviour patterns that may ultimately lead to suicide or suicidal ideation.

CHAIR - We have heard some evidence that even down as young as the first three years of life there are factors that could impact on that young person's life and that could have a long-term outcome.

Dr MOORHOUSE - Yes.

CHAIR - Would you agree with that?

Dr MOORHOUSE - I am aware of some evidence to that effect.

CHAIR - Do you think it sounds plausible?

Dr MOORHOUSE - Yes, it does. Notwithstanding some of the background that I have in mental health and psychology and so on which goes back quite a long while, we were aware of those kinds of things then. What I am not aware of is the extent to which those things can be brought to bear in terms of later life stage programs that will help to prevent them.

Mr WILKINSON - What type of things were the problems? You are aware of the studies in relation to the first three years resilience, as some people call it, the resilience factor. What things should be put in place do you think in those first three years that would assist? Are you able to give us any information as to that?

Dr MOORHOUSE - A little, yes. A great deal of the work that has been done in relatively recent times, five to 10 years that I am aware of, on resilience itself as an intrinsic and psychological phenomenon is extraordinarily important. I believe that people who ultimately commit suicide are, by their nature, relatively non-resilient and have probably therefore, in a number of cases, come from families and social community life

circumstances in which their sense of self-worth is not well developed. The notions of resilience do relate very closely to those senses of one's self.

Much of my work, and indeed my PhD work, has been not in psychology but in social-psychology, which is, in a sense, psychology and sociology, the ways in which communities and groups and other non-individual organisations can impact both positively and negatively on the ways in which people come to think as individuals. So through community organisations, through social organisations, there is a great deal more to be done in my view. There is a great deal more potential than is currently manifest in our social and community support systems than currently exists.

CHAIR - Sorry, I am not clear where you are coming from. You are not so much talking about community organisations that are interventionist so much as social groups that actually include people so they are not having that sense of aloneness. Is that what you mean?

Dr MOORHOUSE - Yes, and who as part of their operative brief for whatever it is - whether they are youth groups, community groups, social groups, whether they are some we can make reference to in a little while - are aware of, tipped off to, the problems of and the prodromal clues, as we used to call them, the hints of a young person at risk, a young person who is thinking in these ways. I am sure a number of us, looking back on our youth, can identify people who were in trouble at the time but we did not know what to do about or how to go about it.

CHAIR - And just because someone is a bit of a social loner in grade 8 at high school, you do not immediately jump to the conclusion that later in life they are likely to be a suicidal person?

Dr MOORHOUSE - No, and it would be a mistake to be too free, too broad, too generous in our aggregation of those factors that may contribute toward suicidal ideation. We need to be thinking about suicidal thought and not about successful suicides. By the time that has happens a person has had perhaps a whole lifetime of thinking of that as one of the potential ways of dealing with life's hassles, and there are plenty of them in life for all of us. Some of us are more susceptible to the social and personal impact of those life's troubles than others. To come back to my earlier comment about individual's resilience, community resilience, family resilience, those are extraordinarily important matters to have on the agenda and in the thought spans of people like teachers, youth workers, community group leaders.

Mr WILKINSON - What should the community do? There is a role for the community play. If you had the money at your beck and call what would you be doing?

Dr MOORHOUSE - I am acting now on the Tasmanian Community Foundation and it bears specifically on your question, although that is an organisation that deals with communities. It is a philanthrophic organisation associated with several others, including the Foundation for Rural and Regional Renewal. That is relevant because I have made reference to it and you are well aware of the extent to which suicide is a rurally focussed problem in particular. The Foundation for Young Australians and several other organisations come within the general umbrella of community development

and philanthropy essentially and do good within communities without the expectation of anything in return.

Those kinds of organisations bring young people together around various kinds of activities where they can experience themselves with others and they can set frames of reference and so on. If we can sensitize those groups to the things that may lead to suicidal thinking and behaviour then on a peer basis we can earlier identify people who may be at risk. One of the things that works very poorly for young people, but probably for anybody who is thinking in suicidal terms, is the imposition of external constraints and controls and so on. Not even counselling, not even thinking in those kinds of formal professional health service terms is appropriate because these young people who are fragile in any case will run 100 miles from those kinds of things. I think it would be a useful thing for us to have mechanisms within the formal social and educational settings to have people more aware of the prodromal clues but also to have programs that address up front the topic that we never want to put a finger on really. We never want to name it.

CHAIR - Social taboo in those terms.

Dr MOORHOUSE - Yes, and yet young people, because of the intrinsic resilience, notwithstanding problems along the way, are able to confront these things and talk about them much more honestly and openly than we more mature people because we have all sorts of long honed and developed mechanisms for subjugating these kinds of psychological thought patterns. So bringing this stuff to ordinary, thinking, talking exchange among young people is one of the very simple things that can and should be done.

Mr FINCH - You mentioned earlier about a well-developed ideation in young people towards suicide. How do they develop that? What do you think are the factors that give them that ideation and thought about suicide?

Dr MOORHOUSE - I think there are two, and probably more, ways of explaining that. Some people argue that those patterns can be quite intrinsic within a person's early socialisation. Some argue that the socialisation in young people later on through experience with others leads them towards that line. There is a very strong line of debate which has never got any easier, between psychology and social psychology about whether you attribute those kinds of things to early childhood factors or whether they are things that are learned along the way.

Mr FINCH - Do you think there is a fascination in young people in the fact that they are so full of life and their thinking about anything triggers them to think more deeply about ending it all so that people do go along that path?

Dr MOORHOUSE - I think it's true that young people certainly have a much more robust and sophisticated sense of the problems of life, the problems of the world, than many of us realise. We tend to think, generally, about the spirit, the exuberance, the joy of youth but in fact many of those people whom we see playing in the streets and on the sports fields and so on have very deep-seated worries about the state of the world. I think, therefore, one of the things we can do in practical terms to address this problem, not in concrete, identifiable and measurable ways but in an accumulative long-term sense, is to portray the world in a much more positive light. Not unrealistically, because there is a

heck of a lot to be worried about, but to have mechanisms by which our experiences and our dealings with young people do not dwell on those things. We only have to look at the profile of television reporting, particularly in the last few years, to recognise that at the one extreme there is the newspaper reporting that is pretty horrible stuff for young people who are just getting their sense of life and the world they live in and their future and what they may ultimately contribute. There is for many of them, as they perceive it from the media, not a lot to be lived for. That is an extraordinarily sad view. The things we are seeing, not only in the news media but also in the dramatic media, have to do with short-term consequences of things, short-term goals, ambitions, achievements and so on. I think we probably are selling our young people short by not imbuing within them a sense of life's continuity.

CHAIR - I do apologise but I am going to have to bring this to a halt otherwise our other witnesses will be very late. We do have your paper. Are there any concluding remarks you would like to make, specifically given that we are referring to references 1 and 5?

Dr MOORHOUSE - Both of those do relate to the extent to which community organisations can and in my view should play a greater role than they currently know how to provide or are currently encouraged to provide in naming this problem, in having the sorts of discussions we are having here today. The organisation that I am representing today, the Tasmanian Community Foundation, and various others I think would be very welling and indeed keen to become involved in these matter, if they how to and if there were mechanisms by which they could legitimately do so.

CHAIR - Thank you very much, Doctor. I really appreciate that.

THE WITNESS WITHDREW.

Ms SHIRLEY GREEN WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR (Ms Thorp) - Thank you very much for making yourself available to us; we appreciate it. Would you like to explain your interest, why you are here, perhaps talk to your submission, and then give us an opportunity for questions. I apologise for keeping you late.

Ms GREEN - I am here because I lost my son in January this year to suicide; he was twenty-one and a half. For nine years we had been dealing with problems with him. They started at about 12-years old with his first attempt.

Mr WILKINSON - At 12?

Ms GREEN - Yes. Up until 12, he was an absolutely beautiful child. He was happy, friendly and outgoing - unbelievable. When he was nearly 10 years old he was involved in an armed robbery. We had a business and this happened to him, his brother and myself. It was quite a severe one and we had him seeing doctors afterwards to make sure everything was okay. He appeared to come through that quite well.

Mr WILKINSON - You say he was involved in an armed robbery at 10 years old?

Ms GREEN - Yes.

Mr WILKINSON - With a gun or a knife?

Mr GREEN - It was very severe. He was bound and gagged, with a gun to his head and he watched his brother and myself. We were very careful to observe him all the time. He went back to school - that happened at the end of grade 5. He was in grade 6 and the school were aware of it. They were great and kept an eye on him just in case something went wrong. At 12, he was perfectly happy and went into grade 7. He excelled in grade 7. From the beginning of grade 8 he was put into an outstanding students class - it was a new trial. Simon, unfortunately, was a year younger than the other children. Then he was put into advanced education. In the first term he did very well with work and then all of a sudden he didn't want to go to school anymore and it became a battle. Then came school bullying, so we went to the school to deal with it. Simon wouldn't speak up at the school. It got to the point where he point-blank refused to go to school, so we kept him home and did home education. Again, he attempted to take his own life. At this point he was seeing his GP, a psychiatrist and a psychologist.

