COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

SENATE

COMMUNITY AFFAIRS REFERENCES COMMITTEE

Reference: Suicide in Australia

THURSDAY, 20 MAY 2010

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SENATE COMMUNITY AFFAIRS

REFERENCES COMMITTEE

Thursday, 20 May 2010

Members: Senator Siewert *(Chair)*, Senator Moore *(Deputy Chair)*, Senators Adams, Boyce, Carol Brown and Coonan

Participating members: Senators Abetz, Back, Barnett, Bernardi, Bilyk, Birmingham, Mark Bishop, Boswell, Brandis, Bob Brown, Bushby, Cameron, Cash, Colbeck, Jacinta Collins, Cormann, Crossin, Eggleston, Farrell, Feeney, Ferguson, Fielding, Fierravanti-Wells, Fifield, Fisher, Forshaw, Furner, Hanson-Young, Heffernan, Humphries, Hurley, Hutchins, Johnston, Joyce, Kroger, Ludlam, Lundy, Ian Macdonald, McEwen, McGauran, McLucas, Marshall, Mason, Milne, Minchin, Nash, O'Brien, Parry, Payne, Polley, Pratt, Ronaldson, Ryan, Scullion, Sterle, Troeth, Trood, Williams, Wortley and Xenophon

Senators in attendance: Senators Adams, Bilyk, Carol Brown and Moore

Terms of reference for the inquiry:

To inquire into and report on:

The impact of suicide on the Australian community including high risk groups such as Indigenous youth and rural communities, with particular reference to:

a. the personal, social and financial costs of suicide in Australia;

b. the accuracy of suicide reporting in Australia, factors that may impede accurate identification and recording of possible suicides, (and the consequences of any under-reporting on understanding risk factors and providing services to those at risk);

c. the appropriate role and effectiveness of agencies, such as police, emergency departments, law enforcement and general health services in assisting people at risk of suicide;

d. the effectiveness, to date, of public awareness programs and their relative success in providing information, encouraging help-seeking and enhancing public discussion of suicide;

e. the efficacy of suicide prevention training and support for front-line health and community workers providing services to people at risk;

f. the role of targeted programs and services that address the particular circumstances of high-risk groups;

g. the adequacy of the current program of research into suicide and suicide prevention, and the manner in which findings are disseminated to practitioners and incorporated into government policy; and

h. the effectiveness of the National Suicide Prevention Strategy in achieving its aims and objectives, and any barriers to its progress.

WITNESSES

CRAWSHAW, Dr John Adrian, Chief Executive Officer, Statewide and Mental Health Services, Department of Health and Human Services Tasmania **54**

HAYES, Mrs Diane, Coordinator and Committee Member, Time-Out Project **1**

JOHN, Mr Christopher, Chief Executive Officer, Lifeline Hobart **43**

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RYAN, Mr Scott, State Coordinator for Outright Youth, Tasmanian Council for Sexual and Gender Diverse People **16**

SWALLOW, Ms Michelle, Executive Officer, Mental Health Council of Tasmania **36**

TUNEVITSCH, Ms Verity, President, Youth Suicide Action Group **1**

WOODWARD, Mr Alan , General Manager, Social Policy, Innovation, Research and Evaluation, Lifeline Australia **43**

Committee met at 9.00 am

HAYES, Mrs Diane, Coordinator and Committee Member, Time-Out Project

TUNEVITSCH, Ms Verity, President, Youth Suicide Action Group

ACTING CHAIR (Senator Moore)—Good morning. The Senate Community Affairs References Committee is continuing its inquiry into suicide in Australia. I welcome witnesses from the Time-Out project. I put on record that our Chair, Senator Rachel Siewert, could not be with us today. Hansard will be providing a transcript of today's proceedings, of which you will receive a copy fairly soon. Information on parliamentary privilege and the protection of witnesses is available to you. I invite either or both of you to make some opening comments and then we will go to questions. Ms Tunevitsch, would you like to start?

Ms Tunevitsch—Yes. Thank you very much for taking the time and inviting us to come along and tell you about our fabulous project. Although we are the Youth Suicide Action Group, we call ourselves the Time-Out project or Time-Out House. I would like to introduce Diane Hayes. Dianne not only works for the Time-Out project; she also has her own business through Tasmanian Eating Disorders Support Service, so she works with people with eating disorders. I have made a few notes and I will work through those. I thought I would start off by telling you a bit about myself and where I have come from and why I am so passionate about the Youth Suicide Action Group and the work that we do with Time-Out.

My grandfather suicided when I was younger and from there, of course, it is an issue that you learn about and grow up with. About 20 months ago when I was working for one of the major financial institutions there was extreme pressure put on me and at that stage I also was, at one point, suicidal. So it is a passion for me. Although my suicidal tendencies were only for a very, very short period of time, unfortunately the suicidal tendencies of the clients that we work with are for a longer period of time. I can, in a way, relate to them because I also have been in that position. I am very lucky, unlike some of our clients, that I have a very strong support network in my community, so I was able to reach out, although at my workplace, when I accessed the employee support service for assistance, they told me to google it, and that was all. So that was quite concerning, coming from quite a wealthy organisation. I am now very lucky that I work for a children's charity, the Smith Family, in financial literacy. One of my other passions is financial literacy, because we know that taking one of those stressors away, like finances, will assist people with coping mechanisms and reducing their stress in a crisis time. That is a bit about me. Now I will tell you about Time-Out House.

The Youth Suicide Action Group was formed in 1999. It was formed by a group of business people who worked with the youth in Launceston. They were concerned about the rate of suicides in Launceston and surrounds and they wanted to do something about it. They started home-hosting young people who were at risk and taking them into their own houses. Obviously that is quite risky. Then in 2001 they had the opportunity to purchase a three-bedroom home, which is in a confidential location in Launceston, where they were able to provide respite for young people.

The Time-Out House is a safe haven for young people at risk of suicide and self harm. We have moved a little bit away from promoting that we are trying to reduce self harm and suicide

because we were told that we were less likely to receive government funding if we used that tag line. So we have removed it to try and help us in securing government funding. Because our service is so unique, we do not really fit into any pigeonhole when it comes to funding. We own the house outright. We bought it through a Tasmanian community grant for $66,000. It is now worth quite a bit more than that. Other than that, we have only received two grants from the government. We have been going on for the last nine years through financial help from the community.

We have one major fundraiser through the year and that is because a couple, who are quite wealthy and like to give back to the community, organise a golf day on our behalf, which raised $40,000 this year. They usually choose a charity every five years but they have chosen us for the last seven. Unfortunately, they will not be continuing with the golf day for us, which we understand. It is a shame because it is something that we have relied on for the last seven years because we do no receive any recurrent funding. We also get a lot of support through the local Rotary and Lions clubs—not only financial support but also maintenance support because, like any house, it needs maintenance. We have just recently had some major backyard renovations done by a local club, which was fantastic.

The house is a place for kids between 14 and 28 years of age who have been referred to us by healthcare professionals. We have opened it up to teachers as well with the sign-off of their assistant principal. Those working with young people refer clients to us and we provide them with a weekend respite. The house is open from six o'clock on Friday night and we close the house at six o'clock on Sunday. We have two befrienders—that is what we call our volunteers—staying with the client for their shift. We do not have the same befrienders on for the whole weekend, although we have had some instances where that has been the case because we have had limited volunteers. Our befrienders roster on from six o'clock on Friday night through to nine o'clock in the morning and then from nine to six and so on.

We can only open until six o'clock on Sunday because of our volunteers. Sometimes we are able to offer the service until Monday morning, but because they give up their time and, as you would know, Sunday is when you are getting ready to go back to work and it is a family time, we struggle for volunteers on Sunday. But there are instances when we have had kids who cannot go back to their homes or to the places they have come from, so we try our best to provide the safe haven until Monday, when they can go into another service. We currently have about 31 active befrienders on staff. Quite a number of befrienders are used over a weekend, so there is a risk of burnout for our volunteers.

We only accept one client over the weekend, so it is a fairly unique and specialised service that we offer. The reason we do not offer it to more than one client is that, given a lot of them have some sort of mental illness or personality disorder, they typically try to play against each other. We have learnt from our past mistakes of having two clients. It is the same with having different genders in the house. We have learnt that, if we have two genders, there is the risk of sexual issues or encounters.

Our clients come in and they spend the weekend with us doing things such as painting, gardening, cooking or watching TV. I am a really good TV watcher so, when I am rostered on, that is what we like to do—and a bit of painting. Each befriender comes with their own skill set. Some of them like to play music. We have a little set of drums, a triangle and whatever. It is a

time for them to chill out. We know that our service is fantastic and is used by the greater population of Tasmania. Clients have bussed up from Hobart and clients have been put in taxis at the hospital at Devonport or Burnie to come and stay at our house. It is the only one in Tasmania and it is the only one of its kind in Australia. It is a unique service. If anyone wants to look at the house they can look at pictures of the inside of the house on our Facebook page, but of course we cannot show them the exterior because of confidentiality. But they can see the fantastic space that we have.

We also welcome animals into the house. My dog is a furfriender, so he comes in and stays with a client. We know that animals give unconditional love and they love being patted. Our clients love to have that contact, because we cannot provide the physical contact for our clients but our animals can. We have a couple of furfrienders on the staff. We know that our clients really connect with those animals when they come in.

At this stage because we only offer the service on a weekend basis our costs per annum are $60,000. As I said before, that is all donated by Launceston community members. It is quite a minimal cost for the service that we provide and it is only on a weekly basis. We have only one paid position in the house, which is covered by five different people. So we have a so-called weekend coordinator, which is what Diane is. The weekend coordinator mans our telephone number 24/7 and answers any calls from existing clients or takes calls from concerned parents who would like to have their child referred to our service. They also do the shopping for us and fill any gaps on the roster. A lot of the work that our coordinators do is voluntary, although it is a paid position and they certainly do not get paid a lot for the number of hours that they do. They do about 70 hours per week for us. We really appreciate the volunteer hours that they provide to us. Diane is going to read you a story of one of our past clients—she is probably still a current client—and she has given us permission to tell you her story today.

Mrs Hayes—Sarah grew up in rural Tasmania but suddenly was forced to leave her family due to domestic violence issues. Sarah left her hometown and moved to Hobart to continue her studies. However, things got worse for her. She then contacted SASS—Sexual Assault Support Service—and then was supported through women's shelters. Time passed and Sarah decided that this was not the life for her, so she relocated to Launceston to try to rebuild her life. For Sarah the time was kept busy during the day working part time but difficulties surfaced when alone at evenings or weekends. She would also sometimes suffer panic attacks during work time and felt the need to explain her confronting history to her employer. One day a counsellor from headspace told her about Time Out and the service we offered. Sarah took yet another step out of her comfort zone to use this support and she has never looked back. Time Out became a safe haven for Sarah—somewhere she could feel safe, not judged and do activities like artwork or laughing, activities she had forgotten about.

She could feel at home there and talk about her struggles if she wanted to and she always knew that the house and its befrienders would be there for her—not to offer advice but just to be there in her time of need. At one stage during a weekend with Time-Out, Sarah's recollections of her past became so bad that she did not want to stay on this earth. Our befrienders were there to listen to her and guide her through those feelings and provide that safe space. We do not want to think what would have happened if we were not there.

The opportunity to access such a safe place was crucial at that point in Sarah's recovery. Suicidal thoughts still enter Sarah's days but with the comfort of Time-Out and counselling she now feels more confident in being able to control the situation. Her stays at Time-Out helped her to remain positive and have something to look forward to. Our befrienders also assisted in how to go about finding shared accommodation and the questions to ask when looking for housemates. They took the time to work through the weekend papers and come up with a short list of options. Sarah now lives with two housemates, which we know was a huge step for her.

Sarah is about to commence a full-time job and is proof that with the blanket of safety and support that Time-Out gives her she is able to further enhance her lifestyle. Sarah now has hobbies, a comfortable social life and just feels that she has so much more in her future. Through the various circumstances that led Sarah to the deep, dark hole of suicidal risk, she had to muddle through—often in secret—while searching and contacting any avenues of hope for a better life.

There were no clear signposts for Sarah and certainly no case management. With funding changes to service providers, she found that when accessing the same service she was told they could not assist as the government had now changed their funding. Sarah knows that Time-Out does not have that same issue so we were there constantly for her, along with the fact that our service was free.

Before knowing about Time-Out and getting to know what service we can provide, Sarah did have difficulty accessing help after hours. She told us of the need to call Kids Helpline or Lifeline—however, she did not have a landline and the cost of calling these services on a prepaid mobile was enormous. She had to struggle alone or face getting in the car and trying to find a payphone in the middle of the cold Launceston nights; or, alternatively, sit in a hospital waiting room for four to five hours at a time.

Our befrienders and coordinators have worked closely with Sarah and her counsellor to ensure that she knew she had the support of our group. But what about those young people who do not have the courage to contact these services? This is Sarah's story.

ACTING CHAIR—Mrs Hayes, do you want add anything now on the record about the other work you do? We were told about the work you did with body—

Mrs Hayes—Yes, I have set up a support service for eating disorders. A lot of the clients who come through Time-Out do have disordered eating or a manifested eating disorder that puts them at very high risk. Anorexia, for example, does have the highest mortality rate due to either starvation or suicide.

ACTING CHAIR—I just thought it might be useful, when we know that you do that work, to get something on record about it.

Ms Tunevitsch—I would just like to finish off with some statistics. We have helped over 65 clients in the eight years. We have assisted clients over 220 weekends. We have trained over 300 people in befriending. I would like to just give the committee some recommendations.

ACTING CHAIR—Certainly. That is your job.

Ms Tunevitsch—We would like to recommend that all NGOs receive free or subsidised mental health first aid training along with first aid training. We found that mental health first aid is quite an expensive course to put our befrienders through but it is one of the most fabulous courses for them to get the base knowledge of mental health issues.

We would like to recommend that phone booths, or an SMS call back service, be available for young people. We are not aware that there is an SMS call back service and we see constantly in the community, especially in rural communities, that phone booths are being removed.

We would like to recommend that there are more services available at night, not just the hospital, for young people to go and visit. We would like to recommend that Time-Out receive recurrent funding and that recurrent funding be available for administration costs for successful projects. What we have found in the past is that any funding that is out there is for new start-up projects and not those existing projects—for our administration costs because that is all we need the money for. We have bought the house; we just need the admin costs.

We would also like to recommend that a Time-Out House be located in every community in Tasmania and Australia. In the last three weeks I have been approached by the youth worker from the Kingston Council here in Tasmania to set up a service similar to ours down there. So we are going to work with the Kingston Council to try and set one up.

Senator CAROL BROWN—Would that be funded by the Kingston Council?

Ms Tunevitsch—We do not know. We are looking at different grant opportunities. It would be classed as a new project so we could potentially get some funding for that. We have been approached by other people like Janette Papps from DHHS and Michelle Swallow—she is coming to talk to us later; she knows about our service and I am sure she would be keen to support us. But there is also the need down in Burnie/Devonport here in Tasmania and we have been approached by a couple of social work students to help set up a service down there like ours. We do not want to run it because it needs to be a community based approach, but we would like to use the model that we have developed because we have done the groundwork. We know what works and what does not and we can help the communities develop their own Time-Out House—because it is that safe haven and we know that it has worked. Out of those 65 clients we only know of two that have actually gone on to complete suicide. All the rest are either still receiving treatment or for others they are actually giving back to the community. Currently, out of the 31 befrienders, we have two that have been classed clients.

Senator BILYK—Can you remind me what period that has been over?

Ms Tunevitsch—Eight years.

ACTING CHAIR—Is that all your recommendations.

Ms Tunevitsch—That is all of my recommendations.

Senator ADAMS—Thank you. I think you are doing a great job. What sort of checks do you do on befrienders? I am just concerned that you might have someone coming from out of town

saying they want to be a part of it and that they then might not turn out to be quite the person you thought they were.

Ms Tunevitsch—Absolutely, and given that we do not have a full-time administration person there have been instances where people have slipped between the cracks. We have now funded, for a couple of months, somebody to redo all of our paperwork. But we ensure that all of our befrienders have current police checks on file. It is difficult in following up 31 active befrienders—and we have got about 45 that have their name on the list but we have 31 active ones—so we ensure that they have current police checks and that is about it. We have a strategic planning session. Whilst, as I said, there are paid positions, we are all volunteers and we rely on people to give their time to us. In terms of admin, we ensure police checks are done. Reference checks, on the other hand, would be something that would be nice to do and something that we are looking to do in the future.

Senator ADAMS—So as far as training, if I come to you and say I would like to be part of it—

Ms Tunevitsch—Yes. At the moment we have an in-house training coordinator who does our training for us. It is probably not working the best, and in the past we have engaged other groups to come in and do the training on our behalf—like the Lifelink Samaritans who do the telephone befriending and who have just adapted it to do face-to-face befriending. We also do Mental Health First Aid when we are able to afford it, and we have got a group that will come in and do safe TALK for free for us. So all of our befrienders go through about seven 3-hour sessions and then we have constant upskilling as well. Every month we provide our befrienders with upskilling for different things.

Senator ADAMS—With your clients, obviously you get their case history and all of that before they come?

Ms Tunevitsch—Yes, we have a three-page referral document that we go through with our referral agent. If you want to look at it, it is on our website. We do not get their full case history unless clients or referral agents want to pass that on. In the past we have had 20-page documents for our befrienders to look through, but most of the time we just take the client at face value, after the risk of the client has been assessed by our coordinators. We do not take high-risk clients. We have learned that we cannot take a client who is just coming out of a drug dependency. But we can assist other, lower risk clients. The clients have to want to stay in the house over the weekend; we cannot force them to stay there. They surrender their mobile phones, which is difficult for some clients. For some, because they are so dependent on their mobiles, we have had to put a plan in place for them to have access to it at certain times during the weekend. But we do not have internet access. So it is not that the client is secluded, but it is a safe haven, a retreat, for them for the weekend.

Senator CAROL BROWN—What is your experience of clients coming back to you, after they have spent the weekend and moved out of the house, wanting to access other services in the community?

Ms Tunevitsch—I should have clarified that. Our clients can access our service six times, from their first visit, in a 12-month period. We are currently working on a care plan—and we

have had such plans in the past—for a client who needs to access our service more than six times in 12 months. But we work closely with the referral agents. We are finding that this particular referral agent does not have much time—they have way too many clients—so it is extremely hard for us to sit down with them and work through this client's care plan. But we do often find that the clients who have been out in the real world and have come back to use us a month later, which is typical, have had trouble with other referral agents.

Senator BILYK—Who are your referral agents?

Ms Tunevitsch—The majority are places like the Karinya young women's shelter, Laurel House, Centacare, pathway planners or social workers at schools—

Mrs Hayes—Headspace.

Ms Tunevitsch—Yes, Headspace are a big referral agent for us.

Senator ADAMS—Do you have a waiting list so that, if somebody does not turn up, you can take someone else?

Ms Tunevitsch—At the moment we have clients booked in for the next three weeks. Sometimes a client will pull out at four o'clock on a Friday. If that happens, we put the call out to the referral agents saying, 'We've got a space available; give us a client,' and we might get none or quite a few. For that weekend, the following week's client can be bumped up if needed.

Senator BILYK—Following on from that, do you have any contacts or links with the local police, ambulance and emergency service people, who often come in contact with people at risk?

Ms Tunevitsch—We do not. We have been in contact with the local police station. The house has panic alarms and that kind of thing, but—

Senator BILYK—I meant is it possible, if something happens and they know you have a space, for them to make a report of someone that might need your support?

Ms Tunevitsch—Not really. In our previous experience with the police, they have just knocked on the door—they know where we are—with a client and said, 'Here's a client for you,' when we already have a client booked in. It is just about improving that communication. They are so busy anyway. We do work with the hospital, and all the emergency services know of us, and we are more than happy to work through the referral form with them. We know that they are so busy that they might not have the time to work through the three-page document that we request, so we sometimes do it verbally, over the telephone, which is much quicker. But we do need that basic information from them.

Senator ADAMS—In terms of the gender mix you said you had problems. If you had a male coming, would you have a male befriender?

Ms Tunevitsch—We try to. At the moment, predominantly our clients have been female. We very rarely see a male get referred to our service. If it is a male it is generally a male who has a sexual identity issue. We very rarely see a male come in but we try to have a fairly good gender

mix. With our befrienders at the moment, out of 31 there are five male befrienders. There are clients, especially those that are referred by Laurel House or Karinya, who are wary of men. We try to roster according to their preference but this weekend, for example, we will not be able to accommodate the clients' requests; we need to roster men on because otherwise we would not be able to offer the service.

Senator CAROL BROWN—Why is it that the majority come to time out is women or young girls.

Ms Tunevitsch—Women are more likely to reach out for help. Men or boys typically are not; they just suffer in silence. That is what we have found. Sometimes it is all about stigma. There is a local private school that referred a client to us who was a boy with an eating disorder but the parents did not want the client to come into the house, because they thought if everybody in the community found out that they had visited the house that they would be stigmatised. But our house is confidential so we would not have told anyone at all; it would just have been the family that knew, but they did not want the stigma that they needed to access outside support, attached to them. That poor client just had to stay at home and keep on going as he was going.

Senator CAROL BROWN—In your submission you talked about the government—you did not indicate whether it was federal, state or local government—and that you had to change your tag line.

Ms Tunevitsch—Yes.

Senator CAROL BROWN—What did you have to change your tag line to?

Ms Tunevitsch—Our tag line was, 'We provide a safe haven for young people at risk of suicide and self-harm.' Our tag line now is, 'We provide a safe haven for young people at risk.' We were told by people who do regular submissions to the state government that we would need to remove 'suicide' and 'self harm' if we were to get funding. I do not have time in my day to apply for big grants so we only do the small grants at this stage.

Senator BILYK—Was that someone from the government?

Ms Tunevitsch—No, it was somebody in one of the other NGOs that told us that.

ACTING CHAIR—Have you spoken directly with the state government to talk that through?

Ms Tunevitsch—No, we have not. We put in a submission recently to the state government for $ 60,000. We were declined for that but they did give us a $2,000 donation. That came from the Premier, with the proviso that we put the state government's logo on all of our promotional material. We have not written back yet with regard to that—

Senator ADAMS—$2,000!

Ms Tunevitsch—but the committee did discuss whether putting a state government logo on our flyers would inhibit other organisations like Rotary and Lyons from donating to us, because

they would think that we were getting recurrent funding. Whereas $2,000 is great it is certainly a drop in the ocean when it comes to our ongoing costs.

Senator BILYK—Did that come from the Premier's sundry grants program, so that it was a one-off.

Ms Tunevitsch—It was a one off.

Senator CAROL BROWN—Was the submission or the application for $60,000 put through the budget process?

Ms Tunevitsch—There was a recent grant that came up about six months ago and Michelle O'Byrne's office assisted us with regard to that but we were not successful.

Senator CAROL BROWN—Was that through the community development grant?

Ms Tunevitsch—Yes.

Senator CAROL BROWN—You mentioned in your written submission that many of your clients have been discharged from hospital with no place to stay. Can you just fill us in on how many and also in what state you believe they are in?

Ms Tunevitsch—I have been involved with Time Out for about two years, and in those two years I think we have had three—I have not got the exact statistics here—clients come from Northside in Launceston. One of those was an extremely poor referral, which came from a doctor who did not disclose that that client was coming off a drug addiction—they were actually chroming. For those who do not know, chroming is sniffing of aerosol cans. We were not aware of that, so we had aerosol cans in the house, as you do. When we found that and called him on his behaviour—we are not trained to do that, we are just trained to listen—he became quite agitated and we actually had to have him removed by the police. He assaulted one of our befrienders. That was an extremely poor referral by the doctor, because our coordinators asked all the questions: asked if there was anything we should be aware of and if there were any behavioural issues, and we were not made aware of that. There are others who have just been referred to us because they cannot go back to home; it is Friday night and we have to pick them up from the hospital and bring them to the house until Monday morning when they can access the other service.

Senator CAROL BROWN—Is it one befriender and one client in the house at a time?

Ms Tunevitsch—Two befrienders and one client. With regard to the recent referral with the young guy, our befrienders are fine; it was not serious, but it could have been serious. We just know that the practitioners in the hospital, especially in Northside, are just so busy that they cannot take the time to give us all the information if they are referring to agencies like us.

Senator CAROL BROWN—So in emergencies you just ring the appropriate emergency service?

Ms Tunevitsch—We have the panic alarms now, so we just press the panic alarm and everybody comes. We are very close to all the emergency services; we are located about two minutes from the hospital and two minutes from the ambulance.

Senator CAROL BROWN—In your view, do you believe that the services in Launceston are overloaded for the client base they have to deal with?

Ms Tunevitsch—Yes, especially the young women's shelters. They are understaffed.

ACTING CHAIR—One of our witnesses is unable to come because of illness, so we can let this session go on. As the people in the next session do not have a time constraint we will just let it run on. It gives us a chance to keep talking.

Senator BILYK—Thank you for your submission and your personal story because it is not easy to talk about personal issues, especially with regard to something as emotional as suicide. Can you also pass on thanks to Sarah for sharing her story with us? It is good to hear from someone who is involved as the client, as opposed to the administrative people. I did read your submission, but I want you to tell us for the *Hansard* how people learn about your organisation.

Ms Tunevitsch—We do not have somebody to do our marketing so it is very much word of mouth. I am very lucky with my organisation that I am working with a community. I constantly drop fliers around the place, as does Di. I have some fliers here to hand out to you and our business cards. With regard to the inquiry that I received from Kingston council, that came from our happiness kits. One of our volunteers makes up happiness kits and gives them to all our clients and referral agents because we want something unique for people to remember us by. Our happiness kits have just been distributed to a number of different places down in Hobart, and that is how we received the call. It is just getting the word out as much as we can in our day-to-day life. Diane does amazing stuff with her pamphlet dropping too!

Senator BILYK—I think some of us at the table know about pamphlet dropping. We won't go there. Have most of the people who come to you already attempted suicide, or have they just had the thoughts? What is the breakdown?

Ms Tunevitsch—I would not be able to tell you.

Senator BILYK—Obviously, some people come from the hospital.

Ms Tunevitsch—Yes.

Senator BILYK—So one presumes they have made some attempt.

Ms Tunevitsch—Yes. We have moved away from the model of seeing that crisis and helping after. We have tried to move to more of a preventative service so that we get them when they are struggling with their eating disorder before they get into that crisis of suicide, or have that idea.

Senator CAROL BROWN—A shoulder to cry on—support.

Ms Tunevitsch—Yes, especially for those who have gender issues. They need to have that space to go through all of their thoughts. That is another big training issue that we go through with our befrienders—gay, lesbian, transgender, intersex issues and how to talk to somebody who is going through all of those experiences.

Senator BILYK—Who runs the mental health first aid you were talking about?

Ms Tunevitsch—It is run by a group called Mental Health First Aid. I know that the Rotary Health Group has just received some Commonwealth funding to deliver it out.

Senator BILYK—Is that run by the government or by a separate NGO type of organisation?

Ms Tunevitsch—Separate. We have a guy who actually works for Centrelink. He gets time off from his work. He travels up in his own personal time to do that training for us. Unfortunately, he is ill, so he cannot be here.

Senator BILYK—How much would a session cost? If I wanted to volunteer to your organisation and wanted to undertake that training, how much would it cost?

Ms Tunevitsch—I think last time I looked it was $320 for two days. We probably have about 10 who have done the training in the organisation already, out of 31 people.

Senator BILYK—I recently read a media release that made the suggestion that police should be able to detain people who have attempted suicide—been taken to the hospital and then released because the hospitals say they are okay to be released. What are your views on that?

Ms Tunevitsch—With the young boy who got referred from north side, the police told us that they could take him away from the house but all they would be doing would be dropping him somewhere in town. They could not detain him.

Senator BILYK—But what if they could? Do you think there is merit in that suggestion? Or do you think there are problems involved in that?

Ms Tunevitsch—There would be problems, depending on the level of training that the police officer had received. It is another skills set. Is there a place like ours where the clients could be taken? We are not trained in psychotic episodes but we are trained to listen to clients who are at risk.

Senator CAROL BROWN—That goes to one of your recommendations—after hours care.

Ms Tunevitsch—Absolutely. In Launceston you know that at 5.30 pm everything closes. If you want to access Headspace, too bad. Headspace is a fantastic group of people and service. It should be open all hours. Crises happen at all hours, 24/7.

ACTING CHAIR—I am interested in the network you have. We have heard across the country about the coordination of services and getting people to know what else is available in the community. You mentioned Headspace a couple of times, and this committee in various guises has met with Headspace, not in Tassie but elsewhere. In terms of an audit of what services

are available—and I know you are focusing on Launceston but please talk about anywhere; in my briefing before coming here I was warned about the north-south stuff in Tasmania—are you linked into any kind of cross-agency grouping? Do you meet together? If I were in Launceston or in Burnie or Hobart, would there be any place that would be able to tell me what is available for people in need in the region?

Ms Tunevitsch—I brought one of these along with me. This is an absolutely fantastic guide—the ‘Family Support Guide’. It is done by Uniting Care. They do it every two years. They do not receive funding for this. I should have put down as one of recommendations that every parent, every adult gets one of these guides because it is a comprehensive list. It becomes fairly outdated quickly and their online version is from 2007 because they do not have the support to update it regularly and consistently. The Family Support Guide is what we call the bible. It is an amazing resource, but you have to know that this guide exists. So when I am doing work up the coast, I see these because they know that it is a great resource for Launceston and then I see others who do not have this and do not know of this.

ACTING CHAIR—Is that Launceston focused or Tasmania focused?

Ms Tunevitsch—This is for greater Launceston. I believe they might do one down in Hobart, but I am not sure.

ACTING CHAIR—We might contact Uniting Care because they are regular participants in our committee hearings. So that is online as well but it is 2007.

Ms Tunevitsch—That is right.

ACTING CHAIR—Are you in there?

Ms Tunevitsch—We are in here in our old form with our old contact details. We have recently updated our website and email address.

ACTING CHAIR—That is not a government publication; it is an NGO publication. Is there such a body as an inter-agency group where people who are focused on youth or people who are focused on people at risk have some kind of coordinated network?

Ms Tunevitsch—The Launceston City Council coordinate a group called YAG, Youth Advisory Group, which we have attended and some other committee members attend their meetings in their work capacity. Time Out is not a member of it as such; we just attend occasionally. We are a member of TasCOSS and we are a member of Suicide Prevention Australia. We have found that there is not a well-advertised advocacy or services group. There are little ones around the place. The Migrant Resource Centre has a fantastic referral support meeting once every two months.

Mrs Hayes—It is very fragmented.

ACTING CHAIR—And they do not talk to each other.

Ms Tunevitsch—No.

ACTING CHAIR—One of the other things we have been told is that all of these networks are dependent on someone who has the passion to do the work, that they are not specially funded for this coordination role. So usually someone who is driven takes it on themselves and while that person is around it works, but if that person moves, then it goes. Is that your experience?

Ms Tunevitsch—That would our experience, yes, and I would be that person. I currently do about 40 hours on average for Time Out on top of my day job.

ACTING CHAIR—And you volunteer.

Ms Tunevitsch—It is completely voluntary. I am here in my own time. With our organisation you can see when there is somebody in the president role who is passionate about the organisation and it does extremely well and when it is somebody who does not care so much or they are in it just because it looks good on their resume, the statistics of our clients have decreased. So yes, it absolutely depends on the group. At the moment we have an amazing group of committee members and coordinators who are absolutely passionate about getting this service funded and continuing in the community on a long-term basis. We would be able to survive for the next two years realistically without receiving funding, but we cannot go outside our weekend scope, if that were the case and we really need to provide some more crisis service and we need to have the time to go out and market our organisation so that we are not at risk of burnout. That is a factor with our befrienders. We have 31 active befrienders but this weekend it is a struggle.

ACTING CHAIR—You do not know from weekend to weekend.

Ms Tunevitsch—That is exactly right. Everyone has their personal life, and we understand that. It is fantastic that they are able to give up the time, but if we are relying on the same befrienders then they are also at risk of attaching themselves to the client and becoming quite well known to the client, yes.

ACTING CHAIR—In a small community, too—somewhere the size of Launceston—the possibility of that personal stuff is a big one.

Ms Tunevitsch—Exactly right.

ACTING CHAIR—To the best of your knowledge, do you have a personal friends and mentors—

Ms Tunevitsch—Personal helpers?

ACTING CHAIR—That one. Do you have one of those in Launceston?

Mrs Hayes—We have a Personal Helpers and Mentors program—the PHaMs program. I am PHaM trained; I have gone through the training to be a personal mentor. It is not a paid position in Tasmania; it is in other states, so I am told.

CHAIR—That is another Commonwealth funded network that works with people at risk, and it is one of the questions I have been asking about the link between that group, which again is

taken locally, and your service and other services. Apart from your own person experience, is there any kind of linkage?

Mrs Hayes—No.

Ms Tunevitsch—No.

Senator CAROL BROWN—You mentioned some limitations about just opening for the weekend. Is it the aim of the house to provide a seven-day service if funding were available?

Ms Tunevitsch—In a month's time, we will go through some more strategic planning, because our plan runs out this year, but going 24/7 is something that was in our current plan, and that is what we would like to do.

Senator CAROL BROWN—Is that realistic, do you think? Obviously you would need a lot of befrienders.

Ms Tunevitsch—Yes.

Senator CAROL BROWN—You have talked about burnout.

Ms Tunevitsch—Yes. We would need to move to a model that reimburses our befrienders and gives them some monetary reward for providing us with a service.

Senator CAROL BROWN—You have looked at the cost? I am just wondering. You have put in a $60,000 grant application, which was declined.

Ms Tunevitsch—Yes.

Senator CAROL BROWN—Have you done any figures on what it would cost if it were seven days?

Ms Tunevitsch—No.

ACTING CHAIR—Is it part of your strategic planning to do that costing?

Ms Tunevitsch—Yes, absolutely.

ACTING CHAIR—You said earlier that your budget is about $60,000 at the moment, and that involves the $40,000 you raised from one source, which you know is time limited now. So the other $20,000 is from donation and personal engagement—that kind of thing?

Ms Tunevitsch—Yes, that is right. The Rotary Club of Central Launceston just gave us $15,000 from their Sally's Ride event, which is an event that raises mental health awareness for young people. Our logo is displayed and our service is displayed, and we get really great promotion at that event. But we have to go out begging for money, and it is not great to be doing that all the time.

ACTING CHAIR—That is another voluntary activity?

Ms Tunevitsch—Yes.

ACTING CHAIR—Is there anything that you want to tell us that we have not got from you with our questions? Is there something that your really want to put on record?

Ms Tunevitsch—I would like to display some artwork. We go to different events occasionally. We had a stall at National Youth Week, and we had one of our volunteers go and collect handprints and get the children to do handprints. It was an event for 15- to 25-year-olds. It was concerning in some of the handprints that we received—I have brought a couple to display to you. We asked them to do their handprint, put their name at the top and then write the supports that they have—if there were a crisis, who would they turn to for support? This says, 'I am Veronica.' She would go to Michael, Sarah, Claire, Rani and Kat. Then we asked them to put in the middle of the handprint how they are feeling at the moment. This is a great one; the person there has five resources there if she needs to access them. This one says, 'I am George: Dad, Mum, dog, soccer and dance.' That is where he would go in crisis, and it is lovely, because it has a little love heart. But then we have ones like this. The person did not want to put their name. It says, 'Me, Dad, family, life and support,' but they have crossed out a little bit. They have put a smiley face, but it looks concerning. Then we have this one: 'I am Billy,' with 'Mum, Dad,' and nothing else. What would happen if Mum and Dad were not there? He would have nothing. It is the same with our clients. I am so passionate about this. They may not have support, but we are their support. We are there to help them and guide them through. It is an absolutely fantastic service. Thank you so much for giving me the opportunity to talk and cry in front of you!

ACTING CHAIR—Thank you so much. If there is something else that you think about later and think, 'I should have told them that,' which does happen to so many people, please just contact the secretariat. Good luck.

Ms Tunevitsch—Thank you.

[9.56 am]

PUNCH, Mr Julian, State Coordinator, Coming Out Proud Program, Tasmanian Council for Sexual and Gender Diverse People

RYAN, Mr Scott, State Coordinator for Outright Youth, Tasmanian Council for Sexual and Gender Diverse People

ACTING CHAIR—Good morning, gentlemen. We thank you so much for giving up your time to come and talk to us this morning. You have information on parliamentary privilege and the protection of witnesses. You heard that the *Hansard* record will be sent to you. Please make an opening statement, then we will go to a discussion.

Mr Punch—Thank you very much for the opportunity. I am sure you have a copy of our submission.

ACTING CHAIR—We have. Thank you.

Mr Punch—That was done prior to the incorporation. We found it necessary to incorporate because there were a number of groups coming out of the same process. There have been two fundamental turning points in my life, which have both involved suicide. I was a Catholic priest for 10 years. I became aware, through parents who would come to me, that their male children were significantly suiciding. In each case there was, aligned to that, a priest in the community who was berating people for their sexuality, whether they were gay, lesbian or whatever. That has not changed, unfortunately. It has only got worse in our church. For me, that was a turning point in my life. I thought about how lacking in courage I was not to be out about who I was, my basic sexuality. The second turning point was the suicide 18 months ago of my gay nephew, John, in Sydney. That has been another turning point in my life, through my involvement with this organisation.

There are two significant things about suicide. One is that you have no position in the community. You have come to