PUBLIC

THE JOINT SESSIONAL COMMITTEE ON GENDER AND EQUALITY MET IN COMMITTEE ROOM 2, PARLIAMENT HOUSE, HOBART ON MONDAY, 21 NOVEMBER 2022

SHORT INQUIRY PROCESS INTO
GENDERED HIGH RATES OF SUICIDE IDEATION AND SUICIDE

Hon JEREMY ROCKLIFF MP, MINISTER FOR HEALTH AND WELLBEING, WAS CALLED AND EXAMINED.

Mr DALE WEBSTER, DEPUTY SECRETARY, COMMUNITY, MENTAL HEALTH AND WELLBEING, DEPARTMENT OF HEALTH, TASMANIA, AND **Mr GEORGE CLARKE**, GENERAL MANAGER, MENTAL HEALTH, ALCOHOL, AND DRUG DIRECTORATE, DEPARTMENT OF HEALTH, TASMANIA WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - Welcome to the committee. This is part of a short inquiry process we are having into the gendered nature of suicide and suicide ideation in determining whether we need to do a further inquiry into this space. We will get you to introduce your team at the table. I will need them to make the statutory declaration. Has George presented to a committee before? You understand that parliamentary privilege - I don't need to go through that with you.

Mr ROCKLIFF - With me, Chair, is Dale Webster, Deputy Secretary of Hospitals and Primary Care and George Clarke, General Manager of the Mental Health Alcohol and Drug Directorate.

Thank you very much. I might take off my mask. I have a bit of a sniffle. I've had RAT test: negative. I thought I'd be extra cautious.

Chair, I have an opening statement, which I'll run through as quickly as possible, then I'll leave you in the capable hands of Dale and George. I thank you and the committee for your time today talking about suicide and suicide ideation. It's critically important. Talking about suicide can be very challenging. I encourage everyone to reach out to your natural supports if discussion raises any issue for you and those listening to this broadcast. It's important to take care of ourselves, and each other as well.

Tasmanian Lifeline is available on 1800 984 434 from 8 a.m. to 8 p.m. every day. The Lifeline Crisis Support Service is available 24/7 on 13 11 14.

Chair, ABS data released in October this year shows 80 Tasmanians died by suicide in 2021. They each had people who loved them and cared for them, people who now miss them, and grieve their loss. Their deaths have had a devastating and widespread impact on all their families, friends, children, workmates and communities. We offer deepest sympathies. The impact of grief can be profound. Too many Tasmanians continue to experience or be impacted by suicidal behaviour and sadly die by suicide. Preventing suicide is challenging. The reasons people take their own life are complex and not necessarily connected with mental illness. However, I know we're all deeply committed to working with all Tasmanians to ensure that everyone who experiences suicidal distress can access compassionate care and support when they need it.

Suicide prevention is a whole-of-government, whole-of-community issue. It's up to all of us to what we can to support each other, to reach out to others in time of disruption and distress, and to build hope for the future. Since coming to Government, we've been delivering on actions in the Tasmanian Suicide Prevention Strategy. Rethink 2020, Tasmania's overarching mental health plan, includes suicide prevention as a new focus area. We are continuing to work to build the resilience and capacity of local communities to develop and implement suicide prevention community action plans and have extended this work to include engagement with local councils. We are supporting communities to understand and safely talk about suicide and the impact of suicide through development and release of the Tasmanian Communications Charter. We have established Tasmania's first Suicide Register and in December last year, had the second report from the register from the period 2012 to 2018 was released.

Reports like this, as I have said in other forums, particularly budget Estimates, ensure we have the best available detailed data to guide us. Consultation on the new suicide prevention strategy has been occurring in recent months through a range of activities, including a broad community survey, key informal interviews, stakeholder workshops across the state. The prevention strategy provides a broad overview of the general direction of the key areas for suicide prevention in Tasmania. Given the complex ways suicide impacts our diverse communities across the lifespan, we are taking a whole-of-government approach and developing this new strategy. I anticipate releasing the new strategy before the end of this year and this will be followed in early 2023 by the release of the strategy's first annual implementation plan that will include more targeted actions and supports, including for priority population groups.

I can provide some high-level comments about the new strategy, if that was the wish of the committee, as background.

In February this year, our Government signed the National Mental Health and Suicide Prevention Agreement with the Commonwealth, and in March, the Tasmanian Commonwealth Government signed the Tasmanian Bilateral Schedule on Mental Health and Suicide Prevention. This commits both governments to implementing systemic mental health and suicide prevention reform in Tasmania. I have also made the decision to elevate suicide prevention, along with mental health, to a Premier's priority. What this means is that the Department of Premier of Cabinet will have a central role working with the Department of Health as our lead agency for suicide prevention, but also all government agencies and our partners from Primary Health Tasmania to drive suicide prevention across all levels of government and collective action across the community and across the service system, and collective action government wide will ensure we are doing all we can to reduce suicide and suicide attempts in the state. I will have more to say about that when the new strategy is released in coming weeks.

We have consulted with more than 600 community members and key stakeholders to inform the development of the new strategy, seven consultation workshops and three lived experience focus groups were held in Queenstown, Smithton, Burnie, Launceston, St Helens, and Hobart. I know George attended all of these. A series of 23 interviews with key informants and sector thought leaders were also conducted, we conducted two online community surveys, including a survey to inform the first draft of targeted survey for young people aged 12 to 25, as well as feedback on social media. We have also sought feedback from the community on

the consultation draft. The department also hosted targeted focus groups to ensure views of representatives of specific population groups, including LGBTQI+, culturally and linguistically diverse communities, Tasmanian Aboriginal people, Australian Defence Force personnel and veteran communities and organisations focusing on men's health initiatives. Meetings were held with representatives from the Tasmanian Suicide Prevention Committee, and the state-wide Mental Health Executive Committee.

Six themes emerged from our state-wide consultation; enhance the services we provide to be connected, affordable and accessible; compassion is key to our approach across all settings; strengthen our communities to be empowered to plan and respond to suicide and its impacts; prevent and respond early to distress, including addressing the social and economic factors that contribute to distress; build and support our workforce so they can deliver a person centred approach and improve the way we implement and evaluate a strategy. These themes are broadly consistent with the final advice from a national suicide prevention advisor, which stresses that suicide prevention must become a shared responsibility for all levels of government, all portfolios, and all communities.

I am confident, Chair, we have captured the views of the Tasmanian community on suicide prevention in our new strategy, but we know we need to focus our collective efforts on effective implementation and sustained funding to ensure we can absolutely make a difference. From those few words, Chair, I will leave it into your hands, thank you.

CHAIR - As you would know, this is the gender and equality committee. In terms of what you talked about target groups with young people, LGBTQI+ and a range of others, has there been any particular work looking at the gendered impact of suicide and suicide ideation and what work can be done there. How have you assessed that and how will you report against that?

Mr ROCKLIFF - Sure, we can talk about men's suicide prevention if you would like, to begin with. Given what we know about the disproportionate impact of suicide and suicidal distress on men, the Department of Health has prioritised consulting with men's health organisation representatives, including Men's Resources Tasmania to inform the next Tasmanian Suicide Prevention Strategy. This has involved thought leader interviews with key experts and advocates for men in Tasmania and nationally to present their views and to help better understand how we can improve our suicide prevention and mental health services to ensure we are meeting the needs of our male population.

Through consultation we have heard male suicide is more than a mental health issue. It is a complex, social issue caused by a range of factors and requiring a targeted response. The new strategy, as I spoke about, will prioritise initiatives and activities and yearly implementation plans throughout the life of the strategy, including activities that address the complex issues that contribute to men's suicide, suicide ideation and suicidal distress as well.

Dale, would you like to add anything further to that?

Mr WEBSTER - We know males die by suicide at a higher rate than females. However, females are more likely to attempt suicide and be diagnosed with depression, which is one of the main leaders to suicide. Men are more likely to die as a result of their attempt. That is a global phenomenon and is reflected in the national statistics on suicide also. In 2021, our

preliminary data shows males died by suicide three times that of females in Tasmania, while for the period 2012-18, males died by suicide at nearly four times the rate of females.

I put a note of caution to that. We have heard from some of the committee we need to close the gap between female and male suicide. We need to be cautious about that type of narrative. It is the view of the Mental Health Services we need to understand all we can about male suicide and suicidal thinking, and equally need to understand all that we can about female suicidal ideation and suicide. We must understand and promote the protective factors we know exist for suicide, such as increasing social connection, reducing stigma and discrimination, accessing help early when people are in distress. We also need to continue to work with our priority population groups, including young people, Tasmanian Aboriginal people, LGBTIQ+, culturally and linguistically diverse, the ADF personnel and veterans.

Indeed, co-designing actions to take forward into an implementation plan, informed by people with lived experience, evidence and research is a focus. We also need to remain vigilant in relation to the suicide data. The Tasmanian Suicide Register operating since 2017 allows us to interrogate, to draw a deeper picture of all deaths by suicide in Tasmania. The reason why it is only as far as 2018, as the committee would realise, we rely on the data from the Coroner's office and we do not include data in that register unless it has been confirmed by the Coroner. That way we can look deeper into the data.

The national data is also assisting us, in understanding psycho-social risk factors for males and females. In 2021, the top three psycho-social risks associated with male suicide under 25 were personal history of self-harm, disruption of family by separation and divorce and disappearance or death of a family member. For women under 25, the top three were personal history of self-harm, problems in a relationship with a spouse or partner, or disruption of family by separation and divorce.

However, for males 65 years and older, the three highest psycho-social risk factors were limitations of activity due to a disability, personal history of self-harm or disappearance, and death of a family member, so the grieving process. In 2021, males aged over 85 nationally had the highest age-specific suicide rate, while females 50 to 54 had the highest female age-specific suicide rate.

Tasmania's age-standardised death rate for females from 2017 to 2021 was higher than the national average, and is the third highest in Australia behind the Northern Territory and Western Australia. For males, it is again higher than the national average; the third highest in Australia behind the Northern Territory and Queensland.

I give that information more to show you how complex it is. There is not one answer that we can deliver for males. We need to know about the community, we need to know about the age group, we need to know about the risk factors in order to deliver them. That is why our strategy will work on implementation plans at a community and priority population level.

Mr ROCKLIFF - I just want to add very briefly to that. I'll try to remember this as best I can. In the first suicide register we put out, which covered the years 2012 to 2016 inclusive, I believe about 359 people died by suicide. One of the reasons we're drilling down far deeper is to get a better understanding. At that time, I believe about 50 per cent of people - males, maybe - that had some contact with police or the justice system. This is noteworthy data. We

can focus on those particular area where we need to put resources to support people more in that cohort.

CHAIR - Thanks for that, Premier, because it leads to the question I was going to ask you. The data is interesting, complex, dense, and you can't apply a one-size-fits-all approach to any of this. I don't think anyone's suggesting that you can, but how will that inform the strategy and the policy development around the gendered nature of suicide completion, acknowledging that there are still a significant number of women who have suicidal ideation?

Mr WEBSTER - I think the first thing it does is help us understand and shape any of our male-led social services, in particular. We need to break down our community-based continuity of care very narrowly on community. Rather than taking the whole of the northwest coast, we do need to look at the individual communities, for instance. It's also telling us and pushing us to say we need to move away from a focus on mental illness and focus on the psychosocial stresses such as financial stress, relationship or family breakdown, child custody issues. We have to get down to those sorts of issues, because they are coming up as the major stressors in people's lives.

We also need to have better targeted research. It is a small cohort, so the longitudinal work that's been done through the register, which we have funded and will keep going, allows us to better understand Tasmania and what the focuses here are that might be different from everywhere else. It allows us to also focus our education and training on the narrative of male suicide and finding ways to build meaningful connections between males. The narrative is showing us that females are better connected in our community than males. We need to work on that. We need to take action to address the social determinants of health. We need to improve health Tasmania-wide in all populations.

It is also about training our service system on ways to relate and interact with those who are coming forward. If I pull out one particular priority group, which is the LGBTIQ+ community and the work we're doing there through Rethink, the national research is showing us that mainstreams services often fail to meet the needs of that community.

The main drivers there are experience of stigma, prejudice, discrimination, abuse, violence, isolation, exclusion. It is not the individual attributes of gender, intersex, et cetera, that are the stresses that lead to the suicide, it is actually the reaction of the community.

Mr STREET - External reaction.

Mr WEBSTER - The external reaction and the impact on them, as well as the minority stress that comes from expectations and the fear of not fitting in, if you like. We need to take that into account, which is why we are working with Working It Out for specific, lived experience workers to be established within Working It Out. So, they have that shared lived experience, they can work better with that community

That is just one action from the data that we can move forward with that will assist in that sort of way. I could go into a bit more of that, but I have summarised it enough.

CHAIR - We will go to Rosalie and we will come to you, Nic.

Dr WOODRUFF - I have two questions, but I am happy to take my turn. One of the issues, which I think you touched on, Dale, was about looking at community groups and finer-grained demography. It is one of the things that is really important for us to bring to a strategy.

The recent federal government intervention in the availability of paracetamol is an excellent example of this. Overall female suicide rates are less than males, but in that short period of time, young people, mostly girls, but some boys, who were born from 1997 became a cohort of people who are incredibly vulnerable to committing suicide through paracetamol overdose. That was shown through the data. That was an intervention that was specific and could be targeted. I expect, and I am sure you do this, the information we are getting about suicide attempts, as well as suicides, is quite fine-grained in how we target our interventions for men and women and gender-diverse people. Otherwise, if you just looked at it globally, you would have missed that trend. We hope it will make a big difference.

My question is about the fine-grained-ness. Among men there are very different groups. Older men whose wife has just died have a vastly higher risk of suicide than men generally. If we don't have specific approaches to connect with people whose wife has just died in their 70s, 80s, 90s, then we are going to miss that very important group.

Mr WEBSTER - Good question. We 100 per cent agree with you. It's why the registry is so important and being able to report on that registry. That gives us that longitudinal picture. We have a five-year strategy but one-year implementation plans, because things change. Paracetamol is a really good example of that. It was not even on the radar three years before the intervention, so we have to be adaptive.

You're right, you then need to look at each cohort differently. Men who have recently lost a partner, who are in a rural area, are more likely to die of suicide than most other groups in our community. That is the connectiveness issue. We really have to work with organisations, such as Rural Alive and Well, to make sure we have those services beyond the urban areas when we recognise that there is a need in those areas. We have to respond to our LGBTIQ+, which is why we think it is a really good idea to have lived experience workers sitting within the key organisation that's assisting people in that community and working it out. One of a few, but it is fairly key they are well connected. It is designing and implementing actions that are current and relevant. We think the implementation plan being 12 months allows us to be adaptive quickly. We are not on a course of action that says for the next five years this is all we are going to do. We look at the data that is current and say let us respond in the way we did. Because of the issues that surround suicide, for instance, outside of Hobart the Rural Alive and Well people were available to support people at every session.

Mr ROCKLIFF - Our peer workforce will also be crucial in the future. We have launched a Peer Workforce Strategy for Mental Health in November 2019 and more recently the Drug, Alcohol and Other Drug Sector as well. As Dale briefly mentioned, it is going to be crucial to keep building the capacity of our peer workforce, because they relate so much better to people's lived experience.

Dr WOODRUFF - I have a second question, maybe for the Premier. All members might have heard from people who contact their office, very devastated about something that is happening in their lives. That is why they contact us. I have seen time and again how people can be tipped over from, as Dale was talking about, living conditions which are hard but they get tipped over by some correspondence or communication from a government department.

The way in which information is given out about they cannot get elective surgery when they were expecting it, or they will not get a house, or their child won't get some response from their school is enough to add insult to injury. I am not saying it would lead to a person taking their life but it might, but it certainly leads to an accumulation of unnecessary harm.

I am wondering for a government, and Premier, you have the capacity to do this because of your experience and because you care, something our mental health strategy could do would be to get people with lived experiences, mental health counsel people, psychiatrists to have a lens over every piece of communication that is delivered from every department. Necessarily, some of it has to be legal. Necessarily, some of it has to deliver bad news. However, I believe from some of the letters I have seen handed to me, it could have been done better and it would have helped people to feel there are people on the other end who care. They are sorry. We can make our communication less. What do you think about that?

Mr ROCKLIFF - It is a good suggestion. You might find some example where it has not quite worked but seeing the communication from our office, there is a lot of focus on where we cannot meet everyone's needs, we are mindful of the language we use and deliver that information in an empathetic way as possible. We have spoken about this in our communications across the Health Department at the very least and how we can improve the way we communicate in the way you are speaking about. I am sure you have some examples where it has not quite hit the mark. I know both Dale and George are mindful of that. Would you like to comment, Dale?

Mr WEBSTER - In the Department of Health, we are focused on rolling out training to all of our staff who might have an interaction with consumers. That is trauma-informed practice. It is not just there for our doctors and nurses. The admin people writing letters need to operate in a trauma-informed way. We need to assume every interaction we have across Health is with someone who is having some form of trauma: it is traumatic to present to an ED; it is traumatic to be told you need an operation; it is traumatic to have your outpatient's appointment deferred yet again.

We need to focus on when we talk about a trauma-informed practice that we are not just talking about doctors and nurses. We are talking about every interaction of the department with the public. That is also why, as the Premier said, a whole-of-government focus on suicide prevention is required as well. We need to then roll that out across all government agencies and we act in a trauma informed way when we are communicating.

Dr WOODRUFF - I suppose that is what I am suggesting in this mental health strategy, that there is a commitment to doing that, Energy, Aurora, all agencies, not just service deliverers, but all corresponders.

Mr ROCKLIFF - Yes, very good point.

Mr STREET - I actually think the breakdown by gender is somewhat misleading. I did not realise until today the attempted suicide figures for women are worse than for men. I have heard the message that men are three times more likely to die from suicide. We need to be talking about the factors that cause it rather than breaking it down by gender.

I also understand the sensitivities around reporting attempted suicide figures, but it sounds like if we dealt with attempted suicide figures that it probably evens out across both

genders. So, the focus on it being a male problem is probably something that is also having an adverse effect in the community.

Mr WEBSTER - Just an extra comment is that I agree with you, which is why I say a note of caution on the figures. What is important is that is when we focus on prevention, we focus on the factors that are leading to a greater level of male suicide. Again, what the data is showing us is the reason for that is that a male is more likely to choose a quicker, more lethal means, such as firearms, versus a female may choose something such as paracetamol use which might mean a medical intervention can undo the harm. We have to focus on what is behind both. We have to have strategies that address each of them individually as a causation, and that is not to do with gender, it is to do with causation.

Mrs ALEXANDER - My question is open to who has the answer to the question. It is in relation to the strategy that is being formulated and also on the back of what minister Street has identified, which I totally agree with, the fact we should stop looking at gender and categorise people, but rather look at what causes a person to undertake that action. That is what is important and what ultimately will ensure we develop the right supports, not based on gender, but based on responding to people's needs, which are very diverse depending on age, whether they are from another background, their gender, their sexuality, everything is so diverse.

In formulating the strategy, I am more interested to find out how are we going to approach this from a holistic perspective. I will give you a best example: if somebody is at risk of homelessness or homeless and they walk through the doors of a charity, they may also be in a very high state of anxiety, potentially walk away and try to commit suicide. Those workers at the front door, for me there is not an understanding of how they can connect those people, as they identify other needs apart from food and housing. The framework, the strategy should include also a way in which it can be linked with other service providers, because my fear is we will be focusing just on facts, figures, but not actually how we can holistically tackle this issue.

That is one thing on the strategy formulation, and the other one is, how do we ensure, or have we captured statistics of people that have come from a different background, a different country, who may not necessarily be so open in reaching out but they may have also their own torments in the process of integrating in our society. I note the long wind up, but I hope it makes sense, thank you.

Mr ROCKLIFF - Thanks, Lara. Before I hand to Dale - Chair, I have to leave, unfortunately.

Part of our reforms in mental health integration, which was south but is now state-wide, is to ensure a more one-stop approach. People who presented to a service, perhaps homeless or in housing distress, were able to be connected and supported through the mental health services. That's being implemented state-wide since a year or two ago. It's part of that approach you speak of. I'll hand to Dale and George to speak more about that. I thank the committee for its interest in this important matter.

Mr WEBSTER - Thanks, Premier. Chair, there are a number of aspects to this. The first one is service navigation. We have worked with the LGBTIQ+ sector to put in peer workers who will help people navigate through our services. We have to accept that health is

a multi-layered, very complex system, starting with GPs, through to surgery and those sorts of things.

CHAIR - As recognised by the Rural Health Committee you'll note.

Mr WEBSTER - Exactly, so we need to help people through the service.

The second thing is rolling out training in this particular space. In Tasmania, we have a training suite called Connecting with People. We've rolled that through our mental health sector, through our prison sector, and we are now funded to move that into the community sector.

It means that when someone comes into Bethlehem House and they're homeless, we want to train the staff there to have some understanding of suicide awareness so they have the knowledge and skill set and there is no wrong door for this. We recognise from a psychosocial point of view it is that extra one thing, it is the straw that breaks the camel's back. We need to design an approach that is all-encompassing.

To ensure we are a bit more connected, we are rolling out technology around a central intake and referral process. This will be whole-of-system-wide, so community sector funded by the commonwealth sector and the Tasmanian sector. Again, no wrong door.

Going to Mrs Alexander's question, we have designed the strategy to have four domains. I will not go through them in detail now, but the first domain is about promotion. We need to lift awareness of the risk factors of suicide. Organisations like Stay Chatty are fantastic at this. They are doing some great work in our schools, workplaces and sporting clubs. As part of the bilateral agreement with the Commonwealth, we will be rolling out Head to Health Kids, and putting it in our childhood family learning centres so we have that connectiveness and integration.

Head to Health Centres are already being put in place by the commonwealth government, but under the bilateral, will extend to the north and north west; the south will be supplemented by our integration centres. When we talk about an integration centre we are talking about Head to Health because we are going to design them so they are all the same and all integrated.

CHAIR - Are you talking about the Head to Health service being in every child and family centre throughout the state and having a person there to do that work?

Mr WEBSTER - Initially it's in core centres, so we have chosen three or four at the moment. The intent is to roll that out over time. We are going to be data-driven, but they will be in northern suburbs of Hobart, the northern suburbs of Launceston, and in Devonport. I am not sure where the Kids Head to Health centre is in Devonport.

The state Government will roll out by the end of this current rollout 17 child and family health learning centres. We are targeting these to go into the first group and then we will extend them out over time.

CHAIR - The intention is to have a person in each of those?

Mr WEBSTER - That is right, or have some support level in each of those. We are doing this through our Child and Adolescent Mental Health Service reforms, so it matches with the Commonwealth.

CHAIR - To talk about raising awareness, one of the highest groups is older men who have recently lost a wife or partner. I don't think our rural communities know that. A lot of them have access to firearms and are more likely to use that as a more lethal method. How do you propose to do this in a way that makes it clear to the community that we need to look out for these individuals?

Mr WEBSTER - We have to do that at the community level, which is why we are working with local government on each local government area having a health and wellbeing plan. Health Consumers Tasmania has been funded to create community health and wellbeing networks. There are trials in Scottsdale, Huonville and Ulverstone. Healthy Tasmania's current five-year program has a mental health, alcohol and drug focus as an extra focus whereas the first one was very much about physical health. There's also funding for organisations like Stay Chatty, Rural Alive and Well, the organisations we know are successful in communicating the message and have a good method of doing that. All of those are in that promotion space that we have as the first domain of our strategy.

The other domains are prevention, so how we respond, how we reduce the access to means. The paracetamol response is a good example, but we need to look at firearms. Intervention is another. If we have contact with someone with suicide ideation we need to make sure we have the right intervention in place. Under the bilateral we are continuing to use the Way Back Support Service, which is an aftercare service. Everyone who comes into our service sector with suicidal ideation or has attempted suicide is contacted through the Way Back Service within 24 hours of leaving the service sector to do follow up and build resilience.

The last one is the ongoing suicide data analysis, the ongoing building of our implementation plans and those sorts of things. We want to make sure we have interventions or activities or actions in all four of those domains, not just focusing on one part of it.

CHAIR - Following up from Rosalie's point earlier in the prevention space, you talked about having at every point of contact for someone who may be feeling aggrieved, upset, let down by the system, whatever it is, for whatever reason, a person who is trauma-informed in their approach. How do you seek to achieve that?

Mr WEBSTER - In the Department of Health we started with putting our executives through that type of training. We are still doing that. We the rolled it out through key areas. We have started with mental health but also the LGH, given the commission of inquiry impacts are one of our focus. It becomes mandatory training for everyone in Health over the next 12 months.

CHAIR - Including the administrative staff?

Mr WEBSTER - Yes, from executive to administrative.

Dr WOODRUFF - Across the whole of government agencies?

Mr WEBSTER - This is the whole of Health.

Dr WOODRUFF - Not all agencies?

Mr WEBSTER - Starting with Health. Other agencies are also doing this. I am aware that, and I am going to get the name of the department wrong, but Education.

CHAIR - The new one that used to be education, DYCE- something?

Mr WEBSTER - That one, are also in this area as well and we will work with that. The strategy broadens out to become rather than a health strategy, a whole-of-government strategy. When we talk about these things starting in Health, the suicide prevention strategy is no longer a health strategy as it has been in the past, it is a whole-of-government strategy.

Dr WOODRUFF - What do you mean by, 'it broadens out'? If this responsibility is now in DPaC, why isn't it starting with all agencies doing a trauma? There is just as much need in schools, in disability care, every agency. Is there going to be a time frame for when that starts? Otherwise, it does not sound like there is a pressure for that to happen.

Mr WEBSTER - I will go back a step. Part of the strategy is that whole of government and DPaC will take joint responsibility with Health. I guess we have a head start, which is why I keep saying 'Health has started'. We are hearing from the consultation we have undertaken over 12 months and actually starting to move on some of these things in advance of the strategy, because we have a desire to do that. Within the strategy and the action plan, that will then give us the where the key areas are we need to focus doing trauma informed training in Government. Places like Services Tasmania and you highlighted Aurora as a another one -

Dr WOODRUFF - I am not meaning to single out Aurora, but many agencies.

Mr WEBSTER - Service delivery, you would say, whereas the policy people in the backroom are probably down the track a bit. Policy is not a good example, but the finance people might be a bit down the track. We really do need to roll this out over the period of time, because the trauma informed training -

CHAIR - TasWater is another one not actually a government entity.

Mr WEBSTER - Yes, so we do need to make sure. But the other thing is that we need to ensure we are providing the resources to the community sector, which is why connecting with people is important, not just for Government employees and we make it available to the community sector as well. We are trying to broaden this out. It will take some time, which is why it is a five-year strategy. We are saying let us have 12-month implementation plans and make sure we are following milestones and actually getting progress.

Ms O'BYRNE - Did you have a budget ask for this, to roll out the training across Government?

Mr WEBSTER - Connection with People is already funded within the agency, but there was funding in the last state budget for us to do Train the Trainer across the community sector so they can then roll it out.

Ms O'BYRNE - That was not the question though. Do you have a broader budget ask for it, or you have said it was funded previously that -

Mr WEBSTER - A broader budget ask; yes, we do, but there are a number of aspects to this. There was initial funding for this year for the consultation process in last year's state budget and we will have ongoing budget discussions on what we need in this area.

Ms O'BYRNE - You are comfortable that will be fully funded to your ask, or is that a negotiation process still?

Mr WEBSTER - It is not for me to lean on the Cabinet process that leads to the formulation of the state budget. However, there has been a number of amounts funded in previous state budgets in this area that leads me to some comfort that we have funding ongoing in this area.

Mr WILLIE - We talked a lot about awareness and reducing stigma today. There has been a lot of work - as you have acknowledged - in the community. Is that having an impact with the next register? If it is not, is there the potential to scale that up in some of those higher risk cohorts.

Mr WEBSTER - What I would say is given the breadth of what we are seeing in the different categories, et cetera, it is hard to say that we are having an impact overall. What I would say is through lived experience narratives we are hearing they are seeing a reduction in some of those stigmas, et cetera. We have a long way to go but we have also come a long way in 20 years in Tasmania. Really, we just cannot not focus on reducing stigma.

I am assuming your moustache is simply Movember, but that is -

CHAIR - I think it is.

Ms O'Byrne - Can you not stigmatise him?

Mr WEBSTER - I wasn't stigmatising. I said 'I assume' rather than commenting on it.

Things like Movember, et cetera, are those programs that help in promoting men's health and those sorts of connections to community. I do not think we can ever stop. If I get philosophical it is the nature of humans. We are always looking at what group can we denigrate to make us feel better. It is the history of human kind, isn't it? We have to keep our eye on it and constantly say this is the group we need to focus on next.

Mr WILLIE - It is more complicated than reducing stigma and awareness. There are all these other system approaches.

CHAIR - Underlying practice.

Mr WILLIE - Yes, underlying practice.

Mr CLARKE - The challenges in this area and broadly internationally is the lack of evaluation of suicide prevention programs to date. That is the focus of this next strategy and our partnership with the University of Tasmania and the Centre of Innovation. This will be a

first I am aware of across Australia, that each of the programs we will be implementing, an evaluation process will be co-designed with the university and evaluated externally to begin with. Hopefully, that will lead to better data about what effect some of our programs may be having in this area. We can draw conclusions from the risk factors as to the effect of them, but to have that level of formal evaluation will be the next step.

CHAIR - In terms of following that up, you talked about the outline of the timeline for the strategy, the evaluation and that sort of thing. Can you go through where to from here with this - the timeline for the strategy, the implementation, then the evaluation and what sort of opportunities for input there are into that?

Mr WEBSTER - As the Premier said before he left, he is hopeful of launching the strategy in the coming weeks before the end of the year. The first part of 2023 will be about co-design of the implementation plans. I call them plans plural because there will be elements to them that target particular priority groups. We want to focus on consulting each of those groups. That is the first six months of next year. The first implementation plans we would hope would be 18 months and then we can start aligning for the 12 months, because we will lose a few months in that consultation.

Each of those actions we have put in place is then tied to an evaluation plan. We will have an overall evaluation plan for the strategy. With each of the actions, as George said, we will look at did that action work? We will design the evaluation with the university before we put it into the field, so we are collecting that data early.

Key to us is that we need as much in the field as quickly as possible so, we are not necessarily waiting for action plans where the community has indicated a need. Rural Alive and Well is an example, part of COVID-19, we funded the Tasmanian Lifeline and we have taken the decision to make that a permanent feature of our service sector. The lived experience in Working it Out is something we have gone ahead with in advance of the plan.

As we are hearing from the consultation, high needs, we will not wait for a document. We will look at how we respond to that high need straight away. We would say that the first action plan will be middle of next year and then we will roll them every 12 months from then.

CHAIR - With the data collection that occurs with those, which is important if you are going to evaluate anything, what level of disaggregation will you have in the data? It may be different for each and I accept that, but I am interested in the level of disaggregation and how it will be disaggregated and how it will be published.

Mr WEBSTER - It is really important because we will be talking about small numbers in a lot of cases we need to protect privacy in some of the evaluations, which is why it is important we actually design it upfront. We do not get to the end and think, we have had three people through this action and now we cannot really comment on it. We will be able to say upfront, 'Here's how we are going to evaluate this particular action'.

The evaluations will all be made public. This is about going back to the community to say, 'We designed this action, we thought it would work, here is the evaluation of it, do we continue that one, or do we need to change a course to another style of action?'.

CHAIR - Or change that one or get rid of it.

Mr WEBSTER - Or indeed, has it had the impact it has needed and therefore we should continue it?

Ms O'BYRNE - Or is it impossible to evaluate in such a short period for some of them?

Mr WEBSTER - Yes, for some of them, it may be that the recommendation is, and again, working with UTAS is that this really needs to be longitudinal. This is what we have found with the register - it has to be longitudinal - and that will underpin what we are doing as well, keeping that evaluation and those reports rolling.

CHAIR - UTAS is determining with you and the department the evaluation plan and criteria. That is a joint effort?

Mr WEBSTER - And with community groups. If we are going to say the action is x, y, and z community group will deliver this, we want also them part of the design so that we can contribute

CHAIR - And evaluation.

Mr WEBSTER - Yes, design of the evaluation.

Dr WOODRUFF - You have mentioned a number of groups that presumably would take carriage for being funded to work in the community, RAW and Stay Chatty. There are others and those two do not necessarily touch all regional communities. Another one that does really good work, and particularly in the Franklin area, but also in the north-west, is Wesley LifeForce.

There are definitely different models of touching people and being in the preventative reaching out and identifying people. People who need help the most and support, perhaps after their wife has died, do not pick up the phone and do not necessarily identify themselves as being at-risk until that overtakes them. I suppose I hope you will be casting the net as widely as possible, because some of these groups work in smaller ways and can be, in their own way, very, very effective because they are small and very local.

There is a group in Cygnet - Cygnet Care Suicide Prevention, for example.

Mr WEBSTER - Absolutely, and that is the nature of the network: to identify all those local things. If we can roll out the networks across Tasmania over time, that would be fantastic, because we can actually know what is out there. I will emphasise, in quoting my examples, I am not closing the door to anyone else. I am just using them as examples because they are currently in operation across the state. It does not close the door to any other operation because we are talking about connectiveness. Any group is a connective group that people can feed into, whether it be a church group, sporting group, which is why it is really important we have awareness raising through all those sorts of groups.

Mr CLARKE - One of the strong themes we heard from community consultation was about community-led and designed activities specifically for their region. There was no one-size-fits-all model. What we do in the north-west will have to be tailored for that community and vastly different from what will be provided in the south - same as here, such as Hobart. It

is about working with the organisations and the community from this point forward to make sure we have the appropriate supports and it will be very different.

Mr WEBSTER - In a lot of cases, some of our most isolated people are in our most populated areas and we need to match that also.

Dr WOODRUFF - This has been brought to my mind through a recent personal experience of a young person who killed himself. What was clear in conversations with family and friends after that experience was that a lot of flags had been raised and he was a known risk and his family were trying to monitor him and he had been for a number of years.

As I understand the research - and I am not an expert on suicide prevention - is that it is not as though it is a continuum. People can be in a low state and then just almost fall off a cliff. It is about finding and identifying the flag where they are just falling off a cliff and then bringing them back up again. The threat of that happening again is not that that is necessarily going to go away.

What was identified, and I have heard other people talk about, is that flags were identified: different flags by different people. People when they are really struggling or preparing to take their life show different parts of themselves. They push some people away, they do different actions, they are hyper excited and enthusiastic about the plans that they have got, it looks like it is all great.

It was a question about a tool device support for people who are already wrapped around a person so they all understand what's happening for each other. This group of people has already decided for themselves what that would look like if they were to talk or help someone else, that they should have set up a wraparound group around that person with a sort of a text so they could say, 'Hey, this has happened'. It did not sound to me as though this is something which had been identified and worked as a tool to provide people who are wrapping around a person to help them.

Is there any work been done by the department or awareness of this, and suggestion for people who are already identified, wrapping around and caring for a person?

Mr WEBSTER - There are probably three elements to it. First, where the wraparound is the service sector, we need to make sure that information is readily shared across that service sector. That is the work we are doing on central intake and referrals, that we are making sure that if someone goes to service X in the north-west and then the next week is service south in the south, then we need to know - wraparound in terms of share the info.

The second is that providing the resources, and if you like, the three, Beyond Blue, R U OK? and Stay Chatty have a fairly consistent message around checking in with people and checking in with the people they know. It is that concept of community wrapping around.

The third thing, is that is also the theme of our connecting with people training. There is a need to wrap around people and share information. You might not see it individually but if you have a discussion with someone else they may.

Again, we look at our indicators, things like self-harm, a previous history of self-harm present in around 50 per cent of people who commit suicide. Knowing that someone has self-

harmed in the past is really important to share with the people who care, basically, whether they be the service sector or the individual's personal connections.

The other thing is that you are right, it is that falling off the cliff that becomes unpredictable in this area. I go back to the trauma informed. We know that people coming out of prison or in contact with the justice system, as the Premier said, 50 per cent of males who suicide have had contact with the justice system, and 39 per cent of females. We need to make sure that at that point there are some services available that will support and there are wraparounds there.

Also, as you said, isolated males over 85 who lose a partner. We need to make sure that there is knowledge of that in communities so they do connect. Quite often it is surprising, again, as families, we will wraparound in the initial grieving period, but eventually, we move back to our lives. It could be months after it hits the individual, that they are now isolated. It is that ongoing contact as well.

CHAIR - A lot of that comes down to public awareness, the signs of suicide, getting your affairs in order, giving things away, all that sort of stuff. I might see someone giving away things and think that is nice. Another person might see them getting all the other things in order but we don't talk to each other.

Dr WOODRUFF - That's right.

CHAIR - It's a public awareness thing about things to be aware of. Just because I get my affairs in order doesn't mean I am going to take my life either.

Dr WOODRUFF - It can be a positive thing.

CHAIR - If I talk about my office and desk it would be a good thing. It's an important body of work. We appreciate the work that is going into this. Clearly we need to do something. It's not okay the way it is.

I reiterate the Premier's words: if anyone has been watching or listening who feels stressed or upset by what they have been listening to, to reach out for help and not to think they are on their own. There are people there who can assist them. Ring the Lifeline number and reach out.

Dale, did you want to make a closing comment?

Mr WEBSTER - Only to emphasise that we see this as an ongoing dialogue with community at a local level. That's the theme that came from community to us. We need to honour over the next five years that we have this ongoing dialogue and change our actions to suit our community.

CHAIR - Thanks, Dale and George.

THE WITNESSES WITHDREW.