Mr WILKINSON - How old was he then?

Ms GREEN - He was 12. He wanted to go to school but from that point on he just became further and further withdrawn.

Ms HAY - And there was no trigger?

Ms GREEN - I can honestly say now, yes, it was school bullying.

Ms HAY - He was being bullied?

Mr GREEN - He was being bullied. He was being naughty at home, which he had never been before. Then he wasn't going to school; he ran away. But he would not tell us the full extent of the bullying. We went to the school and spoke to the principal and then Simon said he wouldn't go back. It just went on from there. Simon probably made five or six attempts over the years. The whole time he was being treated. We tried new schools. He tried to go to Clarence High in Hobart where, at that point, one of my sisters was teaching. He had guys of the same age going and thought maybe we could ease him in. It was too late. I now realise his troubles had started and we could not reverse what was happening in the manner we were treating it. I believe there had to be another way. I do not know what it is but he just lasted two months at Clarence, then from there he came home back to Launceston, lived here, then he tried Newstead College, he tried Launceston College but he just got more and more scared of people.

CHAIR - What was his relationship with other kids like?

Ms GREEN - It was, up until 12, fantastic. He had half a dozen friends through that period that so much wanted to be his friends and they got on for a while and then all of a sudden he would push them away. It was just like he would not trust people. He then got severe acne to the point of where it was very large cysts. That continued for another four years.

CHAIR - The stress levels would not have helped.

Ms GREEN - That was it. Apart from all that he had been tried on quite a number of anti-depressants and medications.

Mr WILKINSON - Was he on medication for the acne?

Ms GREEN - Eventually he was. In the beginning they tried antibiotics and everything else. It did not clear. It was so severe. At 19 he was on -

Mr WILKINSON - Right. That has come up before, hasn't it, that people have committed suicide who have been taking that drug.

Ms GREEN - He would get cysts as large as golf balls on his neck and here and that went on for about four years.

CHAIR - So his whole self-esteem and self-image -

Ms GREEN - It was absolutely out the window, and he was under a skin specialist continually also. He eventually completed his education at home - self-taught. We were very pleased with him and we were very proud of what he could do. He decided he could go to university. He applied. He was accepted and went to Hobart and he was there for two years. This would have been his last year. Once again he excelled in his studies.

Mr FINCH - What was he studying?

Ms GREEN - Computer science and also psychology, and he was a high distinction student.

Mr WILKINSON - Was he depressed?

Ms GREEN - He was so lonely. He was depressed because he was lonely and then he tried going to meet people.

CHAIR - I suppose he felt rusty too after having those breaks from 12. He had all those years of learning.

Mr WILKINSON - Did he change his medication prior to -

Ms GREEN - He had stopped taking the medication in the last year and he was not having any. I have to be honest; I considered he was doing better without it.

Mr WILKINSON - So he was not on one line of medication and then they took him off it and put him on another line of medication?

Ms GREEN - That happened over the years.

Mr WILKINSON - Was he worse when that happened? Some say there is a hiatus period where they become worse.

Ms GREEN - He was, yes. I can look back now and I can fully understand a lot of things. I did not understand the drugs a lot either that he was given, and I am not wanting to blame anyone at all. I was not given enough education on drugs. I was given a pamphlet and that was it.

CHAIR - What difference would it have made, do you think? You would have understood better?

Ms GREEN - Yes, because I did not understand that the drug can perhaps go up before it levels or it can go down. A couple of times he looked as though he had had a stroke; it was just complete muscle spasms and then he would have to have a corrective drug. I wish now that he had been in hospital for a month until such time as the drugs had levelled. He was always good at home with me. He showed violent tendencies at about 15 for a while but he was taking drugs. Now I wonder if that was part of the drugs.

Mr FINCH - Shirley, through that time what sort of support were you getting or seeking?

Ms GREEN - Medical, lots of medical. Simon was under Dr Martin for basically seven years; Helen Bindoff, a psychologist; he saw Dr Fisher who is a psychiatrist also. The last time he took medication it was a drug called Soleon, which is apparently quite new. That was in 2003 and he had Dr Friedman who is a psychiatrist.

Mr FINCH - Yes, but I am wondering about the support for you. Were they communicating well with you or were they referring you to counselling or giving you any support in any way, or did any come to you when you went to the principal of the school?

Ms GREEN - No. That disappointed me. When Simon stopped going, that was where it finished. There was never contact. Nobody called us to ask, 'What's going on? Can we come and help?' No, I didn't get that.

CHAIR - In terms of just understanding the effects of different medications, do you think extra information would have assisted you at home in knowing how to deal with your son's moods, for example?

Ms GREEN - Yes, absolutely, and, after seeing what some of these drugs can do, I really do believe a person needs to be not perhaps isolated but certainly kept in an area where they can be monitored completely.

CHAIR - To make sure it does suit them.

Ms GREEN - Yes.

CHAIR - Because they don't always, do they?

Ms GREEN - No. Simon was given seven different types of drugs over a period of time.

Ms HAY - What do you think it was that made him attempt it this year, given that he was over his acne, in Hobart, quite independent and excelling at school?

Ms GREEN - This was the shock. We have no idea. I actually spoke with him four hours before. My sister had been with him that day. He had aunts in Hobart. He lived alone and he was doing great. He used to call me probably two or three times a day. If he was feeling down he would call. He would call an aunt. He would call for help, and we have no idea whatsoever why at that one time he just decided to end his life. We cannot work it out. My belief is it started at 12. That was the crucial period of perhaps fixing that. I can say now that maybe by the age of 19 we were too late, because I believe there would have been a lot of effects physically from the drugs as well, with changes in the brain chemicals.

Ms HAY - How old is your other son?

Ms GREEN - My other son is 25 now.

Ms HAY - And just listening to the person who gave evidence before about resilience and self-worth, did you note any differences in your two sons?

Ms GREEN - Yes.

Ms HAY - Even before the incident of the armed robbery?

Ms GREEN - They were just normal little boys prior to that. Both of them appeared to come across it quite okay. My eldest son a few years down the track was bashed walking home one night, and I thought, 'Here we go'. Once again we got him through that. So, yes, resilience; there is a lot of difference, isn't there?

CHAIR - What can society do to make sure the help is there for people?

Ms GREEN - It is the help that has to be there. First of all people have to be prepared to stand up and admit they have a problem, and not the one necessarily that wants to take their own life but, okay, me. I used to go to my parents. I was a bit lucky, I had a very large family, and I had a lot of support around me in that respect, but people have to be first willing to stand up and be counted and say there is a problem with their child. I just don't know what sort of help can be given.

CHAIR - So a willingness socially for people to talk about the realities.

Ms GREEN - Socially I believe it is hidden a little bit. It is pushed under the carpet a tad.

CHAIR - A social taboo.

Ms GREEN - Yes, and sadly the young ones unwittingly can be cruel too if a child is isolated or is alone. They can magnify that, and it is unwittingly.

Ms HAY - When you told your son how much he meant to you and how much you loved him, was he able to absorb that?

Ms GREEN - He knew we all loved him; it was always shown to him by all the family.

CHAIR - Did he leave a note or anything?

Ms GREEN - No. However - and this is why I can have so much insight into the things that troubled him - I have found pages and pages of writing and drawings.

Mr WILKINSON - Of the same thing, suicide?

Ms GREEN - Of what his troubles were. That is how I can so confidently understand what started his problems.

Ms HAY - And was it loneliness or the robbery?

Ms GREEN - No, it was the kids at school. I am not saying that they are on their own, though, because it is one thing and then another thing. There are 15 pages on just writing about the kids at school.

Mr FINCH - Was it verbal abuse?

Ms GREEN - Yes.

CHAIR - Put-downs?

Ms GREEN - Yes.

Mr FINCH - Jealousy, do you think, of his academic achievements?

Ms GREEN - That is a possibility; it did cross my mind.

CHAIR - That happens to a lot of kids; they get isolated because they are considered 'brains' or the nerds.

Ms GREEN - At the end of grade 7 he had 12 subjects and got 12 OAs. That isolated him a bit.

Mr FINCH - At the time he was put into that special class, did you feel that it was appropriate for him?

Ms GREEN - Academically, yes. I was a bit nervous about it but then I thought, 'No, I have faith in the school. I have faith that they know what they are doing'. I probably should have pursued that a lot more. It wasn't good and it never lasted. He only went for the one year in this particular trial.

CHAIR - It would be interesting to see why the trial was scrapped.

Mr FINCH - Did the principal have an understanding of the journey that you were on with your son?

Ms GREEN - Yes.

Mr FINCH - You had discussed this situation with the principal?

Ms GREEN - Yes.

Mr FINCH - It is interesting that that person perhaps didn't follow through with that and keep in touch with you. I suppose the life matters project that we have heard about earlier today would be perhaps something that would cover that. It just seems that if that person was cognisant of the life matters procedures that that would have been followed through with you and wouldn't have let you slip away like that once the boy left the school, then to not be concerned about his welfare and your welfare.

Ms GREEN - I honestly think that if that person had come to us and pursued it perhaps it would have improved Simon's self-worth, his thinking that 'I'm not the one who was wrong at school'.

CHAIR - So that is following up on the whole bullying thing, isn't it? In lots of these instances it seems that the victim of bullying is the one who bears the consequences rather than the perpetrators.

Ms GREEN - Yes.

Ms HAY - Were there anti-bullying programs within the class?

Ms GREEN - There were supposed to be. It was 10 years ago -

CHAIR - And that was the beginning of it really.

Ms GREEN - For things like that, yes.

Ms HAY - I know there are now.

Ms GREEN - That's right.

Ms HAY - I am just wondering if there were then and they just didn't work.

Ms GREEN - It was not pursued. Now it is a very important issue.

CHAIR - Because people are coming to the realisation of how serious the consequences are.

Mr WILKINSON - Did you ever want to get some information or assistance but not know where to go?

Ms GREEN - Yes, that did happen.

Mr WILKINSON - How could the committee make some good recommendations? It should be made more open that you can contact Lifelink or Lifeline or something along those lines?

Ms GREEN - Yes. I spent many days, as I said, going to doctors, always taking Simon to the doctors or whatever.

Mr WILKINSON - Did they refer you on to anybody?

Ms GREEN - No, and I think that is where it is important.

CHAIR - So it was a medical model only, rather than a social.

Ms GREEN - Yes.

Mr WILKINSON - And the doctors would say either he needs to come back or alternatively he is okay now. See you later.

Ms GREEN - Brilliant; try him on this one then. Simon was going every fortnight if not every week depending on how he had been, and then he would come good so it would be every month.

Mr WILKINSON - And he was going both to a GP and a psychiatrist or a psychologist?

Ms GREEN - His GP to start with when he first started - I called it being naughty at school but it was not really - and then his doctor referred him on to a psychiatrist.

Mr WILKINSON - And did the psychiatrist say there was anything mentally wrong?

Ms GREEN - He never said he is schizophrenic or bipolar.

Mr WILKINSON - Behavioural disorder or something like that?

Ms GREEN - No. He has never put a name to it.

Mr WILKINSON - Right. What did he say?

Ms GREEN - Mostly it would be just him treating Simon because -

CHAIR - Particularly when he became an adult.

Ms GREEN - That is right. I could be told so much.

Mr WILKINSON - Can I ask, and if you do not want to answer it then do not, but were the six or seven attempts that he made on his life all by the same means or different ones?

Ms GREEN - No. Either tablets or hanging.

Ms HAY - And after each was he happy to talk about what he had tried to do and why he tried to do it? Did he ever give any answers?

Ms GREEN - He was lonely. I will always put it in the terms that I do not think he really wanted to die but he just did not know how to live and that was the thing. That is the problem.

Ms HAY - Do you think now, when they have web sites and chat rooms where people can talk who have also tried or feel alone or are at that point, he would then realise that there are so many other people feeling like that, and that might have helped?

Ms GREEN - I think that is great. I like the idea of being able to chat but it takes away the social aspect, which is the important part. I also believe if they are going to do that they really need to be monitored on it because some of those lines are not really good either. There used to also be a suicide site.

CHAIR - How to -

Ms GREEN - Yes, explain everything. And there are a number of sites I disagree with but you have to monitor.

Mr WILKINSON - You have got another son and another daughter?

Ms GREEN - No, just the son.

Mr WILKINSON - Have you had any post intervention at all, or postvention as they were calling it this morning, so that it does not occur with another relation, because we have found if it has occurred with one, sometimes it can be like a house of cards - one goes and then another goes. Have you had any of that assistance at all?

Ms GREEN - Yes, we have. Adam, the eldest boy, lives in Brisbane now but he has been home a bit this year. Whilst he was here we went to see Helen and that was fine. Helen gave us the names of places in Brisbane for Adam and they have also suggested Compassionate Friends to him, which I think is quite a good group. He calls me quite regularly. He is with people. He is sharing with people.

CHAIR - So he is not only his own, physically?

Ms GREEN - No, and that I think is good and I believe that was probably a downfall. Simon was just so proud that he was living alone and he had done it for two years and he was looking after himself. I think that helped loneliness.

Mr FINCH - What about for yourself, Shirley, in respect of support when your son did suicide; was there support there for you?

Ms GREEN - Yes. Once again a lot of family. My GP was really good and I still go to a psychologist. A lady from Compassionate Friends contacted me which I thought was very good. If I wish to speak to people -

Mr FINCH - Did you use that service?

Ms GREEN - I called them, yes. I think it would be nice to see services like that for the bereaved. I think it would be good if I had known of Compassionate Friends. I didn't know of them before Simon took his life. I think it might have been good if I could have spoken to people prior.

Mr FINCH - It might have helped you with your intervention.

Ms GREEN - Yes. Good old hindsight, a wonderful thing.

CHAIR - It sounds that the clear message - I hope we are interpreting you correctly - is that you are concerned about the possibility of bullying and lack of response at a school level, so it is the person who receives the bullying who seems to be punished by not being able to go to school any longer -

Ms GREEN - That is correct.

CHAIR - and more emphasis on support organisations and more information from doctors, so you are not locked in a medical model and only getting information from that kind of source.

Ms GREEN - That's right. That is much more needed there. If I had been given a list of five places and told, 'Call this person', that would have been fantastic.

Ms HAY - And also the drug monitoring.

Ms GREEN - Yes.

CHAIR - They are the three main points. Shirley, thank you very much, and we appreciate very much your coming. It is very brave of you and we appreciate it very much.

Ms GREEN - Thank you very much.

THE WITNESS WITHDREW.

<u>Ms ROSEANNE BRUMBY</u>, CLINICAL PSYCHOLOGIST, MANAGER COUNSELLING SERVICES, RELATIONSHIPS TASMANIA, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR (Ms Thorp) - Thank you very much for coming today and making yourself available to us. We do appreciate that. You would be aware of our terms of reference.

Ms BRUMBY - Yes, I have had a look at them.

CHAIR - Basically from your point of view and your involvement with the whole issue of suicide could you let us know your thoughts and experiences on the subject, and then if we could have a chance to ask you some questions later, that would be great.

Ms BRUMBY - I am from Relationships Australia in Hobart. I am the manager of the counselling program down there, and we have offices in Hobart and Launceston and Devonport, and we also do quite a bit of outreach to Flinders Island and the west coast and the east coast.

I don't know how much you know about RA. We are quite broad, and people are always shocked when I tell them the range of services that we do. I think most people know we come from the old marriage guidance system which was a volunteer system and then it got funded in the 1980s and started providing professional relationship counselling services. It is done under the Family Law Act and so that means that the whole idea in setting the service up was to prevent people having to go to the courts, so the idea is early intervention, trying to keep families together and trying, I guess, to stop the flow of people into the adversarial system, and also to save money, I am sure, because the waiting list and the cost of the court process is huge, as well as the emotional effect and the impact particularly on children of adversarial processes when people are having family disputes.

Since then we have broadened and we have a mediation service, which really is to help but it is primarily oriented towards separating couples, separating families. The idea is to help them develop an agreement which they can agree to and they can file with the Family Court if they need to in order to, I guess, look at what the separation will look like, what the parenting agreements might be, financial settlements, the whole range, and in fact the mediation program service is much more than families. We do workplace and neighbourhood community issues as well.

They are probably the two main programs. The others tend to be smaller and the funding has recently become more solid, so we are really set up now with programs throughout the State which have permanent staff on board. The family programs that we offer are really oriented to families who are in crisis, so people who have split up - have you heard of Children's Contact Services? - we have Children's Contact Services which are designed to help parents have access to children. They do assessments to see what kind of access should be allowed where there have been questions and concerns perhaps related to drug and alcohol use or abuse or any risk to children. That has been a fabulous service and we have had a fabulous response to the Children's Contact Service.

We also have a parents in contact program which again is really oriented to those families where there is high conflict, where children maybe have not seen a parent for some time or have difficulty getting access to that parent. It is a counselling process so both parent parties are seen separately, the children are often included in the process and decisions are made and I guess facilitated in terms of contact and in terms of changeover and in terms of an agreement that, as I said, can be registered with the Family Court or might just be something that all parties agree to and feel comfortable enough with. So it is about compromise and it is about often what is good enough. Some parents would prefer their children never saw their partner and those are the kinds of families often that are entering into the program.

The other important program which I reckon has contact with a lot of suicide clients is our Tassie Male Program which again is based heavily in Hobart and Launceston. It is a permanent program and the funding for that is oriented towards men in crisis, particularly men who are having problems parenting and having access to their children but also a whole range of other programs which I guess put people in crisis. The vast majority of people approaching us are in crisis. Often they are feeling that the system is against them and that the system is not fair. They often have a lot of anger and under the anger there is a lot of grief and despair and a sense of unfairness and a sense, men particularly, that their role as a parent is not acknowledged and is not valued and that perhaps they are seen by the powers that be as providers and that that is their job, to pay their maintenance, and that is as far as it extends. So TassieMale is very much oriented towards educating and giving advice and referrals as well as support.

Mr FINCH - Are those clients referred to you?

Ms BRUMBY - A lot of clients are self-referred. We have a phone link service so a lot of the contacts through Tassie Male are just telephone calls where somebody sees a card or gets it out of the phone book or gets referred by government agencies or GPs, psychologists. They come from all over.

Mr WILKINSON - Law officers?

Ms BRUMBY - Since Safe at Home has happened and the victim safety response teams have been very interested in what we do, we are increasingly getting referrals from that and they are actually including us in their information provision for families in crisis. So increasingly. I would not say we have had a lot in the past. I find with the police merely you need to know a face and they need to know who you are and what you do. As I said, RA does not do a lot of advertising so a lot of people do not realise that we offer those broad services. They think that people come to split up whereas obviously that is not our goal. Our goal is to help families find ways to have good relationships, whether it is a separated family or whether it is a family that wants to find ways to work effectively within one home together. So our goals tend to be quite diverse.

CHAIR - The TassieMale part of your work is the men who are in crisis. Does the suicide link come because of the potential perhaps for that crisis situation to be resolved through suicide?

Ms BRUMBY - Often. I got some stats from one of the Tassie Male workers earlier who said they talk to about 3 000 clients a year and probably one-third to one-half of those are

people who were in such a state of despair and hopelessness that often they are in a panic mode, they are really aroused over a long period of time and they find it very hard to think strategically to think about what it is that they are actually needing and be clear about that. They might be focusing, for example, on the Child Support Agency and saying, 'That is the source of all my grief and I need you to help me figure out how to manage the Child Support Agency'. That is not what we do but we can help people to look at the whole problem and look at the things they need to do to get some sense of control, perhaps being able to achieve a stability in their life, where they have contact with their children, when they can bear contact with their ex. Often there are stepfamily issues and there are a whole series of issues there as well.

CHAIR - Is it common for men to externalise difficulties? You have mentioned the child support agency. I hear that so often. So rather than saying, 'My issues are my anger management', the issue is really child support, so it is externalised. Is that common?

Ms BRUMBY - I think there is a bit of that. I noticed in your terms of reference the comment about the media. I think there is a stereotype out there, which our workers feel strongly about, and that is that when men are not coping they tend to be angry and aggressive. Often the men we are talking with might present angrily at first but as soon as you get them talking you get the whole range of emotions underneath to do with losing their children, their sense of control, their homes and financial situation. Often they lose their jobs because of their level of distress. It might mean that they are not able to function at work. There can be a whole range of these problems.

CHAIR - So what I said then was the stereotype?

Ms BRUMBY - Yes. It is not an uncommon stereotype. We get a lot of referrals into counselling and the counselling workers really are the ones who would do a lot of assessing risk. So if a worker in the children contact service or in mediation had concerns about a client or a client's level of distress, it is often because the client is presenting as really angry and unapproachable and it is hard to stay in a room with them. Often they will try to get that client either to counselling or to TassieMale for some exploration of what the issues are and something a bit more strategic.

Mr FINCH - I suppose it might exacerbate the issues for the person, but I am just wondering who finances the service that you have? If somebody feels they may be low financially and they think, 'If I get help from Relationships Australia, it is going to cost me even more money and I can't afford to do that'.

Ms BRUMBY - I think that is a misconception that that might stop some clients coming into our services. Certainly we pride ourselves on equity of access. If somebody can't pay, we're not going to not provide a service. We always provide a service and we try to give clients a sense of some responsibility for making a contribution. We are a not-for-profit organisation and we have an interest, obviously, in providing services to everybody, but we also have running costs. We try to encourage people to pay something but there are clients who don't. Certainly when someone is referred in crisis we don't even talk about money; we just try to get them into the building so that we have a starting point to work with them. Sometimes we would refer them on and if finances are an issue we would refer them for some financial assistance as well.

Mr WILKINSON - You keep statistics it seems. Do you share those statistics with anybody?

Ms BRUMBY - We are funded primarily through FaCS and we give them statistics on the demographics of clients.

Mr WILKINSON - Should there be some type of overarching body where all the statistics are fed into? I know you can never really know exactly what is going to cause it or when it is going to happen, if it does happen, because of those trigger points. Should there be an overarching body where your statistics are fed into so that people probably could learn from that research?

Ms BRUMBY - It has been an issue at RA for a long time. We have an excellent database that we have developed specifically for our work. There are years and years of data sitting there, talking about who are clients are, what the success rates are, what the issues are, what the demographics are. We are very keen to use those statistics. Often, if there is a student at the university who wants to do a PhD or a Master and use that research, we do make it available. It doesn't get used a lot. In terms of feeding it back, we feed it back to FaCS, of course, and they use that data.

Mr FINCH - I just want to get some sort of understanding of Relationships Australia, about the times that you deal with a suicide issue or if people who are dealing with you complete a suicide. How prevalent is this occurrence of suicide or attempted suicide in the clients that you deal with?

Ms BRUMBY - Sorry, we don't collect statistics on that. We don't have a database on that. We keep records of it so that we can look at what our responses are and how effective they are, so I cannot actually tell you what the stats are.

Mr FINCH - Is it part of the aura and the circumstance that you have always got to be aware of that circumstance?

Ms BRUMBY - Absolutely. In the TassieMale Program and the counselling program, the workers are all allied health workers. They are all trained in conducting a suicide assessment, knowing what the risk factors are so they can be cognisant of that and be vigilant and aware when somebody is at risk. We do have a lot of clients where suicide is identified as one of the issues.

CHAIR - When we have finished our investigations we will be writing a report and an important part of that will be a series of recommendations of what can change and what can be improved to actually reduce suicide. If you were in that situation what would your wish list be?

Ms BRUMBY - I will talk for TassieMale first because at TassieMale we have had a lot to say about that. One issue we identified, particularly for the high risk group, was male workers. It is really hard in Tasmania to get skilled, qualified workers. There is a lot of people out there who are in private practice but often that is not available to the client group that we work closely with.

Mr WILKINSON - Can I ask what type of male workers?

Ms BRUMBY - Counsellors.

Mr WILKINSON - There is a 16-week course which we heard about from Lifelink this morning. Is it that type of counsellor or alternatively a trained psychologist or a trained psychiatrist? Which one do you mean?

Ms BRUMBY - All our counsellors have postgraduate qualifications in something relevant to counselling, so they are very highly trained people.

Mr WILKINSON - So what you are saying is you want more male, trained psychologists or psychiatrists who -

Ms BRUMBY - Who are working for not-for-profit organisations where everybody has access to it. I think that is really important.

CHAIR - Is that a pay thing? Are people getting paid more in private practice?

Ms BRUMBY - I am sure. I think that the people who work in not-for-profit are usually attracted to not-for-profits specifically because they want to help anybody without having to worry about the bottom line in terms of their business.

CHAIR - That is common and you often see a predominance of women there for that reason, interestingly enough. That has been my observation over the years anyway.

Ms BRUMBY - We carry a waiting list most of the time and the people who are waiting to see a male counsellor are often men who are in crisis and they want to talk to a bloke. They want to talk to a man, so the waiting list often carries people who are specifically for male counsellors. I think there are a lot of male psychologists out there. They are out there and they are available but it is very hard for us to attract them to Relationships Australia, and I think that Anglicare and Centrecare have a similar situation, where they can get support workers but few who are highly skilled and able to do long interventions with people who are chronically at risk. It is hard to attract male staff.

I think the other recommendations that TassieMale workers would make about resourcing would be about funding to get out into the workplace and educate people. Recently TassieMale ran a group for one of the Government departments. It funded TassieMale workers to go in and conduct four lunch-hour groups. It was looking at men, parenting, health and relationships, so it was very much looking at early intervention, dealing with feelings, being able to talk about problems and early intervention approaches to crises that happen in families.

That was so successful. We got really good feedback from that and certainly some of those people had been fed into our other programs for people who had crises or subsequently had crises. They knew that they could come and get support from RA. Again, it is that face-to-face issue where they knew a name, they knew someone who is a good person to talk to and they did approach us.

CHAIR - It is a bit unmet need out there.

Ms BRUMBY - I think so. It would be nice, and this is a bit of a fantasy I guess, if we got employers to play a role and offer those kinds of services to their employees. I know that is simply not feasible, but for us to go into a workplace and provide a service like that it was just so clear that the men -

CHAIR - We have actually taken evidence from employers who are doing exactly that.

Ms BRUMBY - That is fantastic. That is really encouraging.

CHAIR - But only a few.

Ms BRUMBY - I think too anecdotally we have had quite a bit of feedback since the Safe At Home legislation came in, looking at the effect that has on men, and there have been some quite concerning reports, and they tend to be - there is not a trend there that we could about, but there do tend to be reports about men not understanding the structures that are in place in the way the Child Support Agency works, the way the police work, the courts, the way that the services work that they might come in contact with, and what their rights are and their ability to actually articulate their situation and get help and get an understanding of how the system works so that they can participate in it more effectively.

Mr WILKINSON - A lot don't understand, do they, with maintenance? They think it is the wife asking for maintenance, as opposed to the child support system doing the asking, and if you have to have an enemy they are the enemy. It is not the female. And with things like that they seem to put the blame if they can, because it is probably easier for them to do that, rather than accept that they might be at fault. They endeavour to put blame somewhere else, and they are doing that in the wrong areas because, as you say, they do not seem to understand.

Ms BRUMBY - The question is where would you put blame, and I think that is a much deeper issue and that is an issue that tends to come out of lots of conversations and lots of perhaps telling of your story and an ability to have insight into your own participation in a scenario and understand why you are getting the reactions from your ex, from your children, from your family that you are. So that is not a quick process. That is not something that can happen in a 20-minute phone call; it tends to happen over a series of weekly meetings that that kind of, I guess, insight and as a consequence the ability to be strategic and to be powerful in affecting what the outcomes are occurs.

One of our main focuses is on children, of course, and everything that we do is aimed at helping the parents parent their children well and provide children with the best environment that they can have, and we get a really great response from men. In Launceston there have been a few programs begun lately where there has been such a great response to that and a sense that finally somebody is hearing that we are not just here as angry men who are trying to fight the system; we actually just want to parent our kids. I think that is a really big issue.

CHAIR - Are you suggesting, if I am hearing you correctly, that if a lot of these things are in place then someone does not feel their options are so limited that suicide becomes an option?

Ms BRUMBY - I think it can prevent it building to that kind of crisis. Often when people do present, a trend that I have noticed certainly in Hobart has been that we are increasingly getting families presenting where there is a high level of crisis. An example the other week that I attended to myself was a family who rang up. A husband had thrown his wife, holding a baby, out of a moving car, because they had no home, they had nowhere to go to, nobody knew what to do. She was saying 'I'm leaving you' and he tossed her out of the car and, while that sounds horrific, I can just imagine the intensity that was happening in that family to result in that kind of response, which was quite uncharacteristic, and they came to Relationships Australia. The police sent them. Well, the police have their own interventions. They sent them to Mental Health Services who then sent them to Relationships Australia. So while the CAT team is a great service and we certainly get a lot of support from them - they are very responsive when we need a client assessed - there does seem to be under-resourcing in that area for Mental Health Services to have an ability to conduct an assessment with these people. So often they are landing on our doorstep. We are not set up as a crisis service. We are not set up to be flexible and to say, 'Here we are. Come into a room. Sit down and we'll manage it'.

CHAIR - That's not your role.

Ms BRUMBY - We take it on because somebody has to. Technically it is not, no, but you can't not respond to these people when they are in such a state of desperation and when there are children who probably have nowhere to go. So homelessness too, I guess, is a big issue that affects families and perhaps contributes to them getting to that state of crisis where there is so much distress that people get to the point where there is alienation that happens and that can lead, I think, to suicide.

CHAIR - It seems that the pattern that I am getting - I don't know if my colleagues agree - is that there are skills people have as individuals to cope with the situations that life throws at them, if you like, and, depending on their capacity to respond or to know where to go for help, you may end up with a situation where someone is thinking of suicide - because that has been our emphasis - and the other thing is that there are external factors like homelessness, poverty, dysfunctional family units and such, that can have the same outcome if the person doesn't have those skills. Where you are coming from, I suppose, is you are providing, to the best of your ability, services to support people who find themselves in crisis situations. If you weren't there, it may well accelerate into potential suicide or some other violent or inappropriate response.

Ms BRUMBY - Yes, which then alienates them and leaves them isolated without a support structure in place.

Mr WILKINSON - Do you then refer on? Let's say Relationships Australia has done their job, you don't believe that the person should remain at Relationships Australia because obviously you are fairly tight with resources and don't have numerous people running around to do the work, do you send them on to somebody else? If so, to whom?

Ms BRUMBY - It depends what the work is. If it is a clinical mental health issue we will refer on. We work very closely with GPs and psychiatrists when that is appropriate. A lot of the time we continue to work with those people. We have clients we have been seeing for years; we have families who have been using the Children's Contact Service

for years. We refer on if we can't provide a service but generally, in terms of individual needs for support and for problem solving, we can continue to provide a service.

Mr FINCH - I am just wondering, Roseanne, about the future of Relationships Australia. Is it an evolving service that might change the way it goes about its business? What is the security of funding, and I suppose your level of funding too? It sounds as though you are underfunded at this stage.

Ms BRUMBY - Our funding has increased with the advent of the family relationships centres, which were announced last week, I think. We know that we are getting funding from one in Hobart, so we are certainly getting resources brought into that. That is primarily as an early intervention to prevent people having to go through the Family Court processes. Closely aligned to that is the fact that people are in distress; they are struggling and acting in increasingly distressed ways which leaves them isolated and alienated. Our funding is increasing. But you can always use more.

CHAIR - Being mindful of the time, and I sure there is so much more you could have told us, I wonder if you would like to take the opportunity to put something in writing for us, particularly if you can address to any or all or whichever terms of reference are applicable to your work. We would really appreciate that, if you could.

Ms BRUMBY - Sure.

CHAIR - If you had a magic wand and you could get a bucket of money or change society, what kind of things would you put in place, if you could, to try to reduce or eliminate possible suicide in Tasmania? That would be great.

Ms BRUMBY - Absolutely.

CHAIR - Thank you very much for your time.

THE WITNESS WITHDREW.

MS LIZ GEE, MR NIGEL McLAREN AND **MS JENNIFER STANTON**, TIME-OUT, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED

CHAIR - Thank you very much for being here today.

Ms GEE - We are here to talk about our Time-Out youth suicide program. I will start by saying that my role as vice-president of Time-Out youth suicide service is mainly to get funding. We do not have any funding so it is up to me. I go out and talk to Rotary clubs, Lions clubs, bowls clubs, masonic lodges, wherever. I have been down to Hobart, right down the peninsula there, and I am going down to Ulverstone next week to speak with a Rotary club.

Nigel was the person who started our Time-Out service. I came along about two weeks later after having been to Canberra for a forum on youth suicide. I came back and decided I would like to be doing something for the community. Nigel really knows how it started and the background of legal things that we had to do et cetera. I am just in the middle and I am out there trying to rattle the can and do all sorts of things. Jenny, who is the most important part of our service, is our coordinator who works part-time for Time-Out and certainly can give you lots of information on where the young people are coming from et cetera.

That is really my role. I was going to read this at the end but I will read it now and then hand over to the others. This is something that was left by one of the young girls who was in our home. We have quite a few of them and we keep copies. She came up with a few words beginning with the letters of Time-Out: T - to rest and revive; I - I remember my first weekend; M - more tears than laughter; E - every weekend after that first, tears slowly left, laughter became more; O - outstanding what you guys do; U - under the weather then go to Time-Out; T - thank you. That was from a young lass who is now in Hobart. She had a little boy and was in lots of trouble and we had the little fellow in the house with us at one time; we don't say no to anyone. It is probably just a reflection of the feedback that we get from the young people who have been in the house. I was in the house one weekend when one young lass from Burnie was there. I took her back to the bus on Monday and she gave me a kiss and a hug and said, 'Liz, I've just had the best weekend'. I said, 'Oh, come on, with us old fuddy-duddies'. She said, 'I have. I would like to come back again sometime', and I said, 'Well, it's not really a holiday home'.

Laughter.

Ms GEE - We have repeat people coming in, which is great, because at least they know there is somewhere for them to go. They go to their doctor and say, 'I feel in crisis. I don't think I can manage', and they phone Jenny and we take them in for 48 hours. That seems to be long enough for them to get their lives back on track. We are just ordinary people, we are not academics. We don't know how to write submissions and that is one of our faults. We are just practical people who provide a service for the young people. We obviously do it well because it has now grown to the extent that we have a lot of young people coming from Hobart, from the coast - probably more from Hobart lately than anywhere - and they are happy to get on the bus and come up here. Jenny picks them up and takes them in for a weekend. They get on the bus again and go back. It is great to

think that they feel safe; they have probably never felt safe, apart from the weekend they have with us.

I will hand over to Nigel, who can give you some background of how we started.

Mr McLAREN - I think it is important to realise why we started. It was probably just before 2000 and the move into the new millennium. The thoughts of people in government were suggesting that we needed another forum in Tasmania to produce another paper on what we can do for suicide prevention et cetera. I sat in at some of the meetings. I was representing Northern Group Training at the time and we were very involved with a lot of young people. I was in the access and equity area. We were involved in these forums and the discussions about providing a statewide forum and having representatives producing papers from it with a view to putting in some action plans. As I sat there I felt very uneasy, to be quite honest, because I was currently working with someone in the office who had attempted many times and was self-harming before he came to work for us. He was giving me a big insight into the life of someone who counts every day. I find that insightful because I had never come across it before and had never been involved with it before. He would come to work in the morning and say, 'It's now day 1 794 and I'm here'. That is how he started his day.

We had a conversation one day and I said, 'I'm sitting on this committee that is talking about having a forum to produce some papers on what is required in suicide prevention. What do you think is required?'. He said, 'I can tell you straight off what we need in Launceston', and I said, 'What is that?'. He said, 'If I self-harm, I get taken up to A&E at Launceston General Hospital and there is every likelihood I'm going to be let out during the night or early morning. I go back to the environment that is the very place that has caused me to self-harm, or the very people who have caused me to self-harm. We really need somewhere to go that is secure and safe and away from that environment. I think if you did some research on other people in my situation you would find the very same thing'. So I said, 'It's as simple as that?', and he said, 'Well, you think about it. We have all these services available to us Monday to Friday but we have nothing at the weekend and that is our very critical time. We get on the booze, we get depressed, and we have all the environmental and cultural necessity to feel very depressed, with no self-worth, and it just spirals downwards. There is no-one to say anything; there is no-one to hug'. Most of the people he knew that he could talk about had no parents or they were living away from home. A lot of them had done so since they were very young, and we are talking 12 or 13. We talked with wards of the State who were experiencing trouble and not wanting to go back to the wards of the State that were experiencing trouble and not wanting to go back to the places they had been - those sorts of people. And again the common thread from the conversations with them was wouldn't it be fabulous to have something to tide us over from our Thursday or Friday meeting with the professional person, but keep us safe over the weekend and not be involved with some of the influences that we have over the weekend or the things that we seek out ourselves and which cause a very dramatic increase in the probability that we don't want to stay in this world.

So again that is how we started. We got a few of us together and we started thinking that we might take these kids into our home, being the grandparents et cetera that we were, that we would get a few different families together, people together, and we would actually bring them into our place. The logistics of that, of course, and the liability

proved to be that that would be very difficult, but the preparation was done for us to go along that way. But as we looked further into it, it was going to cause more strife than enough for the people that put their hand up, because there were people that had younger children and they had some concerns and apprehensions. So always in our planning of what we might do we need to get a house, so all we did, quite honestly, was move towards getting the house first and letting stage one go behind. We worked on the whole concept of who would be in a house and who would look after these children, and again we consulted with these young people. They did not have any preconceived ideas about any type of respite and where it might be et cetera, except from the point of view that they did not want anyone judging them. Judgment was very much on their agenda all the time. 'It is no good if someone is going to judge us.'

So we came up with the idea of volunteer befrienders that would be trained through Lifelink Samaritans et cetera in arrangement with them, and that is how we basically started. We got a lot more interested people together and put them through training, and as we did, of course, the referrals came very slowly and the public health system was very loath to release their people to us or refer to us. I remember doing some one-on-ones with the consulting staff and the psychiatrists at Ward 1E and I knew very well as soon as I walked out of the room that we wouldn't have a referral from them for quite some time, because what I was talking about was something very intangible: unpaid volunteers with no qualifications taking in these young people and looking after them. But again their understanding was professional as opposed as to the empathetic nature of ourselves, having our own kids and seeing them off our hands and seeing their friends be in trouble and the whole little family sort of bit that we probably knew fairly strongly and fairly well - how tight that can be and how much support it can be. It was probably our resolve from those initial cold feelings from the professionals that made us even more determined that we would get it up and running, and so we were able to work in other ways and talk with more counsellors and some of the social workers through the hospital et cetera, and again the support grew from that. Accident and Emergency staff were probably more aware of the need, that it does happen.

CHAIR - Or they would be looking for options too, I imagine.

Mr McLAREN - Exactly, for sure, and there were very few options. There were no options, to be quite honest. And so the support came from others, and that is just how it has grown, for sure. Of course from my going in and selling something very tangible, of course we have the tangible, and everybody who has been through the house is still with us. I think that is the statistic -

Ms GEE - We have had a 100 per cent success rate, which is so important.

Mr McLAREN - Yes, that is the most important thing.

CHAIR - When you say 'still with us' -

Mr FINCH - They have lost five coordinators but no clients.

Laughter.

Ms GEE - We sort of keep in touch in a roundabout way, don't we. We know where they head, and kids have got back to school, back to education, back to uni.

CHAIR - But you get them when they have attempted, do you? Is that what happens?

Mr FINCH - Or if they are in fear of attempting.

Ms STANTON - Or self-harming.

CHAIR - And who makes that decision - a medical person, or the client themselves?

Ms STANTON - A health professional or a social worker within a school, Anglicare, someone who has concerns and can assess these people, and then they offer them the Time-Out project and tell them all about it, and usually I am called in. I also have a talk with the young people. If they are in Launceston they very often come and have a look at the house. In Hobart or on the west coast it is a bit different. At the moment we are setting up a booklet they can look through because they are bit wary about coming the distance to something unknown because it is a one-off. They know they can leave at any time of a weekend; they don't have to say.

CHAIR - They are not incarcerated at all.

Ms STANTON - No. We ask them when they come to hand over their mobile phone, so there is no outside communication. If they do decide to leave, they are able to do that. We do not force them to stay there.

Ms GEE - We have fairly strict house rules: to hand over their drugs and medication is controlled. With the young lass from Burnie, she had a problem handing over her stash of marijuana because that was the first weekend she hadn't smoked for a very long time. When she went on the Monday she said she was really frightened she might become aggressive with the befrienders. She was so pleased with herself and she said, 'I now realise I don't need it'. They sign a contract to keep themselves safe at the weekend, to respect and honour the befrienders and keep them safe over the weekend.

CHAIR - So there is a strong trust model there?

Ms STANTON - Yes.

CHAIR - Of the young people who perhaps go to Ward 1E, or if there is a concern from one of the high schools about a particular student who is offered the option, did all of them pick it up? Do you get any feel for it?

Ms STANTON - Quite often we get a call inquiring and then they opt out. They decide they will go to their family or somewhere else, but we always give the chance, 'Perhaps you're not going to take it up this weekend'. I ask the referring body to reassure them that they are welcome to try the next weekend if they want to.

CHAIR - If wherever they have decided to go that weekend doesn't work out or they have had a chance to think?

Ms STANTON - Yes.

CHAIR - That must be an incredible relief for the workers on the ground to know they have that option.

Ms GEE - We often think if the parents knew they would probably be our best fundraisers of all time, but because of privacy, when the young people come in, we say, 'Would you like to phone home?' and usually that is the reason; they are from dysfunctional families.

CHAIR - So the parents often don't know where they are?

Ms GEE - No. If they did know, we are keeping them safe at a time when it is probably most critical.

Mr WILKINSON - How many people can you have in the house?

Ms STANTON - We can have three; I have been asked to have three - two in the house is hard work - but one of the young people pulled out. I was put in the position where one group rang me, 'We may have someone for you', and within half an hour another group rang me, 'We may have somebody for you', and then another group rang. I ended up with two out of the three of them thinking, 'Yes, we can take the three'. That meant there were more befrienders to be rostered on because you have to cover them all to make sure they all have good support for the weekend. We definitely can take three.

Ms GEE - Each person has two befrienders with them for the whole weekend.

Ms HAY - Do the young people interact during the weekend?

Ms STANTON - Yes, but we are very careful. As it is very new, you learn as you go along that they interact but you make sure that you're there in the interaction or else you get them befriending one another and you don't want them doing that. They then take on one another's problems and we don't want them doing that so we are very mindful. They can talk and interact, like we all do sitting around the table now. They can sit down for a meal, have a chat, talk and laugh.

CHAIR - Not up the backyard having a cigarette on their own?

Ms STANTON - No, we don't want them doing that.

CHAIR - Do you have a gender imbalance or do you find it is about boys and girls?

Ms STANTON - Up until this year it has been more girls, but this year we have switched.

Ms GEE - Which is really good because we were a bit frightened of the boys. Quite often they come to town during the week and have a few drinks and do something silly and so we weren't getting a lot of boys, but we are now. Ideally we would like the service to be open seven days a week, which makes sense.

CHAIR - I suppose, ideally, you'd like not to be needed.

Ms GEE - Ideally, you are quite right, but the fact is that we are needed and we are able to save young people. The house is not used from Monday to Friday. Because, as I said, we do not have any funding at all we are just running by the seat of our pants really.

CHAIR - I do not suppose you want it - I do not mean this in a terrible way - to degenerate into emergency housing? There is more to what you are doing than that.

Ms GEE - Certainly.

Ms STANTON - When we get the young people - of course we have learnt this along the way, too, and they can have repeat visits - we have learnt on their first visit, during their talk about the house, we tell them they can have up to six visits because we want them not to become dependent on us. We want them to be moving on, so they know that in the first visit and they are also told that if they come back for a second visit and third visit. We have passed that along each time, 'No more than six visits', so they are learning to move on.

CHAIR - Your age spread?

Ms STANTON - It is 14 to 28 but we do get over that.

Ms GEE - 24 is probably where we say they are youth. With the youth stats that came out in the paper recently it was saying that the statistics of the 24 to 34 group had really gone up. We would like to think it is because we do not have a house for the 24s and over, so they have got nowhere to go.

Ms STANTON - Mostly it is below 24s that we have. A few times we have stepped over the age of 28.

Ms GEE - We are very mindful. We would not say no to anyone if there is someone out there that really needs our help. We have been asked to set up a similar service for varying age groups but Nigel has always had the idea that we need something as a parent support because there is nothing for the parents out there of kids who have attempted, and it is really sad.

CHAIR - Two witnesses we have heard have exactly that story.

Ms GEE - They do not have anywhere.

Ms STANTON - Quite often if you have a young person, you have picked them up from their home and their parents are involved. You pick this young person up, you take them for the weekend and you bring them back. Usually I spend a couple of hours listening to the parents while they off-load. I usually allow that especially if I am going to a carer's home, knowing that I am taking this young person back and they are going to go off and do what they are doing. I am going to be there for a couple of hours while the carers - it might be parents or family members or somebody who lives with his parents - just off-load.

CHAIR - Do the majority of them come in from their parental home?

Ms STANTON - No.

CHAIR - They have already moved out amicably or not?

Ms GEE - I think Jen would agree and everyone would agree it is because parents have separated; they have gone off with their new partners but none of the new partners want kids, especially a teenager.

Ms STANTON - Or simply bad homes.

Ms GEE - So they are left to their own devices.

Ms STANTON - It is not always the case. There are a few cases that things have just gone bad in their life. Suicide is like a tunnel vision; nothing else matters and that is what they focus on.

Ms GEE - Our first fellow, Anthony, I will never forget, he was just the funniest kid. It was Easter and we had not had anyone in the house and the doctor rang and said, 'Are you having anyone?' I said, 'We have not really had anyone yet but yes, that is fine'. She said to Anthony, 'Would you like to go here?' He said, 'I do not know. I would like to have a look first. As a street kid you are not going to go just anywhere', which really made us laugh so he arrived in the clothes he was standing up in, nothing else, and he was there for the whole Easter. His greatest fear in the whole world - he had been in and out of jail, he had been dealing with drugs, he had been doing everything and he was 24 - was that he borrowed $5 from a member of a bikie gang. His whole worry was that the this fellow was going to come up and tap him on the shoulder, even on the head at some stage; everything else did not worry him. It was just this $5. We actually sent him down to Hobart to the Salvation Army home on the Easter Tuesday, I think it was. The Major rang and said, 'We do not think Anthony should be here. He should be at one of our programs in Sydney', so we arranged through a Rotary club for a one-way ticket for Anthony to go up. There was a program where they were taught by schools. Anthony is probably running the underworld - I do not know what he would be running now. At least he is away from the bikie now.

Ms STANTON - He lived there for a year.

Ms GEE - If we can help them, we will. I am not sure if a couple of our friends adopted that young girl but they certainly took her in. I believe they did adopt here in the end. If we think we can help them with some work or something, we do.

CHAIR - Would it be fair to say - and I know we tend to romanticise the good old days, if you like - in times gone by, when communities were more cohesive, the functions that you are providing may well have been provided informally within a close community anyway. Is that fair to say?

Ms STANTON - Picture your backyard, out hanging washing on the line, and the two neighbours come to the fence and have a chat. That is what used to happen; people used to offload on one another. Now they don't do that because everybody is too busy with their own life. They're not interested, so nobody offloads their feelings. That is what we tap into with these young people. Always the young ones come on a Friday night. They

are fairly quiet, they might come with a presenting problem and by the time you get to the end of the weekend you have the main problem. Recently we had a young boy who was referred to us from the Aboriginal department. His presenting problem was that he was lonely. He was a big boy, very self-conscious about his size and that was his presenting problem. By the end of the weekend we found out that he had homosexual feelings. He brought that out with us and then he went out into the big, wide world the next week announcing it to other people, which offloaded him immensely.

Ms GEE - Our befrienders are great people; they are all such down-to-earth people.

Ms STANTON - Ordinary people with extraordinary talents.

Ms GEE - Some have tattoos and lord knows what, but they just relate to the people. We have mums and dads, single people, young people.

Mr FINCH - I wanted to ask a question about training. This is obviously a new idea and something that has evolved here in Launceston. You talk about training and I know that Lifelink Samaritans help you with your training as befrienders. Was there a model that you used? This is specific, isn't it, face-to-face, living in a house with people over the weekend?

Ms GEE - It has just evolved, hasn't it, over the time.

Ms STANTON - It has. It is a learning curve; we do learn as we go along. It is based on Lifelink: listening, tapping into the feelings and no judging - no matter what they say. The young ones quite often put something out there that you know is not true, just to blow you away and to see your reaction, and of course we don't have one. Pat Eigo and Peter O'Sullivan do the training. We have five Monday nights with them and one full Saturday and then one night just with the coordinators and the befrienders going through the protocols.

Ms GEE - We do struggle to get volunteers.

Ms STANTON - Yes, that is our big thing.

Mr FINCH - Do you have a manual? Do you keep notes on the training experience?

Ms STANTON - Yes. Pat and Peter have a layout program of everything they do each time: dealing with feelings, grief. Every night is a different focus.

CHAIR - Do you have a lots of mechanisms put in place to protect your befrienders? Potential litigation from sexual assault? Teachers have to be very careful and so do other professionals. Are they well protected in that area?

Ms STANTON - Yes. They know not to touch. There is always a male and a female present. We can have two females but we can never have two males and we are very conscious of that. There is always two people at the house. They are never left in a position where it could be claimed they have done something.

CHAIR - It is a sad reality of life, isn't it.

Ms STANTON - Yes.

CHAIR - I will have to call a halt now. You have the terms of reference there. If you have a few moments to jot down some thoughts or notes in reference to any or all of those terms of reference, that would be really useful to us and guide us when it comes to developing our recommendations. Thank you very much for your time.

Ms STANTON - If you ever want to visit the house to have a look, you are very welcome to. We can show you through and it gives you a better feel for it.

CHAIR - It always does, doesn't it. Thank you very much for your time.

THE WITNESSES WITHDREW.

Ms JANE CHAPMAN AND **Ms SALLY COKER**, HOUSING TASMANIA, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR (Ms Thorp) - You would be aware of what we are doing. We are members of the Community Development Committee and our current reference is on suicide in Tasmania. We have six specific terms of reference that we are looking at. I do not know if your comments will refer to all or some of them, and we do have a submission. Perhaps you could just give us an overall view of what you would like to talk to us about and give us an opportunity for questions.

Ms CHAPMAN - Basically we have put in a submission to cover the northern suburbs. We work in the northern suburbs and we are here to talk to you today about what we are seeing in our communities.

CHAIR - What are you seeing?

Ms CHAPMAN - What we are seeing is whole communities grieving through suicide. We have seen risky behaviour from young people. We have recently done some projects where we saw evidence of young people who have lost friends and family through suicide.

Mr FINCH - I would probably ask about the work of Housing Tasmania. What work do you do with them?

Ms CHAPMAN - I am the youth worker at the northern suburbs community centre.

Ms COKER - I work as a volunteer at the Ravenswood Neighbourhood House and I take the Youth in Search children on the Youth in Search camps and Housing sponsor those children to go on camp.

CHAIR - What you are experiencing, I assume, could be translated to communities like Rokeby, Clarendon Vale, Bridgewater, Gagebrook?

Ms CHAPMAN - Yes.

CHAIR - So where there is a low socioeconomic factor that compounds issues.

Ms CHAPMAN - It does.

CHAIR - You are seeing it specifically there and directly resulting from what - poverty, family breakdown?

Ms COKER - No support.

Ms CHAPMAN - Lack of services.

Ms COKER - Ravenswood has had no trained support worker at all for years so at the moment it is just me on a voluntary basis, with no training and you cannot get in to see a social worker. It is near impossible. I had one child that needed to see somebody over a

drug issue. I tried to get him into The Corner and four weeks later he gave up because he could not have an appointment because that lady is not there very often. It is so hard.

Ms HAY - Do you think the youth centre that used to operate at Ravenswood actually grouped those sort of people who needed a bit of interaction with others, something to do in their spare time and someone to talk to?

Ms COKER - I think it offered a service, yes, especially when the first gentleman, Mark, was running it. It was really well run and they had someone they could go to and talk to. They could get referrals to somewhere if they were homeless and that sort of thing. I work at Laurel House as a volunteer and I spoke to groups there on sexual assault and safe going out, watching your drinks and that sort of stuff, and I think that is what we need.

Ms HAY - Have you seen a change since that is not operating anymore?

Ms COKER - Yes, especially with the Youth in Search kids that come to Youth in Search. There is a high minority that are affected by youth suicide, that have had friends. I get phone calls at midnight from kids that just want to talk because that is what they feel like they are doing.

CHAIR - So you are dealing with two issues really. You are dealing with a community that is grieving for the loss of its members -

Ms COKER - And no-one to talk to.

CHAIR - who have gone along the suicide route but also a set of social and individual issues that have no resolution, so without that support to try to fix the problems it becomes potentially a big suicide problem.

Ms COKER - It goes to that side, yes.

Ms CHAPMAN - There are services in town but we find that we are a little bit isolated out in the northern suburbs so money and transport is a big issue where we are, and they are non-trusting communities. A lot of people out there are non-trusting. They need someone that they see nearly every day. I am only funded to work with 11 to 16-year-olds so we have that big gap to the 24-year-olds, and Ravenswood do not have any youth worker. We are finding more and more that we are doing things in the community with small pockets of money that are doing fantastic things but once that money runs out, we are having to pick up what is happening and it can be heartbreaking really because we are finding it very difficult.

Mr WILKINSON - Do you get the money as a result of grants from the government?

Ms CHAPMAN - We apply for anything that is going.

Mr WILKINSON - And those grants are normally for 12 months?

Ms CHAPMAN - If that.

Mr WILKINSON - Therefore you have to continue to make applications to get your money. Do you believe it would be better if funding was, say, for three years or four years or something like that?

Mr CHAPMAN - Continuous.

Ms HAY - It takes a while to gain the trust of the community for that program.

Ms COKER - Especially with children that have been hurt. And these kids are dealing with sexual assault and domestic violence and drug abuse from either their parents or peer group pressure, the whole lot, and it is out there right from the age of probably 11 upwards.

Mr WILKINSON - You would have spoken obviously with a number of people who were at risk. One of the areas that we have looked at is what are the major things that cause people to be in crisis - is it the loss of a loved one -

Ms COKER - Low self-esteem.

Mr WILKINSON - low self-esteem, loneliness, no dreams, that type of thing. In your experience what would be the major one?

Ms COKER - I think low self-esteem. That starts it. If they have no self-esteem at all then the rest of it just piles on top and if you have no self-esteem you are more likely to be encouraged to do things that the older kids are doing that are not appropriate and then it just follows on.

Mr WILKINSON - Do you know what causes the low self-esteem?

Ms COKER - Probably a lot of it, home life.

Ms CHAPMAN - From what I have heard on Youth in Search, home like, school.

CHAIR - The schools should be a good resource for you. There are social workers, there are guidance officers, hopefully there are good and supportive teachers.

Ms CHAPMAN - Who are overworked and that is what we are seeing. They have not got the time. We have a large number of young people out there who are not in the school system.

Ms COKER - They hang around the skate park day after day.

Ms CHAPMAN - They need an alternative to the normal school system.

Ms COKER - We went to Hobart the other day and looked at Chances on Main and some of their work was terrific. That has an education section.

CHAIR - That has been the cycle, hasn't it, though. Back 20 years ago with Nangara you needed 12 in the units and then that moved to no, to do the right thing, all kids have to be included and now we are coming out the other end again.

Mr WILKINSON - So what do you do? What would you do?

Ms CHAPMAN - We need workers.

Ms COKER - Trained workers.

Ms CHAPMAN - They need community education on how to deal with someone who is in crisis.

Mr WILKINSON - What do you do if somebody is in crisis? Where do you go? I come to you for example, and say, 'Father has died, mother has died and I'm really feeling low'. What do you do?

Ms CHAPMAN - Are you talking about being suicidal?

Mr WILKINSON - Yes.

Ms CHAPMAN - The only place that we know of and the only place that is available at this stage is Ward 1E at the Launceston General Hospital.

Mr WILKINSON - What about Lifelink or Lifeline?

Ms COKER - You have to get a phone box that is working in your area, to start with.

Ms HAY - I thought the people we just had that hearing from were brilliant. They have a house, and some weekends they don't have anyone there, but they can take up to three people for the whole weekend.

Ms COKER - But that's only on a weekend, though.

Ms HAY - Yes. They came out because there was nothing else on weekends; everything was Monday to Friday. I think maybe we could give you a copy of that. It is another resource that you could look at.

Ms CHAPMAN - In the northern family support guide there are two services for suicide, and that is one of them.

Mr WILKINSON - So therefore what you do is contact the hospital.

Ms CHAPMAN - We support people to get there.

Ms COKER - And then it is up to them whether they keep them. We had a young girl who they didn't keep. She had already attempted suicide that day and she came home and did it that night.

Mr WILKINSON - What do you for the follow-ups? Do they come back to you to follow up? In other words, they have gone to hospital, they have spent a couple of days in hospital and then they come back out and they still have problems. Do you send them back to hospital or do you say, 'These are the organisations you should contact'?

Ms CHAPMAN - We are a referral-based organisation; we give advice.

Mr WILKINSON - Which organisations do you refer them to?

Ms CHAPMAN - Whatever we can find that suits the problem.

CHAIR - There is the immediate situation with a lot of people who have had negative experiences - kids with low self-esteem, lack of work, public transport, finding phone boxes that work, fences, get rid of the graffiti - all those things that are current that create an atmosphere where people don't feel particularly valued or happy or whatever, hence negative behaviours and the problems. There are strategies in place to make sure this disappears over time.

Ms CHAPMAN - Yes. It is the community development.

CHAIR - Have you come across FUTI - Facing Up To It? Have you had that program through your community?

Ms CHAPMAN - No, I have never heard of it.

CHAIR - It has been through Rokeby and Clarendon Vale, which is a great program. But all of them take money and take people to apply for them. How many workers are in your neighbourhood house?

Ms COKER - Do you mean as in paid workers?

CHAIR - Yes.

Ms COKER - At Ravenswood we have a paid coordinator. We have administrative assistance there a couple of hours a week; we have child carers if they are needed for child care, but that is about it. We have a grant for Stepping Stones, which is a community for children's grant, and a kids and dads one. One of the other social workers is running a group for parents whose children are with Family Services, but that is it.

CHAIR - So it is the same story around the State?

Ms COKER - Yes.

CHAIR - There is a grant for this, let's grab it and try to do this rather than having half-a-dozen full-time, well-qualified workers on the ground all the time.

Ms CHAPMAN - We don't have any full-time workers. We have about 20 employed people but we don't get funded enough to be full-time. We also have to compete with each other for that funding because we are all different services but we are under the one banner.

Ms COKER - I think some coordinators are not child-friendly, not youth-friendly either, which makes it really hard. You really need a youth worker who is youth-friendly and willing to work with the youth.

CHAIR - Some coordinators are still in the art and craft

Ms COKER - Some coordinators are still in the ark.

CHAIR - You can say that. This seems to me to be a common issue. It is either in the areas like the ones you are describing or you are getting similar problems in the rural areas. Similar but different, the same issues. It seems to come down to, in my opinion - and I don't know whether the other members agree with me - better funding for neighbourhood houses and more support for the support staff in schools to deal with these issues.

Ms COKER - Definitely. If we could get full-time youth workers it would be good - people who are trained to deal with youth.

Ms HAY - Lin mentioned lots more resources in schools as well, and I guess I am hearing 'Of course that is needed but what about those who do not go to school?' so it is probably the first step to be outside the school in the community houses or the neighbourhood programs and then address the school issue as well because otherwise we are just losing those most at risk.

Ms COKER - At Brooks you can go to Student Works. There are issues there but these kids are not in school. They are roaming the streets, and they are 11, 12 and 13. They are not even home. They are terrorising the neighbourhood.

Ms HAY - So you need a focal point within the community that is easily accessible and people can trust and it is open long hours and weekends with the same people that they see day-in and day-out, week after week, maybe year after year.

Ms COKER - Yes. Even if they are not open in school hours, if they are open after school hours so they are not encouraging them to miss school.

CHAIR - So you can run breakfast clubs.

Ms CHAPMAN - That sort of thing, yes.

Ms COKER - But some of them I do not think go home and have meals of any sort. Some of them you see walking the streets at six o'clock in the morning and they are still out there at nine o'clock at night, ten o'clock at night with their can of Coke.

CHAIR - If we are getting your message clearly, in terms of trying to do anything meaningful about reducing suicide in Tasmania we need to address the underlying social problems that create an environment in which people are choosing suicide as an option. Does that sound reasonable?

Ms CHAPMAN - Yes, that is probably exactly what we are saying.

CHAIR - Your submission is great; it is really good because some people only talk to us and we do not get anything in writing. I appreciate the time and effort you have put into it. Is there anything else you would like to say at this point?

Ms CHAPMAN - No, not really.

CHAIR - Thank you. It means that when we are putting our recommendations together we can, on your behalf or on all of our behalves, make a strong point for the need to put more resources into communities such as the ones you describe.

Ms CHAPMAN - Yes.

CHAIR - If you think of anything else later and you want to write us a letter or give us a call, do not hesitate.

THE WITNESSES WITHDREW.