PUBLIC

THE PARLIAMENTARY JOINT SELECT COMMITTEE ON PREVENTATIVE HEALTH CARE MET IN COMMITTEE ROOM 1, PARLIAMENT HOUSE, HOBART, ON MONDAY 25 MAY 2015.

Mr MARK CORRIGAN, TASBUILD, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR (Ms Forrest) - Thank you, Mark. Roger Jaensch is on the phone here. He is on mute because he is driving. We now have a quorum now with Roger.

Thank you for joining us, Mark. Before we start, this is sworn evidence you are giving so I want you to take the Statutory Declaration or the Oath if you do not mind.

The committee is a public hearing. Everything you say is recorded on *Hansard* and will form part of the public record. You are covered by parliamentary privilege while you are in front of the committee but that does not extend once you step outside and speak to anybody else about it.

If there is anything you want to give us of a confidential nature, you can make that request to the committee and we will consider it, otherwise it is all public.

Do you have any questions before we start? We have received your submission and read through that and know that it is fairly narrowly focused on one aspect of it. We did have some evidence from other witnesses about visual air quality as well in terms of chronic illness.

If you would like to speak to your submission, and then we will have other questions from the members.

Give us a little about your background. That would be helpful.

Mr CORRIGAN - My name is Mark Corrigan. I have been in Tasmania for approximately eight years. My wife has recently been sick and we built a home in the Snug Tiers area. She has chronic exposure to substances like chemicals. When we built the home, we tried to investigate the healthiest way we could live.

On living in Hobart, we recognised a huge problem that no-one seems to want to address. That is that it is a wood-smoking area from a number of sources - incinerators, chimneys, burn-offs. It seems to be non-stop. I have been to politicians, council members, anyone who wants to talk to me, and no-one seems to want to do anything about it. No-one seems to be aware of health consequences of wood smoke. People seem to be oblivious. The whole state.

We have looked to other states and other countries to see what they can do to help people here recognise that we have an issue.

Can I go into my statement?

CHAIR - Yes, that is fine.

Mr CORRIGAN - I am here today to speak on an issue that most Tasmanians do not want to speak about. That of wood smoke. I have submitted a New South Wales Wood Smoke Control Report of 2011. This states that if no action is taken to reduce smoke, it will cost the New South Wales health budget an extra $8 billion by 2030.

Passive wood-smoking is more toxic and lethal than passive tobacco-smoking. When you burn wood, it releases a witch's brew of carcinogenics. Chemicals such as benzine, a known carcinogen; bromaldehyde, known carcinogen; carbon monoxide; nitrate oxide; PAH; VOCs and particulate matter 2.5. Particulate matter 2.5 has been described as the new asbestos of the twenty-first century. PM 2.5 acts like a gas and travels into organs and the bloodstream. Health authorities warn there is no safe level of exposure to PM 2.5.

There are a number of sources of wood smoke in Tasmania. Wood heaters and stoves, burn-offs by Parks, burn-offs by Forestry, private burn-offs, council burn-offs, agricultural burn-offs, backyard burns, and burning of land-clearing for development and incinerators. As you are aware, the vast majority of councils still allow burning of rubbish of waste by incineration with land blocks over 2 000 square metres. Our council even explains how to construct an incinerator in the local by-laws.

Where does all this smoke go? Not off to the moon, that's for sure. We as a community breathe it in and it exists inside a cloud of toxic smoke. With the example of a wood heater, 70 to 80 per cent of the smoke re-enters your property or that of your neighbours. If you do not have a wood heater, you are probably breathing in your neighbour's wood smoke. This is passive smoking for the rest of the community.

In regard to children and wood smoke: children's lungs are still developing on to the age of 17 to 18 years. A child has twice the air intake of that of an adult, and look what they are breathing in - wood smoke for eight months of the year. The New South Wales chief medical officer, Dr Kerry Chance, says wood heaters are so detrimental to health she supports banning or phasing them out. Michelle Goldman, chief executive officer of Asthma Australia New South Wales, states 'one wood heater can emit as much pollution in one year as 370 diesel cars travelling at 20 000 kilometres each per year.' Dr James Marcos, respiratory specialist, Long Foundation spokesman of Launceston, states 'wood heaters should be banned from urban areas. The wood heater buyback program from Launceston reduced deaths in winter from respiratory disease by 28 per cent and cardiovascular disease by 20 per cent.' This massive reduction in chronic illness cannot be ignored by our leaders or medical professions. Wood-smoke reduction and minimisation is a key preventative health measure in this state.

Society has cracked down on passive smoking, yet a single wood heater burning 10 kilograms of wood - that is approximately one evening's worth of heating - emits 100 grams of particulate matter PM 2.5, which is equal to the smoke of 5 000 cigarettes. The CSIRO study conducted in Geeveston in Tasmania in 2012 found that between 70 and 80 per cent of the pollution was from domestic wood heaters. The EPA's annual report last year states 'New Norfolk has 50 days over the national standard set for wood smoke.' There is limited awareness that wood smoke and air pollution increases the risk of heart attacks, strokes, cancer, and lung disease.

The toxic chemicals known as PAH have been linked with genetic damage in babies and reducing the IQ levels in children. Five studies by the UK's King's College have concluded that wood-smoke exposure to children and babies is linked to autism.

What can we do about reducing wood smoke? First, let us stop mindless burning of rubbish and waste. Individuals burning green waste and use of incinerators has to stop. Why in 2015 are people still installing wood heaters in new houses? Well-insulated new homes get hot with wood heaters because it is hard to regulate the temperature causing people to shut them down and letting the wood heaters create more smoke.

There are alternatives to heating your home. Facing north and well-insulated homes need little heat. Electric heat pumps are twice as efficient as 10 years ago. Gas is available in city areas. Even pellet fires are an alternative to wood heaters. These pellet fires take the human error of lighting a fire and maintaining it. The loading and controlling is done electronically, hence less pollution and more efficiency in the burning of dry Tasmanian pellets. You don't have to reinvent a wheel here.

The world has solutions from colder countries than Tasmania. Montreal in Canada has banned the installation of wood heaters and is phasing out existing wood heaters by 2020. Montreal takes wood smoke seriously.

As for the state that claims to be clean and green, here we have some of the worst health outcomes in Australia. We have the highest rate of heart disease, the highest rate of lung disease, the highest rate of stroke, and the highest rate of asthma. Tasmania currently has approximately 65 000 registered asthma sufferers. If the New South Wales report states it will cost an extra $8 billion in 15 years for New South Wales, what will be the cost for Tasmania? Tasmania has the highest rate of wood heater ownership in Australia. While councils have the responsibility for air quality, nothing gets done. Council's usual answer is a lack of funds and resources. The EPA just monitors smoke. We require action on this public health issue that affects all Tasmanians.

Local by-laws state that smoke should not be a nuisance or harmful to health. It is both. I have only two questions: why do individuals who burn wood, rubbish and waste, who pollute the air, have more right than I do to breathe fresh air? And why are individuals allowed to use our sky as a sewer?

CHAIR - Thanks, Mark. A couple of points of clarification and then we will go to questions. You talked about the cost to New South Wales of $8 billion. Is that in health costs or other costs as well?

Mr CORRIGAN - In health costs.

CHAIR - Just in health costs, you're saying?

Mr CORRIGAN - Yes. That is if they do nothing. If they do nothing and it stays the same, that's what it is going to cost them. There is a breakdown in phases in the actual document.

CHAIR - Yes.

Mr CORRIGAN - Table 26 is a breakdown of a combination of solutions that might be phasing them out and stopping them from being installed.

CHAIR - You mentioned pellet heaters. It seems to me - and probably other evidence we have heard – that it is people who experience the negative social determinants of poor health like poverty, living in remote locations, poor education, who are the people who tend to rely more on this type of heating because it is seen as cheap. Even though it is not cheap in many ways, it is still probably cheaper for them. It is a bit of a double-edged sword in that regard. Those people struggle to keep warm in the winter because of all their other circumstances. Do you see there is a way to move from using a wood heater to perhaps a pellet heater, which uses the same product effectively, in a different form?

Mr CORRIGAN - As with most issues, there is never one thing that is going to solve the problem. We are still building houses in this state where the priority seems to be being parallel with the road instead of facing north. We cannot readjust buildings that are already built, but we can well insulate buildings.

Pellet fires are an alternative because they take that human error element out of someone loading up a wood heater. It is all done electronically. You cannot shove plastic in there. You cannot put anything in there at all. It is done. It is out of their control. That is where the problem arises of causing smoke – it is from human error in people loading wood heaters.

CHAIR - Are they less smoke-producing than the wood?

Mr CORRIGAN - Yes, and they are more efficient. For one tonne of firewood, I think the equivalent is one kilo of pellets. Pellets are made here in Tasmania. I am not pushing them as an alternative, but they are an alternative. They are dry. They are efficient, and it is the equivalent of being a furnace. When you drop those pellets in, you are not able as an individual to put those pellets into the fire. They go via a hopper and the furnace starts, and then they will automatically go in electronically. It takes the human error out of stacking wood. It is just purely a one-kilo bag, you put it into the hopper, and off it goes. It is like an electric heat pump with a flame. You can thermostatically control it by remote control.

Ms O'CONNOR - Hi, Mark. You talked in your opening statement about your wife's health. If it is not an intrusion on your privacy, could you tell us a little bit about your wife's health condition and how air quality affects her individually?

Mr CORRIGAN - My wife is sensitive to chemicals so we built a house bearing that in mind, and we could not use anything like formaldehyde or glues. The whole structure of the house internally is allowed to breathe. It is not wrapped in plastics. We used materials that were sympathetic and without chemicals or glues. When we are in our home environment, the home actually breathes. When it is hot, that air is allowed to expand outside. Most houses these days are wrapped in plastic. For example, what I was speaking about before, when people put a wood heater in, because houses now are so well insulated, they find it hard to regulate the temperature on the wood heater. They tend to shut down the wood heater, which then causes smoke.

Because of my wife's condition, we have tried to make our own environment as healthy as we can. The only problem we have is that as soon as we step outside the door, there is wood smoke and it is seeping in through the house. These particle matters, no matter how air tight your building is, still come into your house. And we have a pretty air tight building.

Ms O'CONNOR - How does the air quality affect your wife, who has a sensitivity as it is?

Mr CORRIGAN - She will start feeling wheezy and she will start coughing, and she will get irritation to the eyes if it is bad smoke. She does not suffer from asthma, but it does affect her.

Ms O'CONNOR - Do you notice this effect particularly in winter? Are there times of year when it is more obvious that there is an effect on your wife?

Mr CORRIGAN - This time of year is the worst time, but where we live we have burning all year round. Nothing stops it. Yesterday from 8 o'clock we had fires on our street, down the bottom of the road. I counted 12 fires that were started, some by incinerators. We have a big view. We can see quite a bit of land. We are not penned in. I can see fires at Bruny Island, we can incinerators going. The first incinerators started at 8.30 on Sunday morning.

Ms O'CONNOR - The sources of wood smoke that are affecting you and your wife are wood heaters, back yard burns, forestry burns -

Mr CORRIGAN - The whole lot. Smoke is smoke.

Ms O'CONNOR - In your living environment, it is there pretty much all the time?

Mr CORRIGAN - Yes, even in permit time, people still burn off. I can go outside my house and people are burning in the middle of the night, burning plastics and rubbish, because they are not on the rubbish run. They decide to burn rubbish at night time, and you can smell it in the air.

Ms O'CONNOR - Is it enough to put you off living where you live, or living in Tasmania?

Mr CORRIGAN - Yes. Going to other climates where it is warmer and not having this problem. It is a problem world-wide. It is also a problem in New South Wales. If you go to the colder climates, the Blue Mountains, Armidale, which were spoken about in the report, they still have the same issues that we do here.

The answer is to move to a warmer climate and hopefully you do not have that use of wood heaters. It is chronic exposure. We are getting it virtually from March to October with wood heaters.

If you were to take that out of the equation and then you only had the single occurrence of a burn-off, maybe forestry or parks, that is not going to impact so much on your life. When you have chronic exposure to wood smoke, which you have in this state for

virtually eight or nine months of the year - that is chronic exposure. That is when you are breathing in the smoke.

Mr VALENTINE - A couple of things, Mark. In your covering email to the submission, or at least the attachment you have provided - the economic case for wood smoke control - you mention studies have shown passive wood smoking is more toxic than passive cigarette smoking. I am wondering whether the studies you mentioned today - are they the ones that have this information?

Mr CORRIGAN - There is plenty of information. I can give you those studies if you require.

Mr VALENTINE - No. I was just wondering if you can give us the information on that.

Mr CORRIGAN - I can give you plenty of information, yes. A lot of this information is available on the internet, from reputable sources.

Mr VALENTINE - Okay, it was that particular one that was of interest.

Mr CORRIGAN - There are so many studies. I could talk all day about what studies there are - to get across the broad spectrum of what is available is mind blowing.

Mr VALENTINE - No, that is okay. Pellet heaters - you are saying if they are burnt properly -

Mr CORRIGAN - Well, when you say they burn properly - they tend to burn properly because we are taking out the person out of the equation.

Mr VALENTINE - That is right. With the information you have, is it possible to have a wood heater that burns correctly without giving off -

Mr CORRIGAN - That is a good point. Okay. The problem from my point of view -

Mr VALENTINE - I realise you are not an expert. I am asking whether you are aware or not.

Mr CORRIGAN - No, I am not an expert. Testing any appliance in a perfect environment is fraught with hazards. That appliance is then given to a human being and they will put in whatever they want, or whatever they have.

I have lived in a house with a wood heater in Hobart, and I can tell you, it is very hard to get wood - and very hard to get dry wood. I understand the problems people experience with wood heaters, I have been there myself and done it. For whatever reason, it is very hard to get dry wood in this state and that is why the pellet fires take that element out. Where they say people can be trusted to put dry wood in, they can't be trusted to put dry wood in. They can't be trusted to put plastics in because they do. That is the nature of the environment, what we smell. If we can take the human error out where there is no error, as with a pellet fire or electric heat pump, it is talking about eliminating a risk and taking that control out of people's hands to have a better environment, as you would do with an OH&S matter.

Mr VALENTINE - You said something like a kilogram of pellets is equal to a tonne of wood. Would that be right, or is it 10 kilograms?

Mr CORRIGAN - Yes. There was an article last week in the *Sunday Tasmanian* by Pellet Fires Tasmania themselves which talked about the equation of wood - again, it is very hard to get some statistics on it - but the comparison of wood to pellets. I believe it is roughly 1:4 -

Mr VALENTINE - I will look it up.

Mr CORRIGAN - They are making these pellets here in Tasmania. They have started a processing plant in Glenorchy. Originally they were buying them, and still are buying these products from other countries, New Zealand mainly, but now New Zealand only makes up a small percentage as a top-up. I believe, from talking to Pellet Fires themselves, they cannot keep up with demand. What a great growth industry for this state to have. Okay, the pellet fires are not made here. Where we cannot make stuff, let us pick the brains from the world because there are a lot colder places than here, and use that technology. If we can process the pellets here and get this up as an industry, surely it will be a win-win for everyone in the community.

Mr VALENTINE - And reduce the overall smoke load.

Mr CORRIGAN - Of course.

CHAIR - And create some jobs.

Mr CORRIGAN - That is true, yes.

Mrs TAYLOR - Thank you for talking about pellet fires because it is really -

Mr CORRIGAN - It's an option.

Mrs TAYLOR - It's an option, yes. The only difficulty is that people have to get rid of their wood fire and buy a pellet fire, which in itself is a capital investment.

Mr CORRIGAN - It is. They may need help in doing that but we have to look at the overall equation of the health costs to the environment. We have 20 per cent of people still smoking here in Tasmania. Those 20 per cent of people are not going to care about wood heaters too much, are they, if they have a fag hanging out of their mouth?

Mrs TAYLOR - Mark, in the last year or two I have been on a couple of trips to Germany and Austria, and they are tackling this in a couple of ways. Most of them still have fires with a wood product of some kind, either pellets or wood chips, which is more likely, not so much logs as we do. They have tackled this in a way of saying we are never going to stop people necessarily, as you say, changing to gas or electricity so they have done a fair amount of work in two ways. One is educating people on how to build fires. In one of the places I visited they have classes on a Tuesday morning for ordinary people to come and someone will show them how to build a fire and how to keep it going properly. Again, that does not take human error out of it. They have also done a lot of work - and I

am wondering how much you know about that - on chimneys and taking particulates out at the chimney end. That is by regulation so if you want to have a wood fire you have to put in these systems that at least take out the particulates but in some cases also do scrubbing of chemicals and stuff that comes out. Is that an alternative? The technology, as you say, is already there.

Mr CORRIGAN - No, it is. I have spoken to many people from Germany and from the Scandinavian countries, where they see wood as an important resource. When they are hearing about states like Tasmania, they are almost laughing at the ability of people to shove big bits of timber into fires when they could be more efficient in that use. I see we need to eliminate the smoke from entering the atmosphere. Anything we can do personally to stop the smoke entering the atmosphere is what we need to do. I am more in favour of gas, electricity and other forms of heating. Even before we get to the issue of heating a house, let us look at insulation. I have rented here in Tasmania, all over this state, and I have never seen such bad quality rental properties to stay in. I'm not talking about the lower end. I'm talking about the high end. It is just disgraceful. Now, why can't we look at maybe giving people incentives, especially landlords, that are mostly tax-deductible, to help them supply decent accommodation for people, take out wood heaters and maybe install heat pumps? It is not until you probably have a heat pump that you realise, especially for busy people, how effective they are. Who wants to be coming in at 5o'clock or 6 o'clock at night and lighting up a wood heater? All those health effects it has on you, your family and the broader community - a lot of people don't know about the effects it has on the broader community. If you are living in a house without a wood heater and your next-door neighbour has one, you are passive smoking. That is it. End of story.

There is no such thing as good wood smoke. No matter who lights it, who does it, it's all smoke. That's what the EPA will tell you here in Tasmania and any other state. So we have to eliminate that, full stop. There is no easy answer, to say 'Let's get cleaner wood', 'Let's do this or that'. Let's get it at the source and say, 'What can we do better for us, our family and the community?'. Because it's going to save us at the end. We can build as many hospitals as we want, but if people are not breathing clean air, drinking fresh water and eating clean food, what is the point?

Mrs TAYLOR - Is there a combination we could do, say, of education plus regulation that would actually address it without people having to necessarily not do what they want to do and that is have wood fires?

Mr CORRIGAN - We need to take a step back and hit it at the source more. What you are suggesting is let them carry on burning and we may be able to fix up their chimney. We need to say, no, if this is a problem, which I am stating it is, let's attack it at the source. Everything else is really just fluffing around the edges. That is what it is. We need to educate people, let them know they are harming other people in their community and themselves.

Mrs TAYLOR - Do gas fires also produce emissions, even though it's not wood ?

Mr CORRIGAN - Yes. There are emissions internally from - this is not my field of expertise - gas that you would obviously have to be careful of.

Ms O'CONNOR - But there are no particulate emissions from gas, are there?

Mr CORRIGAN - No, not particularly. But you do have to watch indoor air quality as well where you haven't got gas. So you do need to be very careful. There tends to be, especially on gas stoves, a lot of leakage.

CHAIR - One of the things we have been hearing about from different witnesses on a range of community health matters is the issue of planning, and planning for open spaces so people can easily exercise and things like that.

Mr CORRIGAN - Yes.

CHAIR - It seems to me that what you have been suggesting is that, though that's another aspect of that whole planning reform, which is going on at the moment with the single planning scheme that the Government is working toward, is the requirement to perhaps require houses to be built facing north or to capture the sun and things like that. Do you think that's a realistic proposal and should we progress that way?

Mr CORRIGAN - Look, it just makes sense. Why would you want to build a house in a ditch, south-facing? Why not -

CHAIR - People come from the mainland - I have seen people do this. They come from the big island of the north where there is lots of sun, and they have big verandas to keep the sun out. They come here, and think, 'I've got a lovely view, but gosh, it is going to get hot.' So they build it down the other side of the hill and they build big verandas so the sun cannot get in. Those people think they are doing the right thing because they haven't realised that things are a bit different here in Tassie.

Mr CORRIGAN - Again, that probably goes to the issue of education. How many times do you see these shows where people are talking about buying new homes? How many times do you hear one person say, 'Which way is this facing?' Never. I have never heard someone say, 'Which aspect? Where does the sun come in? Does the sun come in from the east or the west?' So in the morning you might not be able to see the sun for obstructions, but from an individual point of view, you want to maximise the amount of sunlight and energy coming into your own home that you don't have to produce artificially by heat. I live in a relatively small house because there is only two of us, and we maximise the amount of sunlight coming into our place by double-glazing and north-facing windows.

CHAIR - Does this need regulation or education?

Mr CORRIGAN - I think it needs education. We cannot have a situation where people - and I have seen it so many times - move into what they think are nice properties, and then realise that for nine months of the year they do not see sunlight.

CHAIR - So it is both - education and -

Mr CORRIGAN - Yes, you would make regulations on new buildings. We seem to be building homes in this state that are more parallel with the street than the aspect. If you

were able to rotate your building 15 degrees one way, the amount of heat efficiency you could gain in your building would be massive. But we do not do it.

Mr JAENSCH - This issue of planning - there are a couple of different levels in that. Some of it may be about building codes and energy ratings, which might be a more profitable area to explore than planning, and talking about not building on south facing slopes. I have just spent time listening to you, driving through hilly terrain carpeted with houses on all fronts. In terms of building codes, and energy efficiency in building codes for residential properties, do you have any comment on what we have now and other places that are doing it better?

Mr CORRIGAN - In New Zealand they looked at the wood smoke problem as more of an holistic problem, involving insulation and home design as well as wood heaters. They didn't just deal with the wood heater, they looked at other issues in existing homes - air leakages, windows, and insulation in the roof, ceiling and floor. They tried to come at it from a number of angles. As I said before, I don't think there is one thing that is going to fix this issue. Without trying to handball this issue - because it is a major public health issue - there are other steps we can take to make this a lot more convenient for people.

We have the burning of waste. Why people are burning green waste is beyond me, but they do. In the home, yes, we have problems with wood heaters. How can we improve the internal living environment for people? We can help them insulate their home. We can educate them about what they are doing at the moment. We cannot undo an already built house, can we? That is the problem we have. It is all very well saying from now on we are going to do this and this and this, but we already have half a million homes in Tasmania that we have to retro-fit, and that is not easy. Not very easy at all.

Mr VALENTINE - Not a cheap exercise.

Mr CORRIGAN - No.

Ms O'CONNOR - Mark, in the previous term of government we invested in free energy efficiency upgrades for low income households. There were about 9 500 low income households, community groups and small businesses that had that energy efficiency upgrade. Would you like to see a program like that standardised and rolled out, particularly to low income households across Tasmania, whether they are in public or private rental or even own their own homes?

Mr CORRIGAN - It should not make any difference who they are or where they are. We should be trying to assist people and educate people. I spoke to a number of low income earners and they had assessments done by this department - they came out and helped them. They were just astonished at how they were able to save heating costs and improve their internal living environment with some simple steps.

CHAIR - Like door snakes.

Mr CORRIGAN - Exactly right. Some of these things seem very obvious to the average person, but people either don't have the time or don't really think about it. There were some simple, basic things they could do themselves, without getting contractors in, to fix up the conditions in their own homes.

Ms O'CONNOR - Would you agree that is very a useful investment of public funds?

Mr CORRIGAN - Yes, I would. It is a no brainer.

CHAIR - Thanks, Mark. Is there anything you want to add in closing? Thank you for your submission, it has been helpful.

Mr CORRIGAN - I just hope that some action is taken, that is all. That we get hold of this issue and get it out to the community, because you are the leaders in the community and you should be leading by example. It is not a very sexy issue to talk about to people, and a lot of people are very aggressive to it but we need to do something, if not just for the children of the state because where are we going to end up.

CHAIR - The terms of reference of the committee focus broadly on a range of matters and it does fit into issues about the social determinants of health as well. Obviously the report will be much more extensive than this issue alone but it is helpful to have that input into that particular aspect of it. Thank you very much.

Mr CORRIGAN - Thank you for your time.

THE WITNESS WITHDREW.

PUBLIC

Mr PATRICK CARLISLE, CHIEF EXECUTIVE OFFICER, BETHLEHAM HOUSE, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR (Ms Forrest) - Thank you for joining us today. You have presented to a committee before, but to remind you, everything you say is recorded on *Hansard*, it is part of a public hearing. You are protected by parliamentary privilege while you are before the committee, but not afterwards if you speak to the media or someone afterwards.

I think you know most members across this side of the table. Mike Gaffney is one of our committee members, but he is not sworn back in after his very successful election a few weeks ago, so he cannot actually participate until tomorrow.

Do you have any questions before we start?

Mr CARLISLE - No, I am fairly familiar with the process.

CHAIR - There are a couple of members who are not here as yet who are on the committee.

Mrs TAYLOR - I do not believe it is an interest I need to declare particularly, but I want to mention that I am actually the Chair of the Bethlehem House board and Patrick is my CEO in that capacity.

CHAIR - Thank you. Patrick, to make some overarching comments, we have received your submission from two years now, whenever it was, and I believe that still stands, but if you would like to make any comments to update that or any additional comments, and then we will have questions for you.

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Mr CARLISLE - As Adriana has pointed out, I am the CEO of Bethlehem House and have been for coming up to three years. I am also the Chair of the Mental Health Council of Tasmania, the peak body for mental health. I am also a board member of the Hobart Clinic, which is a private mental health hospital here in Tasmania, and previously I was CEO of the Richmond Fellowship in Tasmania, which is the mental health service across the state. Prior to that I spent 14 years in health in Western Australia so when I am speaking here today, I am drawing from all of those experiences but in particular my documentation I sent through to you about Bethlehem House.

Most members are aware that Bethlehem House has been the homeless men's shelter in Tasmania for the last 42 years and we have assisted men over that period. We currently provide about 12 500 bed nights per year for homeless men or men at risk of homelessness, and over 40 000 meals per annum to men who are both living with us but also men living on the streets. Currently we have 32 men with us and we have a wait list of up to seven men; it is fluctuating between two and seven men on any given night.

One of the surprising things about Bethlehem House is our average age is the around the mid-30s - 45 per cent of our men are under 35 and almost 90 per cent of our men are under 55.

The primary reasons for presentation at Bethlehem House - 24 per cent are domestic violence; and a third of the population come from housing issues, that's usually lack of

affordable accommodation or over-crowded accommodation before they came to Bethlehem House.

CHAIR - May I clarify that point, Patrick? Is it domestic violence they perpetrate and have been removed from the home, or are they victims of domestic violence?

Mr CARLISLE - It is a combination of both perpetrators and victims of domestic violence. The current statistics the minister, Mrs Petrusma put out the other day were something like 87 per cent of domestic violence calls to police have been from females, but that still means 13 per cent of police call-outs are for males.

Ms O'CONNOR - Some of them could be in same sex relationships as well?

Mr CARLISLE - Correct, yes. The same with those statistics for the 87 per cent, there could be a same-sex relationship the female is ringing about as well.

The average age of death, which was my purpose of writing last time, is 47.49 years for our men at Bethlehem House over the last decade. I found that an alarming statistic when I first came across that. I did a comparison to a similar body in Victoria - that's the Flagstone Salvation Army Centre - and their statistic is more alarming. The average age of death there over the last decade is 45 years, but their trend rate is going down. Their rate is trending towards 42 years of age. It is a very staggering figure. They do have a higher incidence of drug usage than we do here in Tasmania but it is still an alarming figure that we all see.

I am sure you have read the reports, but I will flick through some of the statistics. Aboriginality - currently Bethlehem House has twice as many. We average 9 per cent Aboriginal and Torres Strait Islander men whereas the state average is 4 per cent. Our education levels that come through are very low. Most of our men have not achieved beyond year 10 in schools. As you know, whole-of-health in Tasmania, we top the nine out of 10 primary causes of death for Australia. Housing is the primary reason they are at Bethlehem House, because they are homeless. Obviously they are males; they are 100 per cent male. We do have some that have presented who have been in between their sexuality but while they are at Bethlehem House, they accept the persona of being a male.

As I said, the average age of death is 47.49 years compared to a national average age of a male of 80, or in Tasmania, 78.8, years of age. So they are well below those numbers. Probably 94 per cent of our men are homeless. That is a snapshot of the report you saw.

What Bethlehem House has done subsequently to that, is work with TML last year on doing research around the barriers for health for homeless people. In Bethlehem House, 40 per cent of our population at that time identified having an alcohol issue, 32 per cent had a drug issue, and about 15 per cent had a gambling addiction as well. The national average for drug and alcohol is less than 20 per cent. Tasmania is higher at 22 per cent so our population at Bethlehem House is very high for that.

The same statistics - 85 per cent of our men are smokers, whereas the national average is 16 per cent and Tasmania's number is 23 per cent. We have very high smoking issues, which then probably contribute strongly to their early death rate as well.

For mental health, as we know the statistics, one in five have a mental health issue. Eighty-five per cent of our men in the survey identified they either had or were currently having a mental health issue. Of those, only 71 per cent were receiving treatment at that time.

Ms O'CONNOR - Sorry, can you just repeat that? Eighty-five per cent stated they have a mental health issue?

Mr CARLISLE - Yes.

Ms O'CONNOR - And how many were receiving treatment?

Mr CARLISLE - Seventy-one per cent. So there is still a significant gap. Again it is getting that access to mental health services and also -

Mr JAENSCH - For clarity, I think when Cassy was checking then, it was 85 per cent smoked. One in five had a mental health problem.

Ms O'CONNOR - No.

Mr CARLISLE - No. That is national - 85.2 per cent of our current residents have a mental health issue -

Mr JAENSCH - Eighty-five?

Mr CARLISLE - Yes.

Mr JAENSCH - Thank you.

Mr CARLISLE - Or have had a mental health issue in the last couple of years.

Mrs TAYLOR - That 71 per cent, Patrick, is that 71 per cent of the 85 per cent or 71 per cent of 100 per cent?

Mr CARLISLE - Seventy-one per cent of the 85 per cent.

Mrs TAYLOR - Of the 85 per cent that are accessing services?

Mr CARLISLE - Correct.

CHAIR - So 29 per cent aren't getting any services, even though they have a mental health problem or have hade one in recent years.

Mr CARLISLE - Yes. I will talk about what we are trying to do with that, and I will come back to that in a moment if I can, Chair.

For sexually transmitted diseases, the national statistic is 16 per cent of the 35 to 44 age range are identified to have a sexual disease. Just over a quarter of our men have had a

sexual disease that they have known, and probably 50 per cent have not even had testing. Again, that number could be skewed quite a bit more.

Of our guys that came through, 82 per cent identified as having an oral or dental issue. That is a very high level in that area. As members would be aware, oral health is important because that is the gateway to your gut which allows bacteria to get into your system, which then wrecks the rest of your body's system.

For podiatry, again, nationally there is probably around 40 per cent of people in that age range with a podiatry issue. Of our guys, 43 per cent identified they have a foot problem of some description.

Talking about diet and health, generally, if you are living on the street you are limited on what your dietary intake can be. Once they come to Bethlehem House, I am happy to say that we have assisted men to change their habits. Generally, men who stay with us for more than three months put on about 6 kilograms of weight. We had a gentleman come in late last year who, wringing wet, was 47 kilograms. He is currently about 70 kilograms. That is about the right weight for his height. We assisted him through that process.

What we have been trying to do to assist our men is gain access to a private dental therapist who does a preliminary examination or small fillings for our men. We have garnished some philanthropic moneys to pay for that. It is only a small bucket of money of $5 000 here and $10 000 there that we have been able to get over the last two years.

We now have a community health nurse from the DHHS who comes through once a week. When the worker comes in, he sits with the men, talks about their health, does their height and weight checks, and does their blood glucose levels, monitoring their diabetes. Rates of diabetes are very high because of the nature of the food they eat - so we also look at that. Some men arrive at Bethlehem House with a cocktail of prescribed medication they are taking, which he checks with them. He goes through their medications and assists them to understand what the medications are for. On occasion, he has identified there are a couple of medications that have been equivalent, so they have been able to reduce their medication.

CHAIR - They have interacted with each other.

Mr CARLISLE - Yes. Or they have been a similar medication, because they have gone from one doctor to another doctor and they have been prescribed an antidepressant here and an antidepressant there, so they are taking two or three antidepressants, or two or three heart tablets, which is probably more than they need to.

CHAIR - Do you refer them to a GP?

Mr CARLISLE - Yes. We encourage all men who come through Bethlehem House to link into a GP. We have a number of GPs around Hobart who will take our men and do a quick assessment on their health and then refer them on to further help. That is what we are trying to do. But the most important factor is that the average age death of these guys over the past decade has been 47.49 years.

So, that was just a brief introduction.

CHAIR - You are dealing with a skewed population, by the nature of the service you offer. In a perfect world where would you start to address this long list of issues? They are all important, but what are the priorities? Where would you start?

Mr CARLISLE - One of the first priorities was to get a community health nurse into our premises. There are priorities with dental health. We currently have a PR program - partnerships and recovery - where a worker comes in once a week for a couple of hours to meet with the guys and encourage them to seek out mental health professionals. We are trying to do some work with that.

We are working with Holyoake. They run a Gottawanna program, which is 'gotta wanna' give up the drugs or alcohol. It is quite aptly named. We are working with Holyoake to try to get our men to address their drug and alcohol issues.

Where would we like to work? One of the main areas we would like to work on is smoking - do something about stopping smoking. If we can bring smoking levels down, their co-morbidity from all the other issues - their hearts, their lungs - would diminish quite dramatically. That is where our next focus will be - trying to get a smoking cessation program going within Bethlehem House.

CHAIR - They do it in the prison. This is not a prison but it is a difficult group of people who tend to have higher smoking rates. Is there anything you could learn from that?

Mr CARLISLE - The unfortunate issue we are seeing - because a lot of our clients are ex-prisoners or waiting to go to prison - is that they are finding creative ways of getting around that at the prison. They are getting patches, which are nicotine based, and boiling them off, infusing them into dry teabags, rolling them in a piece of paper, and they have a cigarette. That is how they get their nicotine fix.

It is a very difficult problem. We cannot make them stop smoking like they can in hospitals or the prison complex. We are trying to encourage more active participation in our society - getting them out of our courtyard, because that it where the men used to congregate. When I first went there I used to glibly say, 'The men are going in the courtyard smoking, just waiting for God to come and pick them up'. It is very glib but that is basically how I saw some of them - they were smoking themselves to death because they had nothing else to do. We try to get them active, to do things. We encourage them to go around the corner and kick a football. They do a number of walking places. We try to get them involved in other activities.

Also, with the changes within the Housing Connect, we are able to get men moving straight through to more stable accommodation at a more rapid rate. We are reducing the recidivist habits of some of these men. We are seeing a new population of men coming through, looking for stable accommodation.

CHAIR - Do you want to go through how you fund it? You talk about some philanthropic donations to assist with the private dental therapist, for example, but does this issue need to be addressed more broadly in terms of access of services? What are the challenges around that?

Mr CARLISLE - The broad issue, if I may go to that extent, is that we do not have a men's health centre in Tasmania. We have the Hobart Women's Centre. There's Women's Legal Services. Some of those services that we are currently trying to set up - again, we have that philanthropic grant where we have been funded to try to set up a health service within Bethlehem House. It's a trial period to see what we can do. We are engaging with a GP to see if they can come through and do some work there.

We are looking to do some work with Calvary Hospital. Again, some of their specialists will come in, we're hoping, or take our men to their premises and do pro bono examination and sort of stuff.

There is no single spot where men can go for men's health, and feel comfortable going to that spot.

CHAIR - How you are funded and what are the gaps?

Mr CARLISLE - We are funded through Housing Tasmania to supply short-term crisis accommodation for men, and that's basically up to six weeks. We then have a second part of our house where men can pay a percentage of their pension or other income and stay with us for a longer period, stable periods. We had one gentleman who was with us for 17 years. Now we are moving the average back to about three years' duration. That is to allow them to become more stable. Trying to move them on to long-term stable accommodation in communities is our ultimate aim.

CHAIR - Is there a challenge with moving them out into other accommodation? Is that one of the barriers? What are the real challenges there?

Mr CARLISLE - The biggest barrier there is that once they move out of Bethlehem House, there is no support mechanism for those men to assist them with living skills, learning health skills. There is a lack of follow-through process. Fortunately Housing funds us for accommodation for men in the service there. We have two case workers who are looking after 30-odd men, trying to connect them up to health practitioners, legal assistance, to judicial systems.

A number of men who come to Bethlehem House are waiting to go before courts or have just come out of prison or DPM, places like that.

CHAIR - What I am hearing you saying, and correct me if I am wrong, is that it seems to be a very non-integrated approach. You are trying to do this bit over here and this bit over here, and get money from there, rather than an integrated person-centred approach.

Mr CARLISLE - Exactly. It is not person-centred. It is the endeavour. What we are currently funded for is to move men to stable accommodation with no support. There needs to be that process of focusing on that individual and dealing with their layers of issues.

When we delved through the layers of issues, we have found that trauma, underlying childhood trauma, is the primary cause there. I know other committees are looking at that with childhood trauma stuff at the national level.

We need to be able to get down to the original cause of that person, male or female, being there. They say housing affordability, but if you peel back the onion, there are drug or alcohol issues that cause them to be broke. That's caused by the underlying pain that they have had in their initial stages of their life, and that's where, I think, there's no focus on preventing that occurring, or, when we find that, how we can deal with that in the future.

CHAIR - May I go down this path a bit because I think it is important if you are trying to figure out where you start. If the issue here is that the majority of the men you have coming through your service, and possibly others through other services, is a lack of nurturing in their childhood or some form of abuse - and you are right, there are other committees looking at this sort of thing at a national level, with shocking findings - with so many people who are victims of such abuse, they do not speak about it for a number of years. I guess shining a light on it in the way the other inquiries have has been helpful in that regard but do we need to focus more on the early intervention in children's lives, particularly in the school system? Or where do we do this to try to prevent people ending up in Bethlehem House later on?

Mr CARLISLE - We need to do both ends of the spectrum. We need to look at those who have been affected now, they are going to be with us for a few more decades, hopefully, but we need to be looking at getting back to the basic family needs and understanding. I like to call it the village complex. We all have responsibility of looking over our neighbour's fence to some degree and ensuring that the children and the family as a whole are doing well.

The primary issue here is the children, making sure they are safe. The only way you are going to assist children to be safer in their environment is to also work with the mums and dads, the carers. If they are not well, they have to have an outlet and that is where we see the cause of domestic violence, drugs, alcoholism, the gambling - all of the avenues men and women choose to take their vents out. If we can get back to having a caring community that is where I think we need to be.

How do we do that? Somehow it has to be identifiable as children enter primary school. My example is, my wife was a pre-primary teacher in Western Australia in the special needs area. Her first term was basically becoming a social worker dealing with the issues the children had and where their parents were at. If we can get some work done down at that level to assist those children, to start their grassroots educational abilities to do that, I think it is where we need to be.

My own experience is, I am one of nine children. I came from a loving family and Mum and Dad were there to support us. Mum went to year 7 in primary school and Dad got to the year 9 equivalent but the love we had within the family, the support we had, the encouragement we had, made a difference for us. We also had a neighbourhood with young families, there were parks nearby - those rudimentary things that get children out, to be safe, interacting, to be able to enjoy growing up gives that stepping stone towards making their choices of the future. It's those basic things.

I come from Western Australia and we have higher educational levels than I have seen here. In my experience with mental health, again, the education disparity across this whole state, particularly in the north-west, is horrendous. There is no future for some of

those people. If you go down to the Huon and beyond, there is no future for some of these people so they do not feel encouraged to go on and do something to make the changes. We have to encourage our community to make the change, and some of it is purely making opportunities for younger children to understand their lives, where they are going and how they go forward. If we could have made those changes for some of our men, there would not be a Bethlehem House now.

Ms O'CONNOR - Patrick, thank you, an excellent presentation.

The connection between early childhood experience and late life behaviours and self-harming behaviours, having worked in both Western Australia and Tasmania, do you think there are specific socioeconomic and cultural challenges we have here in Tasmania? You mentioned them briefly before but do you think, because over decades and decades we have not invested in families or invested in family support, that we are seeing the consequences of that come through the system now?

Mr CARLISLE - I think to some degree we are seeing those consequences now. The support around families in those days - you weren't fighting, as we were in Western Australia for a little while, fighting for mums and dads to have jobs. Then we had the mining boom in Western Australia so that made it much easier for Western Australians.

The low economy of Tasmania has slowed down people. The fact that a high percentage of it is rural-based services down here. There is no secondary or tertiary manufacturing here. Once you have started a farm and you've lived on that farm for a while, what do the children do when they grow older? They subset the farm or what?

There is only a limited capacity in those works, whereas we have some other services, manufacturing services, building - something we could ship off to other states or other nations is one of those areas. We need to give prosperity to those sorts of people, to give them the opportunity to create their own wealth. Through that wealth they improve our whole quality of life throughout society.

Ms O'CONNOR - I know you probably have to be a little bit careful about how you answer this, so we won't talk about any specific political frame. But there is an inherent tension in the framing of budgets between investing in capital works and hard-built infrastructure and investing in social services and public services. Would you agree that if you invest in good health, housing and education, that in itself is an economic driver?

Mr CARLISLE - It certainly can be a contributor to that because every time you invest in the community, it creates more employment. Especially investing in the not-for-profit area, the community sector, you don't have to have such qualifications as a masters in psychology. You can do a Certificate III or IV in community mental health; you can do it in Welfare. So they are the sort of basic entry-level positions that allow us to do some work there. It is also the fact that community-based organisations can spend time with those people and make a difference for those individuals.

Clinicians - talking about public health, mental health, for example - they get allocated an hour to deal with somebody's issue once a fortnight, if they are lucky, once a month. So that 45 minutes is, 'Hello. How are you today? You're taking meds. Let's see what's going on. Okay. Sorry, I have my next appointment here'. Whereas services that are

community-based, like Bethlehem House, where our men have 24/7 support around them, can help those men, see them making those changes in their daily living, supporting them to make the right choice at that time is one of those ways.

Ms O'CONNOR - You said earlier that some of the men come into Bethlehem House are there because they may have breached a restraining order or have had challenges managing aggression. Is it possible at Bethlehem House in the time that you have that cohort of men there, to invest in some of those primary prevention messages about respectful relationships and attitudes towards women? I'm sure you would agree, men's violence against women and gender inequality are also foundational to disadvantage and poor health.

Mr CARLISLE - Indeed. One of the things we are trying to do is positive role modelling. This morning there was an incident in our courtyard - a-non resident was with one of our residents and they were shirt-fronting each other. You could see it was starting to build up to that. Short, sharp intervention - one of our staff members stepped in and said, 'Hi, guys. How's it going? What's happening?', and they broke it up. He spoke to both those men individually so there was no accusation between them. Treating them respectfully. Hopefully that works.

We have seen a significant calming within Bethlehem House over the last two-and-a-half years because we have changed the way we deal with aggression within the place. By doing some positive role modelling, we are trying to show you can resolve issues without fisticuffs. If our men understand that they can do that, they are less likely to breach a restraining order. As I said in the paper the other week, a number of men will be at Bethlehem House because there is a family violence order against them. It could be parents with an order against a child, or partners who want to exclude them from the house.

We try to talk with those men about the underlying issues that led to the family violence order. We try to distil the issues and find another way to deal with them. But there are limited resources in that area in Tasmania.

Ms O'CONNOR - Particularly for perpetrator programs.

Mr CARLISLE - Exactly, and also counselling. There is only one counselling service in Tasmania and they will only speak to one side of the argument. There needs to be two or three, to give people options. Luckily I do not have to look in the Treasury bag to see what is in there to fund these things. These are simple things, but it is going to be expensive, initially. However, if we can fund services like that, it will prevent a lot of long term issues.

But the effect of that sort of intervention now can't really be measured. You can't say that we helped 50 boys who turned out to be 50 men who didn't commit violent acts as men. It is very difficult to -

CHAIR - You cannot measure what didn't happen. That is the challenge.

Mr CARLISLE - Yes. Unless you're in one of those futuristic movies and you can travel back in time.

It is the simple things that make a difference. In my time in Western Australia - a short stint - I was doing surgery and we did nearly 700 hip replacements in a short period of time. That made a big difference to those individuals and their families. That is just one measure where you can see a result very quickly.

But surely we should be stopping those people from being on a wait list in the first place. Diabetes and obesity are challenges here in Tasmania, and nationally and internationally. We have to get back to grass roots, thinking about simple things like what we eat, how we eat it and that sort of thing. But I don't know how we can do that. We can encourage people to grow vegetable gardens, which gets them out of their house, and if something is bubbling up, they can go and work on their garden.

Digging in the garden is very zen. We need to encourage things like home gardens - community gardens are making a big difference. My wife currently works at Goodwood Community Centre, where they started a community garden. The number of issues in the streets around it has diminished slightly. Those sorts of programs bring the community back together. We do not have a village and I keep harping on that. I think that is what the Western world has lost - the village mentality.

I hate to say it, but in the good old days you had the village idiot and everyone looked after the village idiot. They did look after him and they made sure that person was fed.

Mrs TAYLOR - I am glad you said it was a 'him'.

Members laughing.

Mr CARLISLE - I am only representing the male sector. When there was a widow or widower, people would take food and crops to the family. If a woman was giving birth, the family would be fed by the neighbours. We don't do that - we don't have that connection as much as we should do, and have need of.

Mr VALENTINE - Let me start by congratulating you on the work you do. It is very important work and quite often work that no-one else is prepared to do. I want to thank you for what you do for the people of Hobart, and Tasmania for that matter.

Your submission is very interesting - you have obviously put a lot thought and effort into it.

I am trying to get a bit of a handle on the prison population that comes out. How many of those men are you actually coming into contact with? I noticed here in your submission of 2012, history of institutionalisation and abuse is 0.3 per cent. Is that the prison population that you are seeing coming out, or not?

Mr CARLISLE - No. It is probably the primary presentation at that time. Most men will come to us and say, 'I am homeless because I cannot afford housing'. That is their primary reason. But as you actually go into the second and third derivatives of why they are there, we have many men who have recently been released from prison or are released from prison, also a number are awaiting prison. If I was trying to guess the population, I would say sometimes it is 30 per cent to 40 per cent of our guys.

Mr VALENTINE - That is quite high, isn't it? When you have 313 clients presenting in a year, you are talking about 120 to 130 of those might be -

Mr CARLISLE - Ex-prisoners or waiting to go into prison, or waiting for the judicial system to decide what is going on there.

Mr VALENTINE - In your opinion, and having worked with these men coming out of prison as opposed to about to go in, do you think there is more that the government could be doing while they are in prison to help educate them, help prevent some of the issues that they have arising? I understand that drugs are always an issue and that may well be changing over time, but are there things that government could easily do that are simply not being done?

Mr CARLISLE - Bethlehem House ran a PROP - prisoner release option program - back in 2009 through to about 2013. During those four years, for three of those years it was federally funded and we were able to bring men out of prison on release and put them straight into some stable accommodation.

Some of it was through Bethlehem House or one of our satellite flats. The primary issue again, is the first 13 weeks of prisoner release. That first 13 weeks sets them up for the rest of that period. Most reoffend within that 13-week window. The longer we can keep them out of prison, the longer chance it is they will not reoffend. If we can stop their reoffending behaviour or put the stretch between it longer, it is better for the community.

Mr VALENTINE - And you get better health outcomes as a result of that, wouldn't you?

Mr CARLISLE - Exactly. If you go back to prison, what do you have to do? Not very much. Whilst they are in that limbo land, they go back to the drug or alcohol and taking risks, they are going to perpetrate some violence against somebody, be it robbery or mugging or whatever it is. There is always that risk to themselves as individuals as perpetrators, but also to the community around it.

How many times have we heard about somebody being injured during a robbery, either be it a physical injury or the psychological injury of being confronted with a sawn-off shot gun. These are the things.

Mr VALENTINE - Is it that anything the government can do to help break the networks that those individuals are finding themselves in can have some good outcomes in the long term?

Mr CARLISLE - Indeed. One of the biggest issues that men face when they come out of prison is, 'What am I going to do next?' If there is nothing there to start them on the road to give them connection back to the community, they are going to be isolated. Whilst they are isolated, they are at risk and the community is at risk.

Within prison, one of the primary things is literacy. A number of men that we have dealt with over time are illiterate. They are the issues that you could be basically working on. Again, it is long time frames. They could be away in prison for six months; some are longer term. It is some of those basic, rudimentary steps to get them connected and

connect them up into the future, to support them once they have come out of prison. You have done your time, great, you move on - but is not -

Mr VALENTINE - It is not as simple as that.

Mr CARLISLE - No.

CHAIR - You cannot apply for housing while you are in prison either. You have to be out.

Mr CARLISLE - No, you have to be out of prison. We are working with Corrections right now to see if there are ways we can reach out to men who are about to be released from prison - to assist them with the transition from custodial care to freedom. Some of the men who come out of custodial care go, 'Wow, I am free. I can do what I like,' and they do what they like. They go out, get drunk, and they re-offend. And they are out on the street drunk and the police arrive. If they have a history of violence, the police immediately assume there's a problem.

Mr VALENTINE - Thanks for that. I really appreciate that.

Mr CARLISLE - Doing something within the prison could involve setting them up for post-prison work. There are also programs like REO, the reintegration program -

Ms O'CONNOR - For ex-offenders. It has been de-funded though.

Mr VALENTINE - This is one of the things that -

Mrs TAYLOR - As was PROP de-funded. Well, their funding ran out and it wasn't picked up the state Government.

Mr CARLISLE - Our PROP program was funded nationally as a part of the national crimes funding.

Mr VALENTINE - Sorry, PROP stands for?

Mr CARLISLE - Prisoner Release Options Project. During the period of the project we had about 44 men come out of prison. In the last year of the project, the number of men that didn't re-offend was almost double the normal population. So we were able to give them purpose, and change things for them.

Anecdotally, we had one young gentleman come out. His issues were drugs and alcohol. He reconnected with his partner and their son. We got him into a volunteers program - he was going out with the ground care people. They gave him some work clothes. A staff member from PROP picked him up to take him to the first day of work. His little boy - this five-year old - was standing at the front gate waving to daddy. 'Daddy is off to work. Bye, daddy'. He was waving frantically. This big strong man got in the car, sat there, drove down the street and was in tears before he got to the corner, because it was the first time his son had seen daddy go to work. He didn't want his son to see him being taken away in a police wagon next. So he hasn't re-offended. That one little tear running down his cheek was enough to help that man to make a difference in his life. That is what we need to do.

Mrs TAYLOR - Patrick, you know about preventative health care. We are looking at a lot of across-the-board stuff. You've said that housing is funded for Bethlehem House - for men to come to Bethlehem House. But obviously the other services are a bit ad hoc, and depend on what you can get private funding or grant funding for. Is there a better model that would prevent progression of the risk factors for the men, and reduce future health costs for the economy? Is it something like NDIS where you ask, 'What does this person need?'.

They need housing. But they also need mental health services, and dental care. But maybe another person doesn't need that. He needs something else. Would that be a solution - if we looked at the individual and funded according to individual needs, rather than provide services and try to slot blokes into those services?

Mr CARLISLE - Whatever the system is, we currently take a person and stick them in the box where we think they fit best. We are individuals and we need individual services. There is a similar system to what you describe running in New South Wales and Victoria. I think it is called the Michael Project, and it is run by Mission Australia. The first thing they do is find stable accommodation for an individual. Then they wrap services around that individual. They will bring in services like mental health, parenting, basic life skills - how to cook, how to clean a house. These are skills that some men and women do not have from growing up. Boys and -

Mrs TAYLOR - But everybody doesn't have the same needs, do they?

Mr CARLISLE - No, that is right.

Mrs TAYLOR - Those individualised packages of care.

Mr CARLISLE - Yes. That is what the Michael Project did; it looked and individual's needs and put that service around them. But it wasn't just a short sharp service, it was a service over two years. It started off very intense, and the end of it was like a phone call.

Mrs TAYLOR - So is that Government-funded?

Mr CARLISLE - I think it was nationally funded somewhere.

Mrs TAYLOR - It was probably through Mission Australia's funding.

CHAIR - Do you know whether that was like a three-year program funded?

Mr CARLISLE - It was a three-year program funded. They subsequently got some additional funding last year. They are doing some more work around that area.

Mrs TAYLOR - But it's not ongoing funding?

Mr CARLISLE - No. Unfortunately it's again project funding that has been there. But something like the NDIA process is something that we need to maybe consider, where there is funding around that individual with their needs. The difficulty is figuring out what the individual needs to what we perceive they need. The generic terms are, be it a

homeless men's shelter or mental health, 'I want my own home. I want a girlfriend or a partner. I want a job and I want money.' They are the basic premises that most men start off with; that is what they want.

CHAIR - Their barriers will be different.

Mr CARLISLE - Their barriers are different, yes.

Ms O'CONNOR - Is housing really the foundational need that many express? Somewhere secure to call home?

Mr CARLISLE - Yes. A lot of research has gone into the fact that stable accommodation is the forefront of everything. A lot of mental health programs are based on getting stable accommodation and then working with their health issues. Again a disability, start with stable accommodation. I call on my friend Maslow's triangle hierarchy of needs. Once you get a basic tenet there, stable accommodation, you can stop worrying. Once you can stop worrying about where I'm going to live, you can then start worrying about the next level of what I need and then working up to some self-actualisation.

Simple things talking about self-actualisation, we had contacted TAFE. We took three gentlemen down on Friday to TAFE where they got a $5 haircut. Those men came back beaming because they were feeling 100 per cent themselves.

A gentleman you will see over the next couple of weeks as part of the Vinnie's sleep-out campaign, came to us, and like most men that come to Beth House he was invisible. They had a hoodie. They have beards. They have long hair because they do not want people looking at them. But this young gentleman has got off drugs and alcohol because he has got a new partner and they have a three-month old baby. His partner spent the same amount of time in the Hobart Women's Shelter. They have now worked with us at Beth House and with the Women's Shelter to stay drug-free for that period. He comes in, does a test with us, because if he goes to community services he has to pay for that test. I understand the figure for doing a drug test is something like $170. He has to pay for that to have access to his children. He can come to Beth House. It costs us a disposable cup with the right chemicals in it, and we drug-test him. It costs us about $5 or $10 for that cup and five or 10 minutes of our guys' time. We work with Children's Services. They accept our word that he has been drug-free for that period. It costs him nothing, except for half an hour of his time to come and get the test done. He is positive that that is what he wants to change. But he no longer wears a cap. We talked him into having a shave. We have talked about getting his hair cut properly. He feels pretty, or handsome, he says. He feels like a person again, just by taking that simple steps of getting a hair cut.

It is the same with oral health. A gentleman was standing at the counter one afternoon and he was smiling at me and saying, 'Hello'. I said, 'How are you today?'. He says, 'Good, good'. He said, 'You don't notice anything do you?'. I said, 'I am sorry, should I?'. He said, 'My front two teeth, I have got them replaced, thank you'. He can smile now because he has teeth to smile with. Simple things like that make a difference to their health.

CHAIR - We are nearly out of time but there are a couple of things. Roger had one and Cassy had one and Adriana had another. Have you finished yours, though, or did Cassy interrupt you rudely?

Mrs TAYLOR - No.

CHAIR - We will go to Roger first.

Mr JAENSCH - Thank you very much for the work you do and for your stories Patrick. How do the men you help come to you? Are they referred? Do they find you themselves?

Mr CARLISLE - A large chunk of them are self referrals and some of them come through Housing Connect. Some of them are regulars, so to speak. They have been before. We are trying to break that cycle. We had one gentleman in the last three years who had been to us 17 times and when he came the sixteenth time we said, 'What is going to be different for you? We have a number of other guys here. What are you going to do?'.

He said, 'I want to get off the gear. I really want to make a difference'.

I said, 'Come back in a day's time and tell us that is what you want to do and we will make the choice because we have a number of people standing outside wanting help'.

He came back. He used to stay one or two days. His record was ten days with us. He stayed with us for three months. He now has stable accommodation at Goodwood. He has regular services going in to support him, because he wanted to make a commitment.

Mr JAENSCH - Do you have any idea how many homeless people there are in your community? What percentage?

Mr CARLISLE - In Tasmania it is about 1 600.

Mr JAENSCH - Let us say in your community -

Mr CARLISLE - That is 1 600 across Tasmania. We capture a lot of people coming from the north-west coast because there is no service in the north-west. There are limited services now for men in Launceston and some of them have to be excluded from the area because of family violence issues, so they move to Hobart where there are services.

Over 50 per cent of homeless are male, so you are looking at 800 homeless males at any given time. People living in cars or tents or living under shelter are probably 10 per cent of that. So about 80 men at any time around the state are living in rough conditions.

Some of them choose to do that because they get the pension and they put it into alternative therapies for themselves. That is their choices.

Mr JAENSCH - It sounds to me like there is a group of people who are motivated in some way to seek your assistance, and for each one of them, there is another couple out there who have not reached that point yet.

Mr CARLISLE - No.

Mr JAENSCH - There is no agency for them. Or they are choosing to sort things out themselves.

Mr CARLISLE - The Salvation Army runs an outreach service, which will go and find them under the bridge and talk to them and try to encourage them to come to Bethlehem House. A number of men choose to come to Bethlehem House. They can come early in the morning and late in the afternoon to access our building.

They can use the toilets and showers and washing facilities and have breakfast with us. That is all free. In the evening, we ask for a co-contribution of about $4 for an evening meal - so they can an evening meal with us.

But they choose to live somewhere else because that is their lifestyle.

Mrs TAYLOR - Bethlehem House is drug and alcohol free - zero tolerance.

Mr CARLISLE - Yes.

Mrs TAYLOR - Which is one of the reasons why people sometimes do not want to come because they do not want to live there but might access services during the day. We talked a little while about smoking, and you said 85 per cent of the men smoke. Have you considered being smoke-free and do you think that would be another deterrent to stop those men coming, as against the benefits of having a smoke-free environment knowing the diseases are a result of smoking? We are talking about preventative health.

Mr CARLISLE - I have toyed with that. I would rather engage men and deal with their issues. That is why we have accessibility to the building both morning and afternoon; that keeps us connected to those members in the community. With that connection we can deal or start making those changes there. We are starting to work on the smoke cessation; it is very important to us to stop the smoking. The primary contributor to their early death is smoking, drug and alcohol abuse, rough sleeping - all the challenges that we have.

I am reticent to change the process. We have made it very strict where they can smoke. There are only two places in Beth house. There is a courtyard which is a very limited area where they can smoke, and outside the premises. They cannot smoke in the building. Apart from the fact that it is a high risk of fire, there is also a risk to the 15 per cent of guys that do not smoke. Most of our staff don't smoke either so we have to consider that side of it. Yes, I would love to go smoke-free but with that cohort we currently have we are better off chipping at the edge and reducing their smoking habits to get them back into healthier activities. It is a longer term approach but yes we are looking at getting patches and how we can connect up.

Mrs TAYLOR - You don't allow alcohol, for instance, so again there are men who do not come off the street because they cannot have alcohol there.

Mrs TAYLOR - Why do we make a distinction between alcohol and smoking in a sense. Are you better to have them in the house and work on things rather than them not come at all and therefore die earlier than 47-49?

CHAIR - If you take that approach, and I am interested on your view on this is that, remember the hue and cry when we said that you can't smoke in pubs anymore. All the pubs will close down because no-one would go there, but that did not happen. Maybe there is an opportunity to bite the bullet. There may be some who don't come, the same as some don't come because they cannot have alcohol there, but ultimately if they want the service, and you provide a good range of services, they will come.

Ms O'CONNOR - He is dealing with highly stressed people, marginalised, temporary residents.

Mr CARLISLE - The catch cry there is that most of our turnover is that people are there for six weeks. Even the hospitals are finding it very difficult to stop persistent smokers from smoking. We can stop it within the courtyard bit they still can go outside the building. That becomes another issue, seeking outside the building at night-time. I would rather the courtyard where they can go and have a safe smoke at 1 o'clock in the morning. We make it difficult for them. They have to go to the person at the front office to open the gate so they can get out to smoke. There are a few that have stopped smoking at night-time. They have the last cigarette about 10 o'clock and do not smoke until the next morning. There is a small cessation problem. We could stop selling on certain outlets so people don't stop and get their cigarettes on the way home.

Ms O'CONNOR - All the service stations and supermarkets?

Mr CARLISLE - Supermarkets, I am thinking of, Cassy.

CHAIR - There is not a simple solution. It seems simple to say, 'Just stop them smoking', without considering all the underlying issues.

Mr CARLISLE - Again, it is a higher percentage than those with an alcohol issue. About 40 per cent of the men have an alcohol issue, but nearly 90 per cent of our men are currently smokers.

Mr VALENTINE - And other drugs, out of interest.

Mr CARLISLE - About 35 per cent of our men have had a drug issue at some stage, or currently have drug issues. We have a regimen of testing for men who come through the house. We do random checks and we will test known drug users every time they come through. We test them, and we advise them. Sometimes it is just takes a short, sharp night outside to remind them they shouldn't be drinking so much. They can have one or two drinks, but most of our men are chronic - once they have had one or two drinks it does not stop. That is the difficulty.

That is my next port of call with the Gottawanna program - looking at how they can do a smoking cessation or reduction program for us. We are trying to work with Holyoake to get that program going.

CHAIR - A quick question from Cassy, we are well over time, then we will wrap up.

Ms O'CONNOR - Patrick, back to housing and the exiting prison population, would you like to see a change in policy that enabled ex-offenders to apply for housing before they are released? The second part of the question is - how difficult and limiting is it, and potentially opening a prisoner up to recidivism, if we don't have housing options in place for people coming out of prison, and the supports that go with them?

Mr CARLISLE - I think you have answered the question yourself. If you have no stable accommodation to come out to, you have to go back to the cohort you know. You go back to the people you know because they are your support mechanism. 'Do you want a bit of this and do you want a bit of that?' 'We are just going to knock over the servo, do you want to come and help?' That is what they are going back to. We need to break that cycle and give them some stable accommodation to go to - accessibility to housing should be available for people coming out of prison. It should be part of the discharge process from prison. It should also be part of the discharge process from DPM or LGH or the Spencer Clinic.

There is no service, and they need a bed on a Friday afternoon. Look at the statistics - these institutions discharge people on Friday afternoon because they want to empty a bed for the weekend. Something needs to be done properly. Discharge planning should not start on the day you leave, it should be started at admission. That should also be the case in the prison. 'What are we going to do with Rob when he gets out of prison? What is he going to do with his life? What can we do to make a difference?' They are the things we need to consider. We have to give them something to come out to. Maybe we will run an art program somewhere and give them a kick start, I don't know.

CHAIR - We need to wrap it up. Thank you, Patrick, it has been very valuable information. We appreciate you hanging around and we also appreciate our next witness waiting. Thank you for your time.

Mr CARLISLE - I appreciate that. If there is anything else I can do -

Mrs TAYLOR - Are you are not going to do a little advertisement amongst these people for your sleep out?

CHAIR - He has already sent a LinkedIn message.

Mr CARLISLE - My target is $4 749. To remind me that 47.49 years is the average age of death for these men. I am happy to say that a number of people sitting at this table have been very supportive over the years and hopefully will be this year as well. New members are quite welcome to go to the CEO Sleepout website and find Patrick Carlisle there and support him.

CHAIR - You will receive a good hit this afternoon, I reckon, once we have finished here.

Mr CARLISLE - Thank you very much for your time.

THE WITNESS WITHDREW.

Ms JAMI BLADEL, ARTISTIC DIRECTOR, KICKSTART ARTS, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR (Ms Forrest) - Thank you very much Jami. Thank you for waiting and for your submission. Everything is recorded on *Hansard.* You are covered by parliamentary privilege while you are before the committee but it does not extend once you leave the committee.

If you have any questions about that? Would you like to make some opening comments about you and your background and speak through your submission and members will have questions for you.

Ms BLADEL - I am the artistic director and the CEO of Kickstart Arts. I have been in the position since 2006. Kickstart Arts has been working in communities in Tasmania, including rural and regional communities as well as urban communities, throughout the state since 1992.

We have been making projects that have been demonstrably impacting on the social aspects of health, their health and wellbeing. I provided a whole bunch of evidence, particularly this morning. I am sorry to send it out at the last minute. I am so busy; it is insane at the moment. I managed to get it to you at the last minute so you can read it tonight.

This is providing evidence from both Australia and overseas of how arts are impacting positively on health and have been for many years. The evidence is there and growing. That is an important place to start.

Arts and health are in an old occupied complex space because we work cross sectorally and it has to be expressed in so many different languages for so many different groups to understand, in different ways, as to the benefits. That is why I am very happy to come and speak in person. No matter what I write, there is always going to be questions that will be understood in different ways.

It is good if people ask me questions. The main thing that I would like to put down as an opener is that people need to take more responsibility for their health. Currently, in Tasmania, people are very challenged and it is not in one socio-economic group. It is across the community. It is represented more strongly in certain groups than others. People find it difficult to identify the choices they need to make, how they can make them and why that would make a difference.

It might be things like smoking or mental health. Mental health, I do not have the stats in front of me, but it is highly representative and under reported in the high socio-economic areas.

It is not about the poverty but the poverty is a big part of it. What I think people need and what we think people need to make those better decisions, is access to an creative process. It is to be able to identify their own inner knowing of what is right and wrong.

Also, their self-confidence in terms of their capacity to think outside the square, make a change, make a difference, work with others, get engaged with something that is going to

be positive for them and for the broader community. To find out what will help them and then take those steps to make that change.

That is not something you can do alone. It is something that has to be done collectively because we are community creatures. We are human beings and evolved in groups. We did not evolve individually. The group will make or break the individual. It is individual choices that have to be made and individual responsibility has to be taken but it is the group that will enable that.

It is the culture of the group that will assist or de-rail an individual's capacity to make the right health choices.

We know through our 20-plus years, my 30-plus years of working in Arts and Health, that working on creative projects in groups provides people with those capacities. It underpins pretty much every conversation you can have about health. That is my argument.

CHAIR - Thank you. From a personal perspective I know how I feel after going to see a live musical event or theatre or any sort of art exhibition. There is something that happens and participating is another level of that.

In the research you have been aware of or been involved in, is there a threshold where you can prescribe a certain exposure to the arts, for example, that could have that positive impact or is that a bit unknown?

Ms BLADEL - From my point of view, we took a bit of a side road in the renaissance when we started thinking of art as being something that artists do. When it occupied the rarefied space of Michelangelo, The Sistine Chapel.

For generations, we evolved making art together. It is our natural state. We tell stories and we share stories. A lot of things that we do in contemporary culture is art but not understood as that. A lot of the digital arts, for example, are really important in social cohesion because of the story sharing that happens.

What I am saying, it is something that we all do. Something that has happened in our culture that has been a bit damaging where, in western culture particularly, we have thought of arts as being the precinct solely of artists.

We are in a time in our evolution where we need professional artists to have those extra skills to work with community groups, to help them back to the place where they feel confident to make art themselves, to share stories confidently, to make something of beauty.

We all dabble in it one way or another. Then there is the other aspect which is of course, the professional art and the art that happens in galleries, and the highly-realized art in theatres and galleries. That is really important too because as audiences we go to those and we see ourselves reflected back. That helps us to make - that talks to our heart and our deeper decisions about right and wrong, wellbeing, not wellbeing - it happens not only in the head, but in the heart.

Art affects our values and our ethical choices. Those things you get through film, television, theatre, dance, and art in galleries. So it is really important for audiences as well as for participatory art. I am an advocate for arts across the community.

CHAIR - It is hard to imagine that people don't have any exposure to or are involved in any arts. But obviously there must be some people who are - some people who are very depressed or in a very isolated situation geographically or otherwise. Is there a threshold? Is any involvement is okay, or does it need to be a bit more than that?

Ms BLADEL - The threshold question. I suppose I am still trying to understand what you mean by 'threshold'.

CHAIR - Do you have to go to three arts events a week or produce three works of art yourself to actually have a benefit? Is there research that makes that connection obvious?

Mr VALENTINE - Take three arts and see me in the morning.

Ms BLADEL - I think it is more complex than that. It would depend on a person's individual situation and circumstances. I guess there is an overall principle that can be applied, which would be that some involvement in art is better than none. Going along to a play will speak differently to every member of that audience. The transformation that occurs will be a very individual thing.

It depends on whether somebody is ready to make a transformation. If they are, something they see or experience will follow at that right time. There possibly are stats. Jing Sun is working with the Griffith University and she is collecting stats on this at the moment. I guess it is 'watch this space' in terms of collecting the stats.

CHAIR - If you are looking at Bethlehem House and the men there, would it be important for them perhaps to have visiting artists come into Bethlehem House? Or for the men who use the service, either residents or non-residents, would it be better to be directed towards activities involving the arts as part of their holistic wellbeing?

Ms BLADEL - Absolutely. There is evidence that supports that, particularly coming out of Manchester. There is a lot of 'arts for health' evidence about art you can actually get on the National Health Plan there. People can claim back participation in a choir, and that sort of thing.

CHAIR - Through the health benefits?

Ms BLADEL - Yes. So those sorts of things definitely -

Mr JAENSCH - Where is that?

Ms BLADEL - In Manchester, in the UK.

CHAIR - Is that a publicly-funded rebate or is it through private health?

Ms BLADEL - You claim it on public health.

CHAIR - All right. There needs to be a distinction though, because sometimes private health companies who want to reduce their costs and make more money will fund things where there is obviously a research base. You would expect there would be a research base for the evidence to lead them to that decision. But public health is another kettle of fish.

Ms BLADEL - That is my understanding of it. So I might need to take it on notice and I will check it. But I believe that is happening.

Mr VALENTINE - You seem to have worked across a whole broad spectrum of people with different issues like intellectual disability, mental disability, acquired brain injury, migrant communities and rural communities. Is there any one of those groups that is a real standout in terms of the benefits it provides? Is that something you can tell us or not? I know it's broad and I understand that there are benefits but is there a particular sector

Mr VALENTINE - There are benefits, there's no question. I get lots of benefits out of going myself, but is there a particular sector that benefits from investment in the arts?

Ms BLADEL - That is a shifting thing because social climate shifts and so does policy, in the way the community is shifts. We have been around for a while now so we have been through a few shifts. We focus on different communities at particular times according to the greatest social need we perceive and the people who engage with us. At the moment we are working on projects that are targeting primarily multicultural groups in Tasmania through the establishing of a multicultural arts centre as a place they can assess to practise their cultures. This is at St Johns Park. At the moment that is a high priority, particularly with settlement issues for refugees. For five years previous to that we have done a lot of work with African refugees. We have had huge success in that area with helping people with settlement. We have been approached by the LINC and Centrecare to see if we can provide some services for the Hazara women refugees to help with language development and that sort of thing. The Ethiopian community approached us to see if we could provide them with a space where they could teach their own children Amharic. That is another issue that happens with refugee communities. When the children are born here or come here very young, they don't speak the mother tongue of their parents very well and that causes a generation gap in the family which then causes family disharmony. We are providing a space to the Ethiopian community to teach their children their own mother tongue.

We have created the Mkono kwa Mkono project - that means 'hand in hand' in Swahili. It was a two-year project where we brought the TSO in to play at a concert. The build-up to that project was two years' worth of workshops with the various African groups. There are several African countries here and they don't necessarily get along. Even within the groups in one country there are rifts. We invited them all to come and share their dance knowledge. Those in the community who knew the traditional dances came to teach the people from the other African communities, who picked it up very fast because they hadn't lost touch with their hips and shoulders like we have. There are high school children who arrived here in primary school so they have not grown up with their families necessarily dancing in groups and they think it is uncool. It is that classic migrant experience of, 'I am not going to be obviously from that culture because I want to fit in here. That's more important to me'. When they see there are all these white people who want to learn how to do African dance and think it is very cool, they think,

'It's okay; I can learn it'. Then they go through a stage of feeling embarrassed that they don't know it already. Once they learn it everyone has more fun.

Mr VALENTINE - It can break down barriers, can't it? I know from my own experience with multicultural festivals and events. Rather than fighting within the communities they are trying to out-dance each other, which is a better outcome.

Ms BLADEL - We had 80 people on stage dancing Ethiopian dances. Part of the process also was a 'food as culture' event where we had an Oromo group - I think a lot of them have moved to Melbourne now. This is another issue, the fact we lose them after a few years. They get on their feet and save some money and then they go to Melbourne because they perceive there are more opportunities there and maybe a better sense of community than we can provide. We are trying to do a very grassroots - step one. 'You are welcome. Here's a place. Here's a kitchen. We want to know about your dances. Here's our music; come play with us. Let's share some culture and some food. While we are sharing food, let us share stories, and while we are doing that we will learn English and maybe we will learn a bit of your language. It goes back and forth like that. From that point of welcome they form friendships and from those friendships networks form and from those networks there are job opportunities and from that the rest starts to flow.

Ms O'CONNOR - Thank you, Jami. We are interested in qualitative evidence here.

Ms BLADEL - That's good because I am not that good on the numbers, I forget them. That is why I write them down.

Ms O'CONNOR - It is the stories of people's transformation through art that you are best at telling. I wanted to give you an opportunity to talk about an example of how participation in a Kickstart Arts project in rural or regional Tasmania or on our urban fringes, in areas of disadvantage, has changed a life or something someone has said to you about how being part of that has made them feel better. You probably have countless but here is a chance.

Ms BLADEL - We went to Flinders Island to do the happiness project, which is a film making project. We work with community members, hosted by the local school and we invite other members of the community to participate with the kids to make films about what their take on happiness is and what happiness means to them. We send professional film makers in.

It is also bridging the digital divide. It is teaching digital literacy skills and that was a literacy project. Happiness is not just a nice topic to explore it is a very conscious, targeted - I really hate the word - intervention. I think intervention has it backwards. We should be assisting people to find their own solutions rather than coming in saying, we have all the answers. That is the only reason it is more effective.

We introduce the conversation of happiness because we did a lot of research before we decided to do that. After about six years of working with young people in Tasmania, we found out what they felt was the most challenging was their fear of what might happen with climate change and how to be happy, what does happiness mean.

We also realised that in rural Tasmania and rural Australia in general, there were huge suicide rates, particularly youth suicide. We decided if you ask the question about what does happiness mean to you and you invite people to have that conversation and explore and we brought in the tools of positive psychology. Positive psychology has the 24 strengths and virtues, so they became conversations about what constitutes courage, what constitutes fairness, kindness, transcendence. The 24 strengths and virtues represent the body of knowledge and three white American psychologists got together and over a couple of years they read a translation of every great philosophical text. Everything from the Old Testament to the Samurai Code to the teachings of the Buddha and Aristotle - Martin Seligman is his name. They made lists of all the things that all these philosophies agreed would lead to a good life, well lived to happiness. They distilled it down to these six virtues and 24 enabling strengths.

The strengths and virtues are the collected understanding of what will lead to happiness. We use them and it was good because it was non-sectarian and it talked to everybody. It is also based in some sound research. We used them as the starting point for our conversation. We said, 'This is what we think happiness might be. What do you think?' Then they made films. To come back to your question, Cassie, we had a young fellow who not in the age group of the group that we were meant to be working with in the school, but none of the teachers wanted him. He had the reputation of being the most difficult kid in the school.

Our film-maker give him a little flip camera, a kind of point and shoot camera, digital so you can get immediate feedback. He gave him a little task and sent him out into the garden to make a film and learn how to use the camera. He was amazing. The shots that he chose, the way that he organised his shots and the voiceover on this little film was just beautiful. This boy who, was really quite tough, was doing things like taking close-ups of daisies and saying, 'Look at this, isn't it beautiful?' And, 'This tree has been here for probably 1000 years and this is in our car park, isn't that amazing?'

Then he went around and did this great picture of the cows. He took pictures of his cows and he said, 'These are my cows. They're just here looking at me,' and the cows are all over the fence looking at him. It was very funny. So he had a really great sense of humour. The point is, when that film with some help from the film-maker was edited together and shown back to the school community, it changed everybody's opinion of him. He started to engage in school more. He started to be treated differently by his peers and by the teachers, and he positively engaged with his education probably for the first time. That is one example.

Ms O'CONNOR - My last question for now. Sometimes in contemporary Australian politics, whatever the flavour of the Government to be fair, the arts are seen as a luxury in difficult funding times. Do you think there is enough of an appreciation on the part of governments and government agencies about the connection between art and health?

Ms BLADEL - It is a bit thin on the ground, although there is the National Arts and Health Framework, which is a very good document. I believe the states and territories are committed to engaging with that. There is a good and growing body of evidence as to how it works. I am here and I am giving evidence, which is an important thing. I was involved on the Health and Wellbeing Advisory Council, which was a good thing.

There are good things happening, but it needs to be built on and increased. If we digest the ramifications of the evidence, you will see that it isn't a luxury. Those who would consider it to be a luxury have not read the evidence, or if they did, they didn't understand it.

Mr JAENSCH - Jami, I need to come along to some of your dancing classes because, as you recall, I walk like a Scottish grandmother. You can prescribe some of that for me. In our economy and in tourism, in particular, lately we have learned how to measure and describe the MONA effect. Are we measuring a health signature around MONA as a phenomenon in our Hobart community, given that Mr Walsh makes it available to Tasmanians for free? I don't know what the demographic profile is of its attendees, but it is there. It is available and it is outrageous. Can you comment at all on its health benefits or health impacts? Are they any different from Speedway?

Ms BLADEL - MONA is obviously a private business and I am not a part of it. So all I can do is say from an outsider's point of view what it appears to me. What I think has happened with MONA is that because it has been established by a private enterprise entity, they have been able to take a risk.

They didn't need to know whether or not it was going to have any positive social benefits. They didn't need to know if it was going to have any impact on anything whatsoever, other than that David had a nice place to keep his mummies.

Mr JAENSCH - You have got to look after your mummy.

Ms BLADEL - That's true. I think they make some attempts to engage the community and have been successful to a certain extent. As far as tourism goes and the financial benefits, they are undeniable. What I am not convinced MONA is providing and what I think there is a need for here is local producers who engage with local issues, local stories and local people to create local product.

It is product and process that is important. The products are where you're just working with a professional artist who is creating the products for the market; so it might be your theatre or your film or your visual artwork or the export stuff. They are a really important and fundamental part of the arts world. We are talking about social determinants of health here.

We need to acknowledge, I think, the huge importance and contribution of participatory art to impacting on the social determinants of health. What you need in order for that to flow is a place where people feel welcome and comfortable and at home. Not everybody is going to feel welcome, comfortable and at home at MONA. Also, it is about the teaching of skills.

Professional artists have a range of skills that they, as teaching artists through community arts and cultural development, can teach to community members. It enables them to develop and strengthen their own creative capacity, which then enables them to contribute and engage in society more fully. That is what I think leads to the positive impacts on health.

The economic injection of funds to Tasmanian that MONA is bringing is good. It's undeniable, but you also have to work at the grass roots. What we need to do is give people a hand up. It's a hand up, not a handout - that old adage. I don't know that one organisation can do that. I think it needs to be broader than that. I don't think MONA is doing it, personally.

Ms O'CONNOR - Don't you think it has changed our sense of ourselves as Tasmanians? It has made people proud that we have something that is international. I have seen people coming out of MONA in ugg boots and tank tops with tattoos. So it is reaching a demographic that the arts hadn't reached before.

Mr JAENSCH - They went in wearing suits. That's the other thing.

Laughter.

Ms BLADEL - That is great. I don't know whether I should talk about that, but I do notice that they are short-listed for program funding and they are up against small organisations. I question how that came to be.

Ms O'CONNOR - For state or Commonwealth funding?

Ms BLADEL - State.

Mr JAENSCH - What I think you have confirmed is that when we are talking about arts as the way forward in addressing social determinants of health, we need to make sure when our audiences are reading that, that they understand this is participatory arts as medicine rather than entertainment; there is a distinction there. I think you made the point that our culture has evolved a view that art is something done by artists you know and enjoy, as compared to something a boy with a camera makes in a car park. I wanted to make that distinction very clear. We have to challenge some thinking to get that message through.

CHAIR - Jami, do you want to comment on that from your perspective? We have had our perspective on this, so we have to get some perspective on that side.

Ms BLADEL - Participatory art is the area in Tasmania that requires some more support because it can be so effective in impacting on social determinants. The fact is that the whole of the arts sector is underfunded. I think it is all important. Participatory arts are fundamental. This is where the change will happen and it needs to be supported. You need the whole vehicle - the wheel, the chassis, the steering wheel and the fuel. At the moment, we have a few separate parts that are all falling apart and they have no fuel. It is a basket case. The arts are so underfunded. You have people burning out left, right and centre. The average age of a small to medium arts company is eight years and that is because that is how long it takes to burn out one artistic director.

Where some cultural programs are delivered that are participatory through local government, that is very positive and is to be encouraged. What local government don't do and what need to be supported are the small to medium organisations who are working in a very creative outrigger way where they are empowered to take a risk because they are not linked into a bureaucracy.

That is why MONA has been so successful and I applaud that. As producers they lead production of the cutting edge work that is going to take some risk. Local government or any bureaucracy cannot do that because that the nature of bureaucracy - and we don't want them to. We don't want our managers out there taking risks; we want them to keep everything very well-organised and safe. But we do need to support the artists and the producers. The small the medium organisations are where that is happening. They can take a risk and do some cutting edge work.

CHAIR - To try to clarify, all the arts are important and you said the arts generally are underfunded when you look at the positive benefits on health outcomes.

Ms BLADEL - Yes.

CHAIR - It is how you try to balance all that up, not picking winners but trying to support art generally; participation is part of that. Is that a fair comment?

Ms BLADEL - Yes. But in the health context, more change happens in a participatory arts that support health. So health should be investing in participatory arts.

Mrs TAYLOR - Does the fact that we call it 'art' and 'arts' and whatever, present a barrier at times? You're really talking about the things like stimulating creativity or allowing creativity to be normal and okay. It is really everyday kind of stuff everybody can do that is good for your health. Is there a better word than 'art' or 'arts'? Does that scare some people off?

Ms BLADEL - Yes.

Mrs TAYLOR - It is a bit like when people say 'art' they think you're going to look at an art gallery and look at paintings.

Ms BLADEL - The word that a lot of organisations seem to have adopted in the last 24 months is 'creative'. There are many organisations that are called 'the creative' something, such as 'creative partnerships' - they are all creative something. I do think that is the bottom line. It is about creativity. It is about building creative capacity. That is important because so much flows from that.

Art can be a tool. Arts Tasmania in their directions statement issued last year or the year before, talked about Julianne Schultz's view of the four areas of public value. They said their budget was too small so they were only going to fund the two of them.

I responded to that in a written reply, which was that it's the same argument. It has to work together. It's an ecology. So you know, there needs to be somewhere for people to move through - pathways for people to move through one aspect of the arts to the other. So creativity is an outcome of participating - not only in art, but a lot of things. I guess growing a garden is creative. I define creativity as problem-solving.

Ms O'CONNOR - With imagination.

Ms BLADEL - Maybe, maybe not. It is very creative to solve a problem. Maybe you need imagination to solve a problem sometimes. So it is actually a fairly ordinary process

when it is broken down to its basic element. Creativity is problem-solving. It happens in a lot of areas. It happens in business; that is why they value creativity. It also happens in science and in art. What we are talking about is policy that supports one aspect of all the things that go into making up creativity. I think I am just really voicing here that the arts are a powerful tool. The instrumental public value is fundamental to the whole thing and it mustn't be neglected.

CHAIR - A quick question to finish up. In light of the poorer health outcomes in lots of regional areas like Flinders Island and north-west Tasmania particularly, do you think there should be a greater focus on funding of the arts in those areas and supporting these small to medium organisations that you've talked about?

Ms BLADEL - At the end of the day, Tasmania is a small place. It takes two hours to get from one end to the other.

CHAIR - These people cannot to travel to participate in Launceston and Hobart.

Ms BLADEL - Yes. But the artists can travel to them. It really depends where the good artists are and whether or not their programs are achieving outcomes.

CHAIR - Thanks. We will leave it at that. We are going to have a 10-minute break. I know we are running late and I apologise to our next witness. But we do need to have a short break. There is some food over there for us to eat and we can have a toilet break. Thank you very much.

THE WITNESS WITHDREW.

Ms GAIL WARD, CANCER SCREENING AND CONTROL SERVICES, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - Gail, thank you very much for coming along. You are probably aware this is a public hearing and everything is recorded on *Hansard* and it will form part of our record and potential report. You are covered by parliamentary privilege while you are before the committee but not is you speak to the media or whatever afterwards.

Ms WARD - I will start off giving a little bit of background about myself, why I am here and the roles I current fulfil. The reason why I requested to speak with the committee separately to other preventative health groups is because the work we do is unique and distinct, although aligned with and in collaboration with others.

My background is in allied health and I have spent most of the last 25 years of my life working in cancer screening. I was involved in the establishment of the Breast Screen Tasmania Program and I have been managing the Tasmanian screening program since 2003. As part of that role, I am on a number of national screening committees including the RMAC Standing Committee on Screening which is not just cancer screening, but any screening program that state and territory or Commonwealth governments determine should be evaluated, reviewed or considered for implementation as a national screening program. I thought I would mention a couple of those programs here today because they are important to this agenda.

Over the last few years, the standing committee on screening has evaluated and developed a national framework for the newborn hearing screening program. If we can detect hearing deficits in babies at a young age, we are able to implement strategies so their issues can be addressed and corrected. In some instances interventions can be implemented so they do not develop the behavioural and learning issues and all the consequences of that.

When we are talking about prevention, there is a very broad spectrum and little niche programs such as these often don't get the level of consideration that they should for the impact they have, not just on the individuals but on the community as a whole.

There is another screening program that also is not mentioned much. For those of us who have had babies, we would remember the newborn blood spot screening where all three-day-old babies have their heels pricked so their blood can be tested for a range of genetic abnormalities. That enabled early intervention to address or prevent serious illnesses developing down the track. These serious illnesses can subsequently cause some significant mental deterioration requiring lifelong care if they are not addressed in the earliest stages of life. I would implore the committee to consider the importance of some of these very niche screening programs. Whilst they are not directly on the usual preventative agenda, they are equally important for the health of individuals and the community and the costs on the community if we do not consider them.

That brings me to my particular areas of expertise which are the breast, cervical and bowel screening programs. These fall into the agenda of secondary and, unfortunately, sometimes tertiary prevention programs. This is where we can't prevent the disease from occurring but we know by diagnosing it early we can in most instances effect a cure.

Particularly for breast cancer but also bowel cancer, it means people are not being struck down in the prime of their lives. Individuals are not being left on their own to raise children and the community is able to realise the benefits of individuals who can remain healthy because we have cured the disease.

As a matter of interest, cervical cancer, prior to the implementation of the cervical screening program, was the fourth biggest killer of women in Tasmania. The program was implemented in 1994 and it is now the eighteenth. We have achieved significant improvements in the mortality of women that is attributable to cervical cancer just in that 20 years. With the introduction of the HPV vaccination program and the changes to the national screening program we believe we will make cervical cancer virtually non-existent over the next 20 years in Australia. Unfortunately, worldwide that is not the case. Half a million women are diagnosed with cervical cancer every year and a quarter of million women worldwide die from it. In Australia we are very fortunate in that regard.

Bowel cancer affects both men and women. We lose five times more people to bowel cancer in Tasmania each year than to road mortalities, which is a fairly significant statistic in terms of the interventions that can make such a huge difference. Bowel cancer can be prevented if we can detect the pre-cancerous cells and treat them. If we can detect bowel cancer early, we can cure it. So the investment in these programs across the state is absolutely critical. My concern with the bowel screening program is that because of the method of delivery and the health literacy required of participants, we appear to be targeting the screening program - the Commonwealth Government appears to be targeting the program - at the wealthy, worried well who have health literacy and who are able to understand the kit and take it in their own home. We have some significant program delivery issues that need to be worked through with the Commonwealth Government about access for people from rural, remote and socioeconomically disadvantaged areas.

When I first started working in Allied Health back in the 1970s, most women, when a lump was found, would have to sign a consent form before they went into theatre saying, 'You can take my whole breast off if it is not good news'. We used to have little boards beside the women in their beds so they would know whether they still had their breast when they were recovering from the anaesthetic. Nowadays, as a direct result of the BreastScreen program, it is rare for women to have a mastectomy. Women know when they go under the knife exactly what is going to happen. Where five-year survival rates back in the 1970s were only about 50 per cent, nowadays women diagnosed through the BreastScreen program have a five-year survival rate of the high 90s and a 10-year survival rate in the low 90s. In most instances, death is attributable to some other cause. These secondary prevention initiatives are achieving significant outcomes for Tasmania and the Tasmanian population and are also saving the health system through not having to treat and manage people with late-stage disease.

I could talk about the inequities that relate to the social determinants of health but I am sure you've probably heard a lot about that already.

CHAIR - We would appreciate you giving your views on that. It is the predominant focus of the committee, so if you would not mind addressing your mind to that.

Ms WARD - In Tasmania, Cancer Screening Control Services works across not just the screening programs but also health education in cancer control. The work we do focuses not just on encouraging people to participate in the screening programs but also talking about the early signs and symptoms of disease - how you can improve your lifestyle risk factors so you can reduce the likelihood of developing cancer. We all know that in many instances it is the luck of the draw whether an individual develops cancer or not. It is hidden in many of the genes we still haven't investigated or discovered yet. One of the things we frequently find, and my community engagement teams come back and report on, is the incredibly low health literacy across Tasmania.

There is a very interesting paper that was published in the US talking about people's understanding of their own bodies. This research identified that 45 per cent of individuals did not know where their rectum was. If you don't have that level of basic understanding of how your body works, how can you make solid decisions on what is going to improve your health - the right choices with alcohol, smoking, diet, et cetera?

A lot of the work my team does is in schools where they work with the upper high school years - 9s and 10s - talking about health preventative screening and early detection to help people to understand what they can do to influence their own lifestyle outcomes and the importance of their own choices on their health outcomes. But it's something that I think is not a regular part of education nowadays. Health literacy from our observations across Tasmania seems to be deteriorating rather than improving.

That means we have significant inequities in participation in the screening programs. I have just reviewed this morning the BreastScreen Tasmania annual data report that we submit to BreastScreen Australia every year. Part of that report includes a breakdown on participation across rural, regional and remote areas, but also by SES quintiles.

What is really interesting is that even though we take our mobile unit to as many rural areas of Tasmania as we can achieve within the timeframe and the resources that we have, participation from the low SES quintile continues to fall and is now around about 53 per cent, compared to participation from the highest quintile, which is around 67 per cent.

Mrs TAYLOR - Even that is pretty extraordinary. I would have thought that more than 67 per cent of the 'worried well', as you say -

CHAIR - That would include women who have had a positive breast screen. They have had surgery and cannot go back to the screening service. You take all those women out for five years.

Ms WARD - Yes. However, it is a really good point that you raise in that Tasmania's population participation in breast screening is around about 57 per cent. That means that we have a significant proportion of women in the eligible age group not participating in screening. There is a range of reasons for this. Health literacy is part of it. The other reason is we operate under a capped funding model, so we have no growth capacity.

We have become as lean as an organisation can become. In 2014 we screened a record number of women, but of course Tasmania's population is ageing. So even though we

screened more, the difference increased by an even greater percentage. Our participation rate actually dropped from 2013, even though we screened more women.

Ms O'CONNOR - Do you have to turn some women away?

Ms WARD - Yes.

Ms O'CONNOR - Do you have waiting lists?

Ms WARD - Yes.

Ms O'CONNOR - How long would someone potentially be on the waiting list?

Ms WARD - That can depend. Obviously it depends on where they are in Tasmania. In Hobart and Launceston, it is not very long - a few weeks. In rural and regional areas where we only visit for a couple of weeks every two years, in some instances they can wait two years.

CHAIR - Those women are given advice as to where else they could have the screening test done. But then there is the cost barrier at that point.

Ms WARD - Where they can have a diagnostic test, yes.

CHAIR - Which is a cost?

Ms WARD - Yes.

CHAIR - Do you know how much that is?

Ms WARD - If they have no symptoms, and if they do not comply with the eligibility criteria for Medicare, then their out-of-pocket costs will be in the vicinity of $150 to $200, and significantly more if they have to have an ultrasound.

CHAIR - This would be the majority of them. That is why they are having the screening, because they are asymptomatic. Is that right?

Ms WARD - That is right.

Ms WHITE - Gail, I want to ask about your capped funding. I have been corresponding with the minister about BreastScreen Tasmania recently. In his reply, he said he is expecting to perform 9 000 additional screens over the next four years as the result of a new mobile unit in the north of the state and refurbishing the current unit. What staffing increase is going to match those two mobile units? I would imagine to perform 9 000 additional screening over four years you will need more staff to do that, particularly as you already have a waiting list. Would you agree staffing needs to increase to perform 9000 additional screens?

Ms WARD - There are a couple of issues there we need to talk about. One is, at the moment we currently screen about 30 000 women a year. The 9 000 additional screens the minister was referring to is a combination of the Commonwealth Government's funding

for the expanded cohort of women aged 70 to 74. We have no definitive funding amount for the extra women who will be screened on the new mobile unit which will be implemented from early next year.

Ms WHITE - The expectation is that you perform the additional screens without additional resources?

Ms WARD - Under the existing funding, yes.

Ms WHITE - My assessment is that a 9 000 increase is equivalent to 2 250 extra a year which is a 7.5 per cent increase in the workload for the existing BreastScreen Tasmania office. That seems an extraordinary increase to be expected to be met with the existing resources.

Ms WARD - Yes, it is.

Ms WHITE - With the mobile units, I thank you because you are doing some extra east coast visits and I know the community is very grateful for that. Including those extra towns, does that place extra pressure on you because I assume your budget allocation does not increase to meet that extra demand?

Ms WARD - That is right. The movement of the mobile unit is costly. We have a driver who moves the bus all over the state and sets it up at each location. At each location we have power costs, et cetera, and accommodation costs for the staff as they move around the state. Each time the mobile unit is moved, it takes half a day to pack it up because everything needs to be packed away. The equipment that is worth $500 000 needs to be constrained so it can be moved safely. Then it is driven to the new location, plugged into the three-phase power, water, et cetera, and the staff unpack the mobile unit. That takes another half a day and then the quality assurance testing of the equipment has to occur. The more we have to move, the less capacity we have to provide screening appointments.

Ms WHITE - In the correspondence I have had with the minister I asked about the One Health reforms that take effect from 1 July. My question was whether BreastScreen Tasmania would remain a stand-alone entity. He has written back and said it will not; it would be absorbed into the THS. I have written again asking the Budget be quarantined because, as it falls under primary and preventative care from 1 July, the risk is that your funds might be used for other things if there are pressures in other areas. You are nodding your head, so clearly you share the concern.

Regarding the move to the THS from 1 July, for an organisation like yours where there are obvious fixed costs, you know how much it costs to screen individuals and you know what your budget needs to be to meet the demand of 30 000 women a year. What guarantee is there, when we move to one THS that the budget for BreastScreen Tasmania will be quarantined so you can keep performing at the level you are and meet the expected growth in demand?

Ms WARD - Some of those questions I can't answer because I just don't know. However, I have been manager of this department since 2002-03 and I have continually strived for the screening programs to remain part of Population Health. The reason for that is we

are population-based screening programs. We are not acute health programs. One of the concerns of our clinicians and the staff who work with the screening program is that these grassroots earlier intervention/prevention initiatives cannot compete with the might of acute health services. We are also concerned that not only will we be required to deliver services unde a capped funding model but that, potentially, those funds could diminish as a result of where the unit is subsumed.

CHAIR - Clearly, this is a preventative health model. If there is any diagnosis they are then into the acute system anyway, so clearly it is a primary health issue. I find it interesting the responses Rebecca has got from the minister. Considering everything that has been going on recently with the health reform, preventative health hardly got a mention anywhere and acute services are the big, money-hungry beasts that we are dealing with. As to funding primary health and what will soon be the Tasmanian primary health service, which is Tasmania Medicare Local now -

Ms WARD - The PHN - the Primary Health Network.

CHAIR - Why wouldn't it sit there? Maybe it will sit there, but you don't know what is going to happen?

Ms WARD - We have been told we will be moving to the THS, so we will be situated under Statewide Services somewhere within the THS. I don't believe that has been finalised at this point in time. The issue for me is the work we do - we bring in well people, we make a small percentage of them sick or diagnose they are unwell so they can receive early treatment and be cured. The long-term costs on the health system are reduced by diagnosing early. In the instances of cervical and bowel screening, it is preventing the cancers from occurring. That thought process and philosophy is anathema to acute health services that have sick people who come in to be made better; so it is the complete antithesis Even our approach to work is completely different to acute health services. Cancer screening is very client-oriented. We continually measure, monitor and evaluate and improve what we do because we want more people to come in and participate in the screening programs.

CHAIR - Have you made representation to the minister around this? What response have you had?

Ms WARD - I have written submissions as far as the role delineation framework is concerned and also the new Tasmanian Health Service.

Mr VALENTINE - Reading the recommendations that have come forward - and this is from someone else's submission but they are talking about mandating physical activity and health impact assessment in all planning and policy decisions. I am interested, from your perspective, whether you see a standard health assessment being of use across the population? Would it assist you in doing your work in certain ways? We have standard immunisations; we have those things that happen. Do you see a benefit in having a population-wide health assessment at periods during a person's life?

Ms WARD - Absolutely. We also work very closely with general practitioners in providing them with information and resources and encouragement for them to encourage their patients to screen. That is only those people who go to the doctor. As we know, with the

inequities in health, those who most need it, and who are most at risk, do not go to the GP unless they are extremely unwell. The last thing the GP is going to be worrying about at that time is whether they have had their bowel screen, their breast screen, their cervical screening or even their blood pressure check because of other co-morbidity issues.

Yes, but I think we have to be real and the important part about this is empowering individuals, improving health literacy and getting people engaged in their own decision-making as far as their health choices are concerned.

Mr VALENTINE - The people who walk through your door come because they wish to come, as opposed to being forced to come. If there was that set health check at certain periods -

CHAIR - Like with a baby where you have your six-week check and then your 18-month assessment. There are a few like that.

Mr VALENTINE - Yes and it might be at the end of high school and at various times. I am not suggesting what it could be but there could be a benefit there in picking up some of those.

Ms WARD - Absolutely. Although, having said that, the BreastScreen program sends invitations from the electoral roll to all women when they turn 50. Once they are on the BreastScreen register, we re-invite them every two years until they turn 74.

Mr VALENTINE - Could that be done at an earlier stage, rather than 50? Does the prevalence below 50 make it not worthwhile?

Ms WARD - Women aged 40 to 49 are eligible to participate in the screening program. For women younger than 40, the risks outweigh the benefits. It means lifetime exposure to radiation. The number of women who are recalled for what may be radiological abnormalities but in fact are not is because of the architecture of a younger breast. There is a range of reasons.

Absolutely, that would be one arm in the preventative health strategy. In Victoria, the Victorian Health Department funded at IT software package that hooks off the side of medical director, called PenCAT which is reminder system for just these sort of things. It reminds them about their age, whether they have had their blood glucose and cholesterol checked, their bowel screen, et cetera. It is a flag reminder for GPs to check with their patients when they are in. When you go to the doctor, you are there for one reason and you don't necessarily want to talk about all of that other stuff. Tools such as that remind both the GP and also the individual that you are this stage of life; these are the checks you should be doing. That would be a really constructive strategy.

CHAIR - I think Rob's point, and you made the point yourself, is that people often don't go to their GP until they're sick - they might have the flu really badly. It is the only time you can get them in the door. Maybe they should do their pap smear and their bowel while they are there.

Ms WARD - Yes.

CHAIR - The last thing you probably want to do is have a pap smear when you're feeling really bad with the flu, but if that is the only time you are going to walk in the door -

Ms O'CONNOR - You need to psychologically prepare for a pap smear.

CHAIR - Too much thinking - you can over-think these things.

Mrs TAYLOR - It takes longer. Therefore an ordinary appointment is not going to -

CHAIR - That's right. My question was: is there a way that the system can be structured? This comes back to the whole Medicare system. It comes back to the way doctors are funded, I guess. Mind you, my doctor doesn't do pap smears because he doesn't like doing them on people he knows. So the practice nurse does it, who is much better at it anyway. It is about getting recognition for practice nurses and nurse practitioners in these spaces where they are often a bit less threatening. Most people feel a bit more comfortable. Do you have any ideas about how that could be structured and how we can sell that to the Governments who fund these things?

Ms WARD - One of the challenges that we have had with the cervical screening program for a number of years is the restrictions on health provider identifiers for anybody who is not a nurse practitioner or a general practitioner. That means in terms of outcomes and quality of screening tests, we are not able to capture the data to be able to feed back and monitor and implement quality improvement initiatives where they are.

As you have identified, you don't have to be a doctor to do a pap smear. However, many doctors also do pelvic examinations at the same time, which is part of a 'well woman check'. If you're really lucky, they entice you to strip off the top as well and do a breast examination. That is part of that holistic check. Does that need to be a GP? I don't believe that it does.

I think that we do not make adequate use of nurses and allied health professionals in that preventative and early detection arena. It could enable doctors to focus on dealing with acutely unwell people. Screening or health checks could easily be done by nurses. Of course, there would need to be a whole framework around Medicare rebates and monitoring and evaluation of performance. I cannot see why it cannot happen. I think it should happen. If you look at what happens in rural and remote communities and in particular in Aboriginal communities in outback Northern Territory, it's the nurses who -

CHAIR - The Aboriginal health workers too. Nurses as well. We have made some progress in some of these areas in midwifery but the doctor still has to sign off on the form for the test that every woman has to have. You need to know their blood group. You need to know a range of other things about her -

Ms WARD - So a nurse cannot request a pap smear or a blood test, and the woman still be eligible for a Medicare rebate.

CHAIR - That is right.

Ms WARD - So there are all of those layer upon layer of impediments -

CHAIR - Is one of the biggest impediments the turf war argument, do you think, in the medical profession? Is there more than that?

Ms WARD - I think that there are certainly individuals who have spent a long period of time developing their skills and their qualifications. They find it challenging when others they perceive to be lower on the rung are wanting to do the work that they perceive as theirs. However, we have to address this and we need to have open and honest conversations about what is in the best interests of the country and the people rather than individuals.

CHAIR - Screening colonoscopy is another thing that is in some countries. Nurse practitioners undertake that role. Can we not do that in Australia?

Ms WARD - Yes, we can. There are a couple of nurse practitioners in New South Wales and Queensland who are doing colonoscopies and limited sigmoidoscopies as well.

CHAIR - But you're saying there is a model there?

Ms WARD - There is, absolutely, and for screening. At the moment the Commonwealth Government is ramping up the bowel screening program so that all Australians aged 50-74 will receive a biennial invitation by 2020. As you can imagine, out of that there is about a 7.3 per cent positivity rate of participants who need to have a colonoscopy. At the moment in Tasmania, it is a double-edged sword because we don't have enough people without private health insurance participating. We have not yet seen the backlog for colonoscopies in the public health system because the low SES groups are not participating in the screening program.

CHAIR - Because they don't understand - they can't read the documentation and all those things?

Ms WARD - Yes.

Mr VALENTINE - I am interested in how you are recruiting people to have the bowel cancer screening done and the success or otherwise of that.

Ms WARD - The National Bowel Cancer Screening Program is a Commonwealth Government initiative which Tasmania supports in the in-principle agreement for Tasmanians to receive invitations from the Commonwealth Government to screen. One of the challenges in the design of the screening program is that it is all done by mail. There are no alternate-entry pathways for people to participate in the screening program. With breast screening and cervical screening you can request a screening test at a convenient point in your lifetime many times over. But the bowel screening program is dictated by when the Australian Government sends the invitation. You then have a window of three months and if you don't take the test then, you can't for another how many years until they send you the test again. The states and territories have been lobbying for a no-wrong-door approach where people can pick up kits from the chemist, their doctor or wherever. However, at this point in time the design model for the National Bowel Cancer Screening Program is set by the Commonwealth Government.

Mr VALENTINE - Is it for women only?

Ms WARD - No. Our role in Cancer Screening Control Services is that for those people who have a positive bowel screening test but have not progressed on to a colonoscopy, we receive advice from the Commonwealth Register saying, 'Here is a list of people who have had a positive screening test. It has been six weeks and they haven't had a colonoscopy reported to the register. Go and follow them up and find out what has happened'. We then transition them along the pathway to ensure they have their colonoscopy, they have either diagnosis or their bowel cancer is excluded. That is the role Cancer Screening Control Services has in that regard.

Ms O'CONNOR - I was quite taken aback before, Gail, to hear you say you thought the health literacy of Tasmanians now is worse perhaps than it has been in your experience. Have you thought about why that may be? What are the causes for that? Is there a generational dynamic to this? There is a health and wellbeing part of the curriculum for young people today. It is a standardised part of young people's education, so most of them probably know where their rectum is by the time they get to grade 10. What do you think is the cause of such poor health literacy despite all the efforts to improve it?

Ms WARD - I think it is like most things. In order to maintain the competency it needs to be constantly reiterated. Perhaps in grade 10 they knew where their rectum was. When they leave school at grade 10 or they go on to years 11 and 12 which have no elements of health or science, those issues are often well forgotten within a very short period of time. Certainly that is what we experience, and we work across the community with community groups, with councils, with workplaces, even with Parliament House staff. We hold education sessions on cancer screening, prevention and early detection.

We have found, as an example, one of the frequent questions that we are asked is, 'My husband had stomach cancer, therefore I have a family history of breast cancer or whatever'. Just the ability to understand some fairly basic concepts of biology is quite rare. With the women who are recalled to BreastScreen for investigation with a screen-detected abnormality, we find similar issues when you say, 'Do you have a family history of breast cancer?'. Then it is often a non-blood relative that is the family history.

CHAIR - Do they know who their blood relatives are?

Ms WARD - And that is another issue as well. Health literacy is the ability to understand those concepts and it is something that we have noticed a clear decline in over the last 10 years.

Ms WHITE - I wanted to follow on here because I was interested in the work you are doing in schools in years 9 and 10. I assume that is under the RACE, Recruitment and Community Engagement units, which also do the work you have just been speaking about. Could you talk about what happens in schools? Which schools you go to and how regularly?

Ms WARD - It varies. I have a very small team of three staff who work across the state and provide community engagement and education sessions. For example, we go to Agfest every year, which generates phenomenal interest and engagement opportunities with people whom we do not often meet. We frequently work with country women's

organisations, Probus and Rotary, across the state. As part of that working within communities, we also try to get into regional and rural schools, as well as schools across the metropolitan areas.

It is very much dependent upon relationship building and a staff member being exposed to a presentation or an education session thinking, 'I could use that'. That is often how it starts. We have provided sessions across public and private schools. It is completely non-selective, but it is, of course, dependent upon invitation from the teachers. We would love to do more. We would love to have staff to be able to do more. Also, the other area of education that we do is working with health professionals, educating them about the benefits of population screening. It is not included in their education.

Ms WHITE - When you do into a school, what things do you normally speak with the young people about?

Ms WARD - It will depend on what module it is we are presenting within. Sometimes, if it is just for girls, we will talk about HPV, we will talk about HPV immunisation, sexual health, or cervical screening. Most of the time it is across the board about prevention, healthy lifestyle choices, diagnosing cancers early and, most particularly for those age groups, we talk about skin and the cancers, and particularly cervical cancer for girls. At that stage, what we usually do is lobby through them to get the mothers to come to BreastScreen. It is a multi-pronged approach.

CHAIR - Mike raised the point with me that there seems to be a greater media campaign about breast cancer than there is bowel cancer and historically that has been the case. When you are dealing with poo as opposed to breasts, it is always a bit better in terms of media campaigns. Is that true or do we not notice it? Do we need to have a bigger focus on bowel cancer?

Ms WARD - Absolutely. Five times more people die in Tasmania each year from bowel cancer than are killed on our roads. The challenge with the bowel screening program is that it is not a joint program of Commonwealth, state and territory as the other programs are. What happens with the breast and cervical screening programs is that we have collaborative initiatives across the jurisdictions in marketing and health promotion campaigns around breast and cervical screening. You probably recall seeing the 'Don't just sit there' with the bottom half of women sitting in a chair.

Ms O'CONNOR - It is through the toilets all through this building - just so you know; the poster is there.

Ms WARD - Excellent.

CHAIR - The prostate check is on the back of the women's toilet doors too.

Ms WARD - Good. The bowel screening program is completely controlled by the Commonwealth Government as far as social marketing is concerned. My team work with individuals, encouraging them to take the test but we do not have capacity to do any other form of social marketing, which is a great shame. We have it on our website but we can't advertise or market.

CHAIR - Regarding getting the message out there, you said you go to Agfest and you have quite a good success there that you might not otherwise. What other community events or festivals do you go to?

Ms WARD - Virtually you name it, we are there - Mother's Day Classic, seniors expos, a lot of work with community houses with the Aboriginal health services. We frequently have training sessions at Karadi, CTAC, and the Circular Head community. We take the mobile breast screen unit to King Island and Flinders Island. In fact, we set the participation record for Flinders Island with 102 per cent of the population participating in screening.

CHAIR - There must have been a couple of babies born at the time.

Ms WARD - No. There were some visitors to the island and they popped in.

CHAIR - What about things like Taste of Tasmania and Festivale and those other events?

Ms WARD - Taste of Tasmania and Festivale do not encourage participation by Health Department education. I manage the Government contract with the Cancer Council, and a lot of their work is being present at these initiatives to put the prevention message out there.

CHAIR - All right. I think we might wrap it up at that, if that's all right. I will just ask Mr Gaffney's question because he cannot speak: are there opportunities for collaboration between the Federal and the Commonwealth Government, particularly in promotion of these screening opportunities?

Ms WARD - Absolutely. The breast screening program and the cervical screening program are wonderful illustrations of how successful these screening programs can be. At the moment, the national participation rate in the bowel screening program is just under 30 per cent. So as an example, because the program sends out the test kits in the mail and only about 30 per cent are returned, there are an awful lot of pathology tests that are going in the rubbish bin. If we could have alternate entry pathways that people could elect when they wish to participate, it could actually save money that would enable us to get those social marketing messages out there.

Ms O'CONNOR - And save lives.

Ms WARD - Yes.

CHAIR - Thank you very much for your time, Gail.

Ms WARD - Thank you for your time.

THE WITNESS WITHDREW.