THE PARLIAMENTARY STANDING COMMITTEE OF COMMUNITY DEVELOPMENT MET IN PARLIAMENT HOUSE, CANBERRA ON 14 NOVEMBER 2005.

INQUIRY INTO STRATEGIES FOR THE PREVENTION OF SUICIDE

Mr KEITH TODD, EXECUTIVE DIRECTOR, OZHELP FOUNDATION, AND **Ms IRMGARD REID**, VISION ACROSS THE YEARS THROUGH NETWORKING AND EDUCATION (VYNE), WERE CALLED AND EXAMINED.

DEPUTY CHAIR (Mr Finch) - We are the Joint Standing Committee on Community Development. Our inquiry at this time has been ongoing for eight months and we are still taking evidence on suicide, self-harm and the prevention of same. We will be looking to make recommendations to the State Government as to the lie of the land as it is now in Australia, and particularly for us in Tasmania, and just how we go about working with that issue into the future.

The proposal now is that if you would like to take a presentation, Keith. Irmgard, if you want to dovetail at the end of what Keith says, feel free to do that. If not, we will ask questions.

Mr TODD - I was going to use the projector here but I have one on computer. Is that okay?

DEPUTY CHAIR - If we can't set it up, could you e-mail it to us?

Mr TODD - I can send you the presentation.

DEPUTY CHAIR - Is it germane to what you were going to present today?

Mr TODD - It was, but I am pretty flexible.

I was going to talk to you about the construction industry because that is where I fit in, partnering with Irmgard who works in the community here. Irmgard will have a broader perspective.

DEPUTY CHAIR - You are with different organisations?

Mr TODD - Yes. Is this confidential? Some of it will not be appropriate. We come together but our two organisations work quite closely. From the perspective of the construction industry, we got going because of some suicides; there were four suicides in the space of three months in about 2000. So it is almost five years ago now. Because of those suicides there is a recognised understanding here in the ACT that there was an issue. The mother of one of those young men who suicided, David O'Brien - who you will see on the video with his mum - went to the CFMEU union and said, 'What are you

doing about it? If my son had have had someone to talk to and somebody who could work alongside him, this probably wouldn't have occurred'. The union then went to the Master Builders and those two organisations collaboratively went to government and lobbied them for some funding for a pilot project. That was in 2001. That project was funded 50-50 from the Federal and ACT governments as a pilot project for two years in the construction industry here in the ACT. That was to find out what we could do to prevent suicide within the construction industry.

The big thing was: is it a problem in the construction industry or is it generally a problem? I think here you have the male aged 25-44 - research will show that that is one of the biggest areas of suicide. Ninety-eight per cent of the construction industry Australia-wide is male and we fitted that pattern. That is why when there were these four within that space of three months it needed looking at.

The pilot project started. At that time we were based at Calvary Hospital, where VYNE is. We were foundered under what I would term a medical model. The idea was that two field officers would go out and scoop up sick apprentices and take them to the psychologist who was based at the hospital.

DEPUTY CHAIR - 'Sick apprentices'?

Mr TODD - That is how they viewed it - apprentices who had mental issues, who had all sorts of problems in their lives. The field officers would go out, find them and take them back to have counselling. That was the view.

DEPUTY CHAIR - Through an agreed process? How did you get people to -

Mr TODD - It was pretty ad hoc at that time. Tied into that fieldwork there was an outside training organisation that was brought in to deliver training. They were great but they were pitched at street kids. They had a great experience in working with street kids but not a lot of working with young men and women who were making a transitional move from school to working life.

My background is in emergency services. I was 17 years in the UK police at a reasonably senior level and my background is in disaster management and training. I was looking at it from a strategic point of view. The other guy I was working with at that time was a carpenter and a social worker. After about three months of this we realised that the medical model just didn't fit, so we went with a proposal to our board because we were a charity in our own right. We said to the board that we felt it should be pitched at a community model. We should aim this not at a medical-type approach but a community approach because things weren't working. To cut a long story short, we turned it around and moved away from the hospital. The board was established and I became the executive director and the other guy, Shaun, took on the support services side. That was January 2003. We also got rid of the outside training organisation and worked collaboratively with the industry. We became a registered training organisation. We have developed a life skills tool box, which is accredited. As well as doing their exams in carpentry or metal work or whatever it is, apprentices have a course in life skills which they do during their apprenticeship, so we do that.

We also have field officers who go out there, not to find sick apprentices but just to come alongside them collaboratively. We do have the back-up of a psychologist and we do have social workers that we can draw upon, but we have found that most of it is early intervention preventive work, so it is pitched right down at the early age. That is what we have been developing. Then we were evaluated by the Hunter Institute for Mental Health. The two-year pilot was fully evaluated and I will actually send you a copy of the evaluation. From that we went to government and we were given, by the ACT, recurrent funding, but opening it up to the whole of the industry so that we now serve the 10 000 workers plus their families in the ACT.

We deliver this training to apprentices. In our journey we found that we could not deal with apprentices in isolation; we also have to deal with the workers and the supervisors and the trainers, so we have developed some collaborative training for them. We do suicide prevention first aid with them. We also deliver coaching and mentoring training to them and we are also there as an industry-based support service.

Then on top of that I guess you have a third layer. In the documentation there is an old document called 'What is Oz Help?' and I will send you the more up to date booklet that we are just having printed. In there it shows the three circles and the third outer circle is actually the industry culture, which is a pretty hard culture. In there we work across those three areas because all of those areas impact on each other. The apprentices are affected by their supervisors and workers and the workplace culture affects the whole set up. This document also describes some of the training that we deliver.

That is where we came from. We were given this recurring funding. We were also given funding last year from the Federal Government to expand our model into the construction industry to other States and Territories. That is how I ended up in Tasmania to present a community workshop on suicide prevention - I think it was part of the launching of your suicide prevention plan. From that the construction industry asked me to come back and talk to them a bit more and since then through Royce Fairbrother they are developing Oz Help Tasmania. We have a consultant who is visiting the other States and areas on the eastern seaboard to basically establish stuff in those States, not owned and controlled by us in this Territory but basically but to support them to get it going.

The other thing that is happening at the moment is that we have been approached recently by other government departments to talk about how to move our model into other industries, things like motor mechanics, horticulture and hospitality, where the same problems exist. They want us to go broad-based across apprenticeships in the ACT, and pilot it here with a view to establishing it in Australia because I guess you are talking thousands of young men and women who are either involved in these industries or affected by these industries. So I guess that is the sort of broad base of what we do. I don't know if that is helpful.

DEPUTY CHAIR - Tell me about your target market, I suppose; is it 16- to 18-year-olds or apprentices?

Mr TODD - Our target area is a pretty male-dominated construction industry, but in here it will describe our vision. Our vision is the early intervention, work-based suicide prevention and social capacity building and fancy terms of resilience. One of the things we have a real focus on is resilient people, resilient organisations and the core goal is to

basically build a training and coaching service that enhances the resilience of our target group. Our target group is three-fold, which is the apprentices, the workers and then the industry culture. It started with the apprentices but it has gone a lot broader in the past three years.

DEPUTY CHAIR - Okay. Yes, because that was what I was thinking. You were talking about apprentices and I thought you are letting the supervisors and the trainers know what they are dealing with as far as the apprentices are concerned but of course, as you say, it is more far reaching than that.

Mr TODD - Also I guess we network with other community groups at a broader level and that is why I asked Irmgard to come along because her organisation is a broad education service for the ACT.

Mr WILKINSON - As a result of the work that you have done, have there been any suicides in the construction industry?

Mr TODD - Not in the ACT. Having said that I believe there will be and I believe we have got to be prepared for that. Certainly at the moment the industry is in a boom but I think there is a lot of stuff coming in that will turn that around. A downturn in the construction industry, the IR stuff that is going on at the moment, will have a huge impact on people's resilience, I think, within a workplace. I am not saying there will not be any, but I think we have to be prepared to work with that. We also do postvention work, so we work with families. We have had family members suicide and apprentices have come looking for support or workers have come looking for support and we have done some postvention support work with them and that, in itself, is preventative for those people. It is actually helping them.

Mr WILKINSON - So how many people a year approximately do you class as the crisis people.

Mr TODD - The high risk?

Mr WILKINSON - The high risk, yes.

Mr TODD - In our first year we saw 12 people who we classed as high risk and it has pretty much been about that number.

Mr WILKINSON - Can I run you through that then. I am high risk. I come to you. What do you do?

Mr TODD - We have a whole counselling service but we actually identify the fact in the way our service is set up that men will not go to doctors. Men will not go to a counselling service. We are a short step because we are there. We are in their face. My field officers wear the industry gear, they go out on industry work sites. One of our initiatives is called Oz Barbecue and we run barbecues on work sites to get our message out. Through those small steps, at the end of three years on, we have had people who turn up on our doorstep on their RDO and say 'I want to talk to somebody'.

It is that sort of relationship-building and then there is a small conduit to feed them on to more indepth services. We do have a family therapist who works with me so we will take them through that process. Everybody is trained in the suicide first aid but we also have our counsellors who are trained in working with the more indepth issues.

Mr WILKINSON - And does government fund you - partly or wholly?

Mr TODD - We are funded in the ACT by the ACT Government Mental Health as a part of our base funding. We also draw from the construction industry and from other available grants and donations. We are a registered charity so donations are made by people and also the construction industry. Some of the building companies make donations to us.

Mr WILKINSON - And feedback for the work that you do?

Mr TODD - Feedback is pretty overwhelmingly positive. I guess you will find in the Hunter Institute, which we pretty much opened ourselves to let the people have a good look at us, there are some areas in there about confidentiality. Because we say we are confidential, we are independent of the industry, we are independent of the unions, and we do not report back, there was a bit of concern and I guess we were viewed with cynicism. People were asking, 'Are they really confidential?' I think over the three years we have broken that barrier. Feedback from the apprentices doing the life skill course is that it has been useful. It is a course that is not just pitched at work stuff; it is the home-leisure balance, if you like.

The course is values-based. It focuses on problem solving, conflict resolution, resilience and emotions, especially for young men. They don't know that they have emotions. They don't know what they can do with them. In fact we are graduating our first 98 next month. That started in 2003 and we are just graduating our first 98 through the program.

Mr PARKINSON - Are all ACT apprentices in the building industry going through that program?

Mr TODD - No, not at the moment.

Mr PARKINSON - How do you determine who goes through?

Mr TODD - Because of how we were formed, there were a couple of group schemes that came under us. So the group apprenticeship schemes brought into it, so when they come in for their group training they will come for a week block and we will deliver four hours at a time. The course is 48 hours so they have 12 four-hour blocks. We have just started chipping in with the local TAFE and they are delivering some but not the whole course. I know in Tasmania they have gone ahead of us in that they have been talking to the TAFE and the TAFE were open to the whole program being delivered. Things have moved on a lot quicker there. I know Royce will be able to tell you a bit more about that.

Mr WILKINSON - Do you believe that all apprentices should go through that course?

Mr TODD - Yes, I do, and I think Linda might talk to you about the suicide prevention plan for the ACT which is going to be launched tomorrow. One of the outcomes in there, one

of the target areas, is that all apprentices in the ACT should receive life skills training. So that is in there with a view of obviously progressing that, but it is a time issue. It is 48 hours over three years, it is only 16 hours a year, not a huge amount of time.

Mr WILKINSON - Does that course assist you to find out whether these people are at high risk?

Mr TODD - Yes.

Mr WILKINSON - And does it tell those people then what to do with the people that are at high risk?

Mr TODD - Yes, we do all of that stuff. That particular course is pitched at apprentices. We have a whole module on crisis management and crisis intervention, and we have found that during those sessions stuff comes up. Although it is a course, the only reason we set it up was to support, so we are supporting apprentices or supporting workers, so the training we deliver is a method of supporting them, and so we may be delivering the training and something will come up, and so they will have a whole group discussion around that, and the training is confidential so it does not leave the room. We have picked up clients through that. Guys have come at the end of it and said, 'I need to talk to you. I'm not suicidal, but some of the stuff you are going through really raises concerns for me'.

Mr WILKINSON - What about post-intervention, because am I right in saying that if a child or an apprentice has committed suicide the family find it difficult, and there is a high risk of one of those family members committing suicide as well?

Mr TODD - Yes.

Mr WILKINSON - Do you do any of that post-intervention work?

Mr TODD - Yes, we do post-intervention. We have not had any apprentices suicide but we have had family members, and not just family members in the ACT. There might be a family member outside the ACT. We had one where they came here for a wedding from Victoria and the person suicided here in the ACT in someone's garage. It was a family member of a building worker. So while they were here in the ACT we did some stuff and then we were able to put them in touch with somebody back in Victoria who could continue the process. But we do that in the ACT, we work with them, and Irmgard will probably talk a bit more about that.

DEPUTY CHAIR - Perhaps if we hear from Irmgard at this stage. You mentioned something before about confidentiality. We can go in camera if there is something that you want to tell us but what you say will not be used as part of our presentation. We won't be able to use that material if you wish to go in camera on any subject.

Ms REID - I have a couple of questions, and being able to see your terms of reference is great. As far as procedures are concerned, it is being taped and will be edited? You will take out certain -

DEPUTY CHAIR - Only if you ask for it to be in camera.

Ms REID - Okay, that is fine.

Basically just to introduce you to VYNE, my program that has been in the ACT since 1999, this stands for Vision across the Years through Networking and Education. When it was started it was funded under the National Youth Strategy. After a year it was evaluated by the same organisation that has evaluated OzHelp, and since 2000, as a result of a very positive evaluation, clearly the VYNE project being seen to provide education and training to the community in the area of suicide awareness and prevention being a very positive thing, has been funded by Mental Health ACT with recurrent funding, and we are housed at Calvary Healthcare. So in effect we operate under a public service structure but are housed and look like actually a not-for-profit community education program, which is very positive.

I want to highlight a few things. Although we initially targeted youth suicide, in the year 2000 when recurrent funding was given from Mental Health ACT, it was then a suicide across the ages scheme, because clearly while youth was targeted back in 1998-99 because of unusually high statistics, we have now identified that it seems youth rates have stabilised. Of course, even one suicide is too much, but really if we want to address the suicide issue we need to be able to do it across the age span. Perhaps you would be aware that at the moment our highest rates and our concerns are men between 24 and 45 and, of course, much older men.

I think, just to concentrate a little more on VYNE, our role is to set up education and training to the broad community. In effect what does that mean? Who is the community? It is everybody, and anyone that comes along to do the training that we offer can see it as of benefit. We are not accredited. Our training that we deliver is not accredited. It is really more in terms of short courses. We offer three-hour presentations, whole-day presentations, two-day presentations. What our calendar tries to reflect, and in fact we strive to do every time we put a whole year's program together, is looking at training to target a whole population, to very targeted and specific intervention training as in the ASIST, and Keith has made reference to that. I do not know if you are familiar with the ASIST training - two-day suicide intervention skills training. It is fundamentally the training that we would support first and foremost here in the ACT because we believe that if as a community and as individuals we are all speaking the same language, we have a common literacy, it makes how we intervene a lot more effective. Through the ASIST training both Keith and I are ASIST facilitators. We know that our crisis team, our CAT team, are very familiar with the training and very appreciative when people do ring in with a crisis call that having done this training they know what to say and the CAT team know how to respond. That is one of the things around common literacy, common language.

In terms of how effective we can be in suicide prevention, Keith mentioned a few things and ultimately we can't do it working in silos, so whatever VYNE runs, if we run it offering it just to, for example, professionals working in a particular field of mental health, we are not getting out there broadly enough, we are not supporting each other in our understandings. If VYNE decides to sit on its own working in a silo mentality, we are not being effective because we need to be working with, and are working very effectively with, organisations like OzHelp. While you are targeting industry and we are targeting community, we are getting out there more broadly, to reach our community

more widely, and running and offering trainings that are seen to be grounded by best practice and latest research.

DEPUTY CHAIR - How many people do you have in your organisation?

Ms REID - At the moment we are in a transitory period. There are three of us as team members, myself full time and I have a part-time office admin worker. I have a woman doing some research for me at the moment; she comes in three days a week. At the moment we are in the process of supporting a mentally healthy symposium, to be happening in 2006, and I have a six-hour-a-day project officer for that. In terms of our team dynamics, it is constantly changing. Next year we will be looking at how VYNE operates and how we work more closely in partnership perhaps with OzHelp. For the moment, those team members I have mentioned to you are performing specific jobs.

DEPUTY CHAIR - Has that stimulated something more from you, Keith, when you were listening to Irmgard speaking?

Mr TODD - We used to deliver our suicide prevention training, our two-day one, just to industry. The first couple did not work so we now bring the industry together with the community. We charge for our training and we have a range of charges - corporate rates - which means that the industry is making a contribution to support people in the community to learn the same stuff. I would agree with that; we can't work in silos.

In the team I have there are about 4.5 of us, and that is why certainly in the ACT you need to work quite collaboratively.

DEPUTY CHAIR - How are you placed in respect of those numbers that you are dealing with? You could always do with more, couldn't you, but do you have sufficient to project and enhance and present the plans and protocols you have in place? Do you feel you need to expand or have more numbers?

Mr TODD - It would be good to have more. One of the things we have addressed is through partnerships we can draw on our psychologists and our social worker. We used to employ them and now we work with a couple of other groups where we have a bit of a fee-for-service thing going where we can draw them if we need to. They key is choosing the right people for staff. I would say recruitment is paramount. Since I took over in 2003, it is looking at who you recruit and how you train them. You have to make the best use of your limited resources and I am fortunate that the person I have overseeing my support can also oversee my training because she has both support and training qualifications. It is just making the best use. I think we are pretty much full to the gunwales, if you like. We see a fair few clients a week as well. Some extra resources are always good but I think you can work well.

DEPUTY CHAIR - Do you both know what is happening in Tasmania and other States?

Ms REID - We have a good sense of it. In terms of giving statistics and things, no. We have an annual conference called SPAR and that gives us the opportunity to come together on an annual basis and talk to other States and Territories.

DEPUTY CHAIR - If you were starting up something in Tasmania, what would you say we should be doing that we are either doing or not doing at the moment?

Ms REID - Take some time to really identify what actually is happening, who has what operating in the community. When VYNE started back in 1999 I was not part of the team then but it really was a case of taking a good look at who is our community. What is a community? Who delivers what services and training in the community, for example. One of the things that people I think generally do not feel happy about is if there is yet another program or yet another organisation that comes into a community to delivery whatever. You are not really being mindful of what is already happening.

The other thing is to identify the gaps in the services. So what are we actually lacking here? What resources are not in place to support positive and effective things happening around, for example, suicide prevention?

Mr WILKINSON - Do you know the Tasmanian situation at all to say what those gaps are?

Ms REID - No, I would not be best placed to know that.

Mr TODD - I guess from the little bit we have done, we came over and did that presentation and came back and talked to the industry. The industry are doing stuff and they are not actually going straight to government, which they will be. I think it has got to be a true partnership but they are actually going to fund the initial stages themselves. They have obviously been doing a fair bit of work. I know you have been out to visit Parakeleo. We also have a firm of consultants called Human Capital Alliance who are doing some work. They have an associate based in Tasmania. I am not sure of her name but I know she has been involved in suicide prevention work. There is another guy whom I know, Tim Johnson -

DEPUTY CHAIR - Yes.

Mr TODD - We know him very well. But again you have got all of these resources and he does amazing work with the indigenous population. One of the things I have discovered in the ACT is that we have to work together. If you do not draw on all of those resources that you have and have them working collaboratively, then they all try and compete. They think they are competing for money. We had the same thing here, but I think we are breaking it down through communication. I will send you two slides of statistics for the construction industry. They are from CBUS, which is the super fund from the industry. They have done their own research. They have only culled the stats from coroner's reports and other sources so they are only a snapshot of what they believe to be the case.

I know the thing that stood out for me when I looked at it was that the ACT and Tasmania, with pretty similar population and pretty similar in terms of industry, yet the big one was the unknown statistics we have. I think we had three in the ACT from 40-something. That was a coroner issue. Having come from an emergency services background I think that is a coroner's call and you can only call it a suicide if you have the evidence. I think overall about 800 or 900 people died in a five-year span, either by drug related stuff, which often ties in unknown circumstances, or single-car accidents

and a whole range of things, so CBUS have done a fair bit of research Australia-wide for their industry.

I know the super funds as a whole have got a committee together now looking at other industries, so they are actually taking corporate responsibility for people in their funds across Australia because it is costing them money. It is costing $50 million a year for CBUS alone, for insurances, so I think that is a good way of looking at it there. In terms of Tasmania, it is only through SPAR and working with these guys that we have come to find out what is going on I guess.

Mr WILKINSON - Is there any ability to get the university working in with one of your organisations?

Ms REID - We have had some inroads with the university not just VYNE itself. There was a project in Canberra a couple of years ago, the SIP project - a peer support program, peer support training. In that training they, over a period of two years, had students nominate themselves to be part of this project, to do the ASIST training, to a whole lot of other training around how to support each other and then become peer leaders. Unfortunately, as is the case, often when a project finishes that is it. That is the end of it and I guess in terms of being effective we need to maintain the contacts. For example, Keith and I did an ASIST training with new students just recently. VYNE is looking into how we can work more closely in the area of education with university students, for example the Education faculty, alongside the counselling group, and it is possible.

Mr WILKINSON - Do you think also it would be worthwhile, because Professor De Leo is, I suppose -

Mr TODD - He's a pretty outstanding expert.

Mr WILKINSON - Sure, and he has an institute, hasn't he, at the University in Queensland. There do not appear to be a lot of psychologists or psychiatrists going through at the moment. There seems to be a lack of them. How would it go if the Government sponsored a scholarship to study with Diego De Leo for a year -

Ms REID - Is that a proposal you are putting forward?

Mr WILKINSON - I am just looking at recommendations.

Ms REID - You are going to talk with them. They have done some work with the Queensland industry up there. But again, the last SPAR conference was about bridging the gap between research and practitioners, and I do not think we have done it yet. I think you need real practitioners to go through. But I think the academic side of it backs up. We know that we need research to almost validate what we are doing. We have the hands up, but we need research to continue. Are you just seeing Diego, or are you going to catch up with Jacinta Hawgood? She is his key researcher.

Ms REID - I would like to suggest what you are saying about targeting the university, not just to stay with psychologists and counsellors. Ultimately we want to be a well-informed community, so with that sort of training that you are talking about, we do need to tap into the education faculty as well -

Mr TODD - Yes.

Ms REID - because of course as teachers in school systems, they are dealing with the bulk of the population in terms of getting them when they are younger, and early intervention and prevention.

Mr TODD - That is the key, isn't it, because you have your professional help, but most of it is first aid. Most of it is your mates, the people you work with, the people if you are in university getting education. It is those sorts of people. Most of the people who come to the training for the two-day course are the ones who really go away with it, the ones who are going to apply it in a first-aid sort of manner. It is like any first-aid course.

Mr WILKINSON - Should it go into the schools? Should there be a week or a two-day course at school in relation to it?

Ms REID - We are certainly encouraging that, but I think the other thing is that in itself is not enough. You would be aware of the Mind Matters program, perhaps, that supports that. Mental health first aid, which is training that we are very strongly promoting as well, supports better understanding and training for teachers as well, alongside parents and other people involved with the school system. So we are looking at our whole community within the settings.

Mr WILKINSON - What age group should it come in at schools? You have the teachers obviously being trained in the area.

Mr TODD - I think the resilience focus is the key for me. We are teaching kids -

Mr WILKINSON - Primary school, intermediate?

Mr TODD - Yes, why not? We actually go in here into secondary school in year 7 - that is just a bit of a contribution group - and they have set up a course in one of the high schools here, and it is called Get a Life. It is all about what helps me bounce back from these things in life. That stuff can be done with kids of any age. It should be done in the home but it is stuff that can be done at school to assist them. You can walk out with all the academic qualifications you can and you want, but one of the things the employers say is these people cannot get through life; they cannot communicate. So it is holding down the job, good communications skills, good problem-solving skills, the things that get missed. That is why we pitched our stuff at life skills as opposed to talking about suicide. We do talk about it, we do not shun away from it, but hitting it from the positive end, the early intervention, the promotion, health promotion, making a really healthy community.

Ms REID - Yes, in fact I think in even asking that question it really does highlight what we are talking about here. It is across the age span. In terms of good education, if we do not target across the age span and we are only staying in little pockets we are really not able to be effective.

Mr WILKINSON - I hear what you say, but how do you do that?

Ms REID - Through education and training, through supporting what is in fact working in schools, for example, or in universities, or in the industry or in the broad community. And I think really the issue of where effectiveness falls down is, as we highlighted earlier, when you work in silos, when you are not supporting each other in good practice, when there are competing agendas. So going back to your original question of setting something up in Tasmania, for example, it is looking at what is already existing, looking at what is working well, looking at where the gaps are, understanding that ultimately suicide prevention is a much broader perspective around promoting wellbeing and resilience and a connected community.

I think the other thing is to be very informed by current policies and frameworks which is what we are doing here. We have our mental health promotion - a prevention and early intervention plan - being launched very soon. We have our ACT suicide strategy being launched this week.

Mr TODD - Tomorrow.

Ms REID - Yes, tomorrow. Whatever we put in place here - and I am sure Keith you are the same - we make sure it is line with our mental health strategy so it is making sure that we are in keeping with current policies, procedures and best practice.

Mr TODD - And being at grass roots. It is no good being up here. We are on the ground and that is why, as I said, we turned our service around. It was only because it wasn't working and what we found works is being in with people and being informed by those people. We found that standing around a barbie works for men. It might be something completely different. What is a suicide prevention activity? There are 'knitting circles' that go on here that actually connect people to other people.

DEPUTY CHAIR - Yes

Mr TODD - Isolation is one of the main things. If you get isolated it all goes on for you.

DEPUTY CHAIR - Tell me something about the suicide strategy that is going to be released tomorrow, how has that been developed here?

Ms REID - There was fairly broad consultation in the ACT. There was a project officer assigned for six months to put that into place. She went around and spoke to all the different organisations working in the field of suicide prevention and asked about what we were doing, how we were doing it, what we identified as gaps, what we would recommend as future strategies and in the process of that then formulating this document that has a whole list of strategies and actions and who will fulfil those.

DEPUTY CHAIR - It might be an interesting document for us to -

Ms REID - Yes. But of course for those of us here, that is great - to already have the funding and to then progress the actions.

DEPUTY CHAIR - So the recommendations are there?

Ms REID - Yes.

DEPUTY CHAIR - Have you seen this suicide strategy?

Mr TODD - We have been party to putting bits of it together and so it is targeted - some of them need budget bits. For example, the one I said to you from my perspective is it is in there to get whole life skill training to all of the apprentices and that needs a budget bit and that budget bit has gone up already.

Ms REID - Can I also make another comment. I think regardless of what Keith and I for example, representing our own organisations do, we can't be effective or make any changes if our policies and our social determinates of health aren't addressed as well. So clearly issues like unemployment and housing, homelessness, alcohol and drug issues need to be looked at alongside the nature of the work that we do, otherwise it is this again working in a silo and not being able to work comprehensively as a community.

Mr TODD - And that is why this other plan has rolled and the promotion of the early intervention plan has been launched. We have also had input to that one - it is not just us two, but there are others out there. Those two documents, I guess, work hand in hand. They are both whole-of-population stuff.

DEPUTY CHAIR - Those issues you talked about, they are the ones that are impacting on people and driving them to self-harm and to consider suicide?

Mr TODD - Yes.

DEPUTY CHAIR - I think with the information that you have given us and what we are likely to see when we receive your presentation, you have given us plenty of food for thought. I could have asked a lot of other questions in respect of the development of your organisation but -

Mr TODD - Feel free to e-mail. I can respond by e-mail. The DVD will give you a bit more background as to how we came about. It is only 15 minutes long and it has four apprentices at the end of it just talking about the impact that it has had on their lives.

DEPUTY CHAIR - Jim only has an attention span of about seven minutes.

Laughter.

Ms REID - I would like to make one final comment around the area of postvention. There isn't enough happening in that area. Clearly, from what you were saying earlier, if we don't address postvention well we are just going around and around in circles.

DEPUTY CHAIR - Irmgard, if there are things that you think of after you leave here - and you too, Keith - please contact us through Charles and get that information to us.

Ms REID - I have a few notes that I would welcome passing on to you that

DEPUTY CHAIR - With postvention or -

Ms REID - Just generally, even this discussion around high risk. We look at high-risk groups but we know we need to not dismiss low to medium either; any risk is a risk.

Mr TODD - We have actually done away with that. In the training it used to be high, medium and low; now it is just at-risk.

Mr WILKINSON - Sometimes it just happens, doesn't it. You think all the safeguards are in place but about a month ago a mate of mine committed suicide.

DEPUTY CHAIR - On behalf of the committee, thank you very much for the contribution you have made today. It has been important for us to have that information from you. Perhaps we may need to contact you again.

THE WITNESSES WITHDREW.

Ms LINDA TROMPF, DIRECTOR, ACT MENTAL HEALTH SERVICES WAS CALLED AND EXAMINED.

DEPUTY CHAIR - Linda, thanks very much for your time today. We have a pretty good opportunity to talk to you now. We can take the full hour if you care to.

Ms TROMPF - That might depend on how many questions you have for us. Obviously you have talked to Keith and Irmgard. I am not sure if you have talked to anybody else yet, but I thought I would give you a bit of an overview of what is happening in how we in the ACT Health department work with our community organisations and how it all fits together. You might have some questions after that.

I am the manager of the Mental Health Policy Unit in ACT Health. That unit is responsible for maintaining the links between what is happening at the Australian Government level and the local level, so it deals with strategic government policy directions and trying to translate that down to the operational areas. Our unit also manages all the contracts with non-government organisations providing mental health services in the ACT. We have contracts with 20 community organisations. We have a total of around $5.1 million going into the community sector for mental health services.

DEPUTY CHAIR - That is from the ACT budget?

Ms TROMPF - No, not totally; some of that is from Australian Health Care Agreement funding that comes to the ACT and we have put it out into the community.

ACT Health is the government health agency. The Mental Health Policy Unit sits within the ACT Health Policy division. That is where the strategic and jurisdictional policy stuff happens. Mental Health ACT is the operational government mental health service provider. As you are obviously aware, this is a really small organisation. We only have one public mental health service and that is Mental Health ACT. That provides a full range of services, from crisis intervention through to supporting the community, so there are all the variations through there.

DEPUTY CHAIR - How long have you worked in this area, Linda?

Ms TROMPF - About two-and-a-half years, so I am a newcomer in mental health.

DEPUTY CHAIR - I was wondering a bit about the history of mental health services in the ACT, whether that might be helpful to us to have some understanding of how you have developed to this stage.

Ms TROMPF - As I say, I have only been in mental health for two-and-a-half years so I am probably not the best person to answer this question historically. It started off as quite a small service. It was situated within the acute service based at Canberra Hospital, which used to be Woden Valley Hospital, and it has grown from there. So it started off primarily providing in-patient acute services, with some community services. Over recent years the emphasis has been on providing mental health services in the community. We have established four community mental health teams - one in each of

the ACT regions - and we have two acute in-patient units: one at the Canberra Hospital and one on the campus of Calvary Hospital, which is the other public hospital in Canberra.

The Psychiatric Services Unit at the Canberra Hospital is our high-acute service provider. It is a 30-bed unit and it has a low-dependency and high-dependency area. Very acutely unwell clients are in that unit. A lot of them are on involuntary treatment and there is rarely an empty bed, which is probably standard for similar services in most other areas.

The unit at the Calvary Hospital is a 20-bed unit. It is still an acute unit but not the same level of acuity as the Psychiatric Services Unit. Rarely do they have involuntary patients in that unit. Though it is based on the Calvary campus, which is managed by Calvary Health Care Australia, that unit is still part of Mental Health ACT - so it is still part of the public mental health service.

We also have a 30-bed rehabilitation facility and that is also based on the Calvary campus. That provides medium- to long-term accommodation and rehabilitation support. Ten of those beds are low secure beds, so we have people in there who are on psychiatric treatment orders and some of them are on orders from the court to reside.

Mr WILKINSON - Do you have enough beds?

Ms TROMPF - No.

Mr WILKINSON - One of the things in Tasmania - and I suppose it is Australia-wide - is where they have taken away the Royal Derwent Hospital and its equivalents. It probably was not the ideal. Do you think there is a need for some type of secure accommodation for these people who need to be somewhere to take their medicine and so on?

Ms TROMPF - I think there is a need for some secure beds and that has been recognised in the ACT. In the last budget the Government funded feasibility studies to explore what our needs are and to look at providing additional in-patient facilities. The proposal currently on the table for consideration is that the Government has definitely agreed to replace the existing 30-bed unit at the Canberra Hospital, which has been the subject, as you may or may not be aware, of a number of reviews over recent years. It has been found that the Government has put a lot of money into making some significant changes to that unit, refurbishing it to improve safety for clients and staff, but it has found that it still needs works so the best thing to do is to replace it, so the Government has committed to replacing that unit.

DEPUTY CHAIR - At the hospital still or will it be in another area?

Ms TROMPF - It will be at the hospital. The other thing is that we currently have no adolescent in-patient facilities in the ACT, so that is another thing we are looking at, together with a high-security unit which will be co-located with the replacement for the existing Psychiatric Services Unit.

So there are no definitive plans about where these buildings are going to be exactly or what they will look like, but the plan would be to colocate them altogether and on the hospital campus.

DEPUTY CHAIR - Why does it need to be linked up to the hospital - because of the services that are required or is it historical that it is normally connected to the hospital.?

Ms TROMPF - As you are probably aware, in years gone by mental health facilities weren't on acute hospital campuses. They were stand-alone facilities, psychiatric hospitals, some of which were good, some of which were appalling and certainly since the beginnings of mental health reform following the Burdekin Report in the early 1990s, part of that reform is to actually move away from those stand-alone psychiatric facilities where, to be kind, the care was often below standard and below what you would expect for people with a mental illness and to try to mainstream mental health services with other health services.

There are a number of reasons for that and one is to try to reduce the stigma associated with a mental illness. If you get taken off to a psychiatric unit locked away in the bush somewhere, it is pretty stigmatising. The care was not always good and often it was hard to reintegrate back into the community. Another reason is so that people with a mental illness have access to the same level of acute health services that they might need, so to have them colocated on a hospital campus where they can also have access to other acute health care that they might need is the way that mental health care is going. It is part of the reform agenda that if you are having inpatient units to have them colocated with other health services where possible.

It is particularly important in a jurisdiction of this size because we don't actually have the capacity to maintain stand-alone units to everyone, but the drive is to have them colocated with mainstream health services anyway.

DEPUTY CHAIR - Tell me about the mental issues in this community, are they comparable to what is happening in the rest of Australia?

Ms TROMPF - I would have thought they are fairly standard across the country. The 1997 health survey I think indicated that levels of depression in the ACT and some other mental illnesses - I haven't the figures with me - are slightly higher than some other jurisdictions but only marginally so, so the issues for us are the same as for most other jurisdictions, I would think.

DEPUTY CHAIR - I am just getting the sense in Tasmania that our closing down of the Royal Derwent Hospital and trying to integrate people back into the community as much as we can has its downside in that some of those people are being isolated and marginalised and they are coming under a fair bit of pressure in trying to integrate back into society. There is a feeling that maybe we have gone too far with that. Have you any thoughts on that?

Ms TROMPF - I think there are a number of people who voice those arguments and I think there may be something in that. The ACT never had stand-alone psychiatric facilities so we were never in that same situation. We didn't close down facilities as we never had them. We have always had, I guess, more services in the community than perhaps places

like Tasmania but I don't know that for a fact but that may be part of the issue. I think there are some risks in trying to manage people in the community and certainly some of them do get isolated, but I think part of that is that the funding that used to go into stand-alone facilities when they closed down did not necessarily go to the community to the same level to enable people to be supported to remain in the community in some instances. So from our perspective, I think, to maintain people in the community wherever possible is the ideal. It does require putting in a whole range of supports, though, to do that, and I think more and more we need to be looking at how we can do that because putting in those supports should not and cannot be the responsibility of Health on its own because a lot of the supports that are necessary to maintain people in the community are not health-related. They focus on issues around housing, access to employment, access to education, assistance with banking, all those sorts of things that enable people to remain in the community, and we cannot meet all those needs. So from a health perspective we are trying to work more closely with other government agencies and with community organisations, with ways to provide those supports in the community that allow us to focus on the specialist acute mental health services that we need to provide, and to work in partnership with other agencies to provide those other sorts of supports that are required to enable people to stay in the community wherever possible. Does that answer your question?

DEPUTY CHAIR - Yes, thank you.

Mr WILKINSON - Can I take you to the terms of reference please, Linda? The first one is the role of the non-government organisations and other community and business partners in progressing suicide prevention in Tasmania. It is fairly broad, but what role can you see non-government organisations and other community and business partners play?

Ms TROMPF - I think the non-government organisations have a huge role to play, and whether it is lucky or whether we have all worked pretty hard to make it happen, I think in the ACT we have a really strong non-government sector. We have a number of community organisations that work really well together, and also in partnership with government, to run a whole lot of really innovative programs that can assist in suicide prevention. You have talked to Keith and to Irmgard. They are two of our prime providers in the ACT, but we work with a range of others, and they are not all, as I say, health agencies. And, as I said, I think the community organisations are the ones who often have a better understanding of what supports are necessary in a community to work with people.

I think people like Keith's agency have found really creative ways to work with men who are really difficult to engage in services. Another program that is funded through Health but not through Mental Health in the ACT is Menslink. I am not sure whether you know about that program. I have printed off a bit of material that I can leave you with today and that provides a link to their web site. They provide a mentoring program for young men up to the age of 25, they target young men from 12 to about 25, and it has been a really good program because it gets young men engaged in services. It is a bit early to say longer term what the impact of that is, but if we can get the young men engaged and acknowledging where there might be issues and trying to address those issues early, hopefully we can prevent them getting into the chronicity of long-term mental illness and reduce their risk of suicide.

Mr WILKINSON - How are the links made for those young men to come into that organisation?

Ms TROMPF - They work strongly with the education sector, so they take referrals from school counsellors, teachers; they take referrals from parents, so a parent can get onto their web site and say that they would like to get a mentor for their son and they will link in. So they can self-refer. GPs. Our Child and Adolescent Mental Health Services will refer to Menslink and vice versa, so there are quite strong relationships with that group. They have membership on our ACT Suicide Prevention Working Group as well. Those sorts of programs I think are really positive. Mental Illness Education ACT provides programs into the schools as well, and they raise awareness and understanding of mental illness and mental health problems, and where you can go to access services. A lot of supported accommodation programs we fund, and they do significant work as well.

Mr WILKINSON - What about investigating strategies to address the needs of the highest risk group, 25 to 44 years? That seems to be a fairly common Australia-wide phenomenon.

Ms TROMPF - It is, particularly men, that is right. As I say, we have been focusing a bit on the getting-in-early strategy, and hopefully linking men into services before they get to that age group, and hopefully preventing so many getting there. I do not know that anybody has a ready answer to this problem, but again I stress one of the major issues for men is getting them to acknowledge that there is an issue and to actually seek help. Issues for that age group are often around employment or relationship breakdowns and a whole lot of things obviously.

One of the other programs that we are currently investigating in the ACT is a model in New Zealand called Working Well - and I am not sure whether you have heard of that. It is a program that provides mental health promotion into work places and it started off quite small. It is run by an independent non-government organisation. It did have some government funding to kick it off but it is now self-funding because businesses actually pay for them to go in and run their programs and they are getting some really good outcomes. So instead of trying to get men in particular, who are hard to engage, to come to services, they provide things in the workplace, a similar sort of thing to the work Keith does but this is on a broader scale. They actually go into workplaces and provide programs to increase people's understanding of how they might get support.

Mr WILKINSON - Can I take you to the third one, if you have finished with the second one?

Ms TROMPF - The only thing I was about to say was that sometimes their activity is not necessarily called suicide prevention to actually have an impact and I am not sure with Imgard and Keith talked to you about ResNeT. Did they mention it?

Mr WILKINSON - No.

Ms TROMPF - It is a resilience network that has been -

DEPUTY CHAIR - They spoke about resilience but -

Ms TROMPF - There is a network of community organisations, government agencies and whoever wants to be involved in the ACT, who are interested in building resilience in the community. They have run a couple of symposiums that anybody can come to and share thoughts about how we might build some strengths and resilience in the community and support the community in better ways. Those sorts of things can all have an impact.

DEPUTY CHAIR - It is good strategy, isn't it, taking the name 'suicide' out of the strategy and 'resilience' is a word that I think I have seen cropping up in our education system. Paula Wriedt uses that word often. I don't know whether that is the case in education generally in Australia but certainly that seems to be a bit of a focus.

Ms TROMPF - Certainly, I think that goes back to the prevention aspect. If we can work with people to build their capacity to deal with issues that arise so they are more resilient when a crisis occurs in their lives, I think that we have a better chance of reducing suicide numbers and reducing the risk.

DEPUTY CHAIR - I think we only have to look at some of those young men at about 15 or 16 years of age and their relationships. If they have the break up with the girlfriend and they haven't developed those resilient skills, that becomes a huge issue and the be-all and end-all of their existence.

Ms TROMPF - That is right.

DEPUTY CHAIR - There is more to life than that issue but their resilience has not been developed to such an extent that they understand that is an issue that will come and go.

Ms TROMPF - Yes, and that is the sort of resilience work and mental illness education work that happens in the schools. Mind Matters and those sorts of programs actually try to build on young people's self esteem and their capacity to cope with life. That is what it is about: that life is full of ups and downs, that it is not always going to be perfect, that there will be disasters, crises and incidents. That does not mean there is anything wrong with them; that is what life is about, and if they can develop skills and strategies for coping with those events when they come up, then we have a better chance of dealing with a lot of those issues.

DEPUTY CHAIR - A lot of times there is not an understanding of that, is there?

Ms TROMPF - No.

DEPUTY CHAIR - Young people think that life is all beer and skittles; it is about being happy and everything is a lot of fun.

Ms TROMPF - Yes, that is right.

DEPUTY CHAIR - But of course that is not what life is about.

Ms TROMPF - Yes, and if you are living life thinking like that and then something bad happens then you either think it is your fault or that is the end of the world - doom and gloom, what does life hold for me now? So I guess it is actually trying to build that resilience in our young people. I don't know whether previous generations were just

more used to coming up against crises, but I suppose we had more facing us as young people. But certainly it is an issue.

Mr WILKINSON - Can I take you to the third point: 'determine the availability of data collection resources and opportunity for research to identify State-specific trends'. It would seem to me that there is a bit being done on data collection at the moment. Could there be more? If so, in what area?

Ms TROMPF - I think data collection, particularly around suicide, is really difficult. I don't think we have very good data and I think it is hard to get, particularly if you are looking at suicide numbers.

DEPUTY CHAIR - Suicide is such an individual thing.

Ms TROMPF - Yes, and you don't always know. In the ACT - and I am sure it is the same in Tasmania and other jurisdictions - a suicide is only confirmed as a suicide once you have had the coronial inquiry. They are the only ones that are counted, which would seem to me that we are missing a lot. There would be a lot happening that we are not counting, but it is also difficult to know how you count those. Who is going to go back and ask whether the guy who ran off the road and hit a tree was an accident or a suicide? A lot of times people would say that some of those single-car accidents into trees probably are suicides, but you don't really know. I think it is a really difficult one. Even numbers around self-harm, I think, can be difficult. I think it is something that we need to keep looking at, better ways of collecting the data and using it.

DEPUTY CHAIR - Just on that point about driving into trees and that sort of thing, I remember a case years ago where a chap drove straight into the front of one of those trucks that was carting cars. It was a pretty big vehicle and he drove straight into it. On talking to the police about that, they assured me that they have a sense of when there has been a suicide.

Ms TROMPF - I think they have a sense, but you can't ever be sure.

Mr PARKINSON - Unless there is some other indication.

Ms TROMPF - If they have left a note or something; a lot of them don't. There might be something leading up to it.

DEPUTY CHAIR - What data should we be collecting?

Ms TROMPF - Having said that suicide data is difficult to collect, I think it is something we should be collecting but I don't think it is necessarily the data that we should be using to measure the success or otherwise of our interventions, partly because I think it is pretty rubbery data anyway. I think the data that perhaps is useful is the number of admissions to hospital. If we can see those coming down then I think that can tell us whether the programs that we are running are having good outcomes. I think if we are intervening earlier and preventing things then we should actually see a corresponding reduction in people seeking specialist mental health services and needing admission to hospitals.

Mr WILKINSON - What about the role of the media in suicide prevention?

Ms TROMPF - I think we need to continually work with the media on the best way to appropriately report or not report on suicides or attempted suicides, or mental illness more broadly, I guess. I think it is very easy to stigmatise people living with a mental illness. Stories that make the press are usually the ones where there has been violence or some other inappropriate behaviour. In actual fact the majority of people with a mental illness are not violent, but they are always labelled with a mental health problem which leads to violence and inappropriate behaviour.

DEPUTY CHAIR - Half a dozen steps backward, the other day there was that woman who chopped her son's leg off. That was a shocker, wasn't it.

Ms TROMPF - That was terrible, and she obviously had some sort of mental health problem. It is just tragic when those things do occur, and they do occur. I think everybody working in mental health acknowledges that, but certainly that is not typical of the majority of people with a mental illness.

DEPUTY CHAIR - And that is where the media are in a bind, aren't they, in a lot of ways, because they need to report that, horrific as it is.

Ms TROMPF - Yes. I actually think the media handled that one reasonably well. They reported it, which they had to do, but I have not seen any sort of big beat up about it, about that woman or that case in particular. Mind you, I have been avoiding the news a bit lately. It is all too difficult.

DEPUTY CHAIR - Do you monitor that sort of thing in your job? Do you keep an eye on how the media are dealing with the issues?

Ms TROMPF - Yes, and we have on occasions written to the local paper here and the local electronic media and reminded them about their responsibilities in reporting mental health problems. We need to take a bit of care in the way we are reporting so that we do not encourage the stigma or undermine people's confidence. The other thing that the media gets caught up in is reporting when there are problems with services. That again is legitimate reporting provided it does not go to the extent of actually discouraging people from seeking help when they need it. If the services are so undermined and people's confidence in the services is so undermined that they will not seek help, then that is not a good outcome either.

DEPUTY CHAIR - Do you have a good rapport with the media here? Are they cooperative? Do they have an understanding of the issues that you are dealing with?

Ms TROMPF - A number of them are. We have a pretty good relationship with the health reporter with the *Canberra Times*. She is pretty good and tries to provide fairly balanced reporting. They will generally come to us for comments if they are doing stories. I think we have a reasonably good relationship with them. There are times when we do not, obviously, and we do not always agree on what is in the media, but generally speaking they are pretty good.

DEPUTY CHAIR - Do you think they would respond well if you were proactive in your relationship with them and maybe had a bit of a conference with them?

Ms TROMPF - I think that is always useful to be open.

DEPUTY CHAIR - Update them on your issues and that sort of thing?

Ms TROMPF - Yes, I think that is always useful, and is probably something that we could do better, to try to work more closely with them. I am not sure whether any of you are aware that there was a national forum last year or the year before specifically around mental health and working with the media. The forum was set up between mental health organisations and media organisations about how we might better work together, and that was a very effective forum. As far as I am aware it is the only one that has been held, but it is probably worth following up.

DEPUTY CHAIR - Where was that held, Linda?

Ms TROMPF - It was in Brisbane but it was a national forum and certainly there have been developed guidelines that have gone into a lot of the universities where journalists are trained, so there are people going in to work with them in their training to talk about mental health and reporting on mental health issues.

Mr WILKINSON - I wanted to get a hold of those because, as you know, one of the terms of reference is the role of the Tasmanian media in suicide prevention.

Ms TROMPF - Those guidelines for the tertiary sector? I can follow those up for you.

Mr WILKINSON - That would be great, thank you.

Ms TROMPF - They are not operating in all tertiary bodies. Some haven't taken them up but a lot of them have.

Mr WILKINSON - And you think they are worthwhile?

Ms TROMPF - I think it is a really good idea. We find that again getting in early when they are just doing their training is a good opportunity to try to shape the way they think about mental health and the way they report it.

Mr WILKINSON - If you were able to design your own suicide prevention package for the ACT, what would you be doing?

Ms TROMPF - Well, you are actually a day too early because we have developed an ACT suicide prevention plan -

Mr WILKINSON - Are you happy with that?

Ms TROMPF - I am happy with most of what is in it, yes.

Mr WILKINSON - But it has to be approved and hopefully we will get a copy of that to look at.

Ms TROMPF - You will get a copy of that. I actually have a copy here but it will be embargoed until tomorrow when the minister will launch it. I think there is some really good stuff in there and, as we have talked about already today, it promotes working in collaboration with all government agencies and the community and particularly focusing on the early end. But we also have actions in there to address the specific needs of high-risk groups and put better things in place for people who have expressed suicidal thoughts or who have had suicide attempts.

I think we need to have the whole spectrum covered. We need to get in early where we can; we need to work to build resilience in the community and within individuals. I think we need to use the GPs better. GPs are often the first port of call for anybody with any issues so we need to continue to build the capacity with GPs to actually work with people with a whole range of mental health problems. To do that I think we not only need to build their capacity, but those of us working in specialist mental health services also need to be prepared to respond when the GPs call on us. I think we are getting better at doing that but I think there is still work to do for specialist mental health services to work more closely with GPs.

Mr WILKINSON - This can be in camera if you want it to be. I am just prefacing the question by saying that. Do you believe that the report that is going to be presented tomorrow can be improved in any way and, if so, in which ways? If your answer is yes, do you want it in camera?

Ms TROMPF - Since I had a fair bit of input into it - I mean, I think anything can be improved! It is a fairly comprehensive document and if we can do all the things that we outlined in there that we want to do I think we can make a significant difference in reducing the risk of suicide in the ACT. If you are asking me if it is a perfect document then obviously it is not. There is a lot of work still to be done but we are pretty happy with what is in there and, as I say, if we can do everything that is in there I think we will be doing pretty well.

Mr WILKINSON - Do you know what is going on in Tasmania at the moment?

Ms TROMPF - Only very superficially. I have had contact with Kieren. I sit on the National Mental Health Working Group housing and homelessness task force. Kieren's area is mostly around housing and housing issues relating to mental illness.

Mr WILKINSON - Do you think there is any benefit in offering a scholarship to a person who works in suicidology. There is a female who works with Wendy Quinn - her name escapes me at the moment - who is just starting out in the area. She has been through university; I think she did a law degree. She is working in suicidology. Do you think there is any benefit in getting the Government or somebody to sponsor a suicide scholarship to work with, say, Diego De Leo for a period of six months or two semesters or something like that?

Ms TROMPF - I think anything like that can really only be of benefit - to work with somebody who specialises in those sorts of issues, to gain understanding and knowledge about how we might better progress. I think anything we can do to improve our understanding is worth doing. I think it is an area in which there is still lots of research work that needs to be done.

DEPUTY CHAIR - Is your suicide plan going to make any difference to the $5.1 million allocation that you have now?

Ms TROMPF - Not immediately because it is unfunded at this stage - so a lot of the actions we feel we can do within existing resources. While it might not make a difference to the amount, it may make a difference in distribution of services, I guess. A lot of the things, such as Keith's Oz Help program and the VYNE program, are things that we have already put funding into pre-empting what is in here. We have some other bids in the current budget process but there have been no decisions around those as yet.

DEPUTY CHAIR - Are those 20 community organisations that you are working with all of the calibre of Keith's organisation? How are they faring in the marketplace in the work they are doing? Are some not performing at the level and according to the plan?

Ms TROMPF - Some are stronger than others obviously. Keith's organisation is very professional. They have business acumen and all those sorts of strengths that they can call on. Some of our community organisations are very small and some are peer organisations, so we fund a mental health consumer network. They are all mental health consumers on that board. They need a lot more support from us and others than an organisation like Oz Help. I think there is a place for them. There is no way we would de-fund the consumer network because they do extremely good work and provide a range of services for consumers. They also provide us with an effective link to consumers.

DEPUTY CHAIR - This is not going to be a shake-up for the community organisations?

Ms TROMPF - It is not intended to be a shake-up for our community organisations, no. It is an assessment - those organisations are not all targeted specifically at suicide prevention. A lot of the work they do will have an effect of intervening before people get to that risk stage, we hope. This plan isn't specifically around what is happening with those community organisations, although there is a part for them to play in it obviously.

DEPUTY CHAIR - About volunteers in this field: of these organisations that you are dealing with here, is that a strong factor in the support that goes into the people who have the mental health issues? Is volunteerism a strong focal issue?

Ms TROMPF - There are some volunteers - and probably a lot that we don't know about. The organisations that we fund to provide that level of support do not generally use volunteers, except for a couple of groups. One in particular is called Connections Volunteers and we fund them to link mental health consumers with volunteer mentors who might assist them with daily living things such as going to the bank, driving them to appointments or helping them with job applications.

But a large proportion of the work that we fund them for is actually delivered by paid staff.

DEPUTY CHAIR - Okay.

Mr WILKINSON - The only other matter of note in the terms of reference is the opportunities in the workplace to promote wellness and suicide prevention. We have probably gone through that - Keith has gone through that along with Irmgard.

Ms TROMPF - Yes, that's right.

Mr WILKINSON - They are the terms of reference along with the catch-all of 'any other relevant matters'. Is there anything else that we haven't asked yet that you believe would be of assistance to us to give us your information about?

Ms TROMPF - I think we have talked about the majority things and, as you say, things in the workplace as well as the working well model. Within ACT health itself - and I am not sure what health is like in Tasmania - here we have quite high levels of claims for stress-related absenteeism -

Mr WILKINSON - There was workers compensation granted, but in the last amendment we had stress went out of the compensable matters.

Ms TROMPF - It hasn't gone out of ours, so it is still there.

Ms TROMPF - Within Health we have just completed a pilot project around health - promoting initiatives, so that is looking at health promotion more broadly but it also includes looking after mental health and reinforcing the link between good physical health and good mental health. So we are doing a fair bit of work there.

Mr WILKINSON - Do you find there is a link between them? Doug's background is in law, as is mine. I used to do a lot of criminal work and I found that a lot of people who had obvious mental problems were all right if you could focus them - if they were focused on anything really. Some of them were fairly sport-oriented, I suppose, and when they were heavily involved in their sport they were okay, but as soon as they fell off that they then started to revert to drugs and then had problems. I will not name them but I know about four or five people who immediately spring to mind who did exactly that. That had a certain resonance with me, I suppose, that if you got the physical health all right then hopefully the mental health runs alongside.

Ms TROMPF - There is certainly a fair bit in the research literature over recent years about the strong links between good physical health and good mental health and if you look after the one then the other will follow. Even for people who have a diagnosed mental illness if they are looking after their physical health they will be better able to manage their diagnosed mental illness as well, so there is certainly strong evidence to support that.

Mr WILKINSON - Do you say that in the booklet that you are presenting tomorrow?

Ms TROMPF - There is a bit of it in the suicide prevention plan. There is more of that though in our mental health promotion prevention and early intervention plan which is still in draft form, but there is a fair bit in there about the links between physical and mental health.

Mr WILKINSON - When will that be coming down?

Ms TROMPF - As I say, that is still in draft and needs to go to Cabinet. We are hoping to have that out early in the new year. I could send you a copy of an earlier draft.

Mr WILKINSON - That would be terrific, if you wouldn't mind.

Ms TROMPF - That builds on or is guided by the National Mental Health Promotion and Prevention Plan. The stuff that we are doing is coming out of the national agenda as well.

Mr WILKINSON - That would be beaut thanks, if you wouldn't mind.

DEPUTY CHAIR - While on that subject, I am greatly in favour of sport and physical education in our education system and that is what I found with sport in particular. The main focus is that this resilience comes through when you are in a sporting team. You learn about injuries, you learn about what happens if you are in form and if you are not in form. Also if you are not resilient in dealing with injuries, it is a tough old time because your -

Mr WILKINSON - You have some doubts too and you don't do too well sometimes.

DEPUTY CHAIR - If you are good at basketball or whatever and you do an ankle or a finger and you can't play for a while that is when your focus is thrown skew-whiff. If that is all you have in your life, then you are in turmoil. What do you do with your life? What happens? But if you have built that resilience and learned that injuries are part of it, you have to work on the program to get through it and you will be back to where you were before.

Ms TROMPF - But I also think you need to work on the fact that there needs to be a balance.

DEPUTY CHAIR - I am only talking about the sport aspect of it.

Ms TROMPF - I think for a lot of people, particularly people with a diagnosed mental illness, but even those without, there is too much of an emphasis these days on elite sport. Really, what we are talking about is anything that can get you out and moving and doing things that look after your physical health. It does not have to be at the elite level; it can be just a walk around the lake with your dog or doing something with the kids.

Mr WILKINSON - Are you saying that because there is such a focus on elite sports that people who are doing the recreational-type activities don't have the feedback that the people who are involved with the elite sports have? In other words, the elite sportspeople are put up on a pedestal but the recreational person who does it just to feel good and to assist others in feeling good are not put up on the same type of pedestal and therefore they don't have that sense of achievement.

Ms TROMPF - No. I think that sometimes there is a lot of emphasis on elite sport so that if you are not good enough to play elite sport then there is a tendency not to do anything. The message we are trying to push is that it doesn't have to be an elite sport; anything you do that builds on your physical health is good so that people don't feel that if they are

not good enough to play in the A grade basketball they don't do anything. It is okay for them to go and do whatever they feel comfortable doing. Anything is positive. Again, particularly in the workplace, it is looking after that work-life balance, and which a lot of us aren't very good at.

Laughter.

DEPUTY CHAIR - It is drawing people into the outdoors, into the physical activity, away from sitting in front of computers or watching TV. That sedentary sort of stuff is not a good mix.

Ms TROMPF - That is why trying to get some things into the workplace helps because it gets people engaged and you have them as a captive audience. I am sure it happens in workplaces in Tasmania as well. We have been running some pilates and yoga classes at lunchtime at work. We have people who come in to do shoulder and neck massages for people in the workplace. You pay for it but if it's there people often will participate. They don't have to go out and look for it and get themselves organised; it actually comes to them. It can make a huge difference.

DEPUTY CHAIR - It was a good argument for us to put in a gym.

Laughter.

DEPUTY CHAIR - In conclusion, is there anything you would like to put to us, anything we should be focusing on or anything you can say to us as we head towards building our recommendations for the State Government? Is there anything you would like to highlight now?

Ms TROMPF - It is hard to do, I think, because it takes longer before you see results but from my perspective we need to be looking at the front end. The recommendations probably would should focus on the promotion-prevention-early intervention end. If we can get in that end, if we can get to having programs that build community resilience and community support, and community identity I guess, and it is not always an easy road to sell because it is hard to see short-term gains; you are going to get your gains further down. But I think to see some recommendations around that end, as well as what we do to provide services to identify at-risk groups, the men that you are talking about in the 25 to 40-year age group to look at programs that might meet their needs. Workplace programs I think are particularly useful, particularly when you are trying to reach men, and you are building community capacity to assist people who have made suicide attempts. If they have been in hospital and then they are going back out into the community, to build capacity in the community to support those people through particularly that early period after discharge which is an identified high-risk period for them, so programs in that sort of area. I don't know if that helps.

Mr WILKINSON - Yes, thank you. And you are kindly going to supply us with the -

Ms TROMPF - Definitely in camera and let it be hidden. I brought a fair bit of stuff, and you can take it or not take it, for a directory of our services. These are the sorts of materials that we give to clients accessing our services. This is a really excellent package called Paths of Healing that we give to consumers and carers accessing our services. It

provides them with a whole list of contacts and services that they can access once they leave our service, as well as what happens internally. This was developed largely in consultation - there was a lot of input from carers and consumers into developing this pack that everybody is really happy with.

This is our health action plan, the secret suicide prevention plan and what I have left out - and I can't believe I have left it out - is our mental health strategy and actual plan but I will send you a copy of that.

This is the secret one, and these I think are useful too. We only put these out this year. This is Helping a Friend or Colleague. It provides some little hints if you have a friend or a work colleague who has a mental illness as to how you might work with them in a non-stigmatising fashion. This is a little flip chart for people again who might have friends or colleagues. You can just put it on the fridge. These are obviously ACT contacts but again this was developed with carers and they are very happy with these little packs that provide them with ready access information for how they might get help when they need it. I will leave you with all of that.

Mr WILKINSON - Thank you very much.

Ms TROMPF - Do you want the stuff on Menslink?

DEPUTY CHAIR - We are developing men's sheds in Tasmania. Is that the same thing? Do you use that terminology here?

Ms TROMPF - 'Men's sheds' I don't know what they are.

DEPUTY CHAIR - Okay. We have a couple up north. Men's sheds - you go to a shed -

Ms TROMPF - No, this is working with young men in the community. They don't actually go into a facility; they work within the community.

DEPUTY CHAIR - Okay. It is for men who haven't got a shed.

Laughter.

Ms TROMPF - So they don't actually reside there?

DEPUTY CHAIR - Yes, a shed out the back.

Ms TROMPF - I haven't heard that expression.

DEPUTY CHAIR - We have the Tresca Community Centre at Exeter, in my electorate, and they have developed the Men's Shed. It is a cottage that was out the back and it is where men meet, talk, hang out and do things together, which is something that is missing in their lives for a lot of them, that contact with other men.

Ms TROMPF - Menslink certainly does things like that. They might do woodwork and things with the guys, but I haven't heard it called 'men's sheds'.

DEPUTY CHAIR - Thank you very much for your time today, Linda. We appreciate the expertise that you have passed on to us today.

Ms TROMPF - I hope it has been helpful. You will let me know if there anything we have left out?

DEPUTY CHAIR - You were a good contact for us to have. When we develop our recommendations we will let you know where it is available to view, or a copy might come to you. We appreciate your time today.

THE WITNESS WITHDREW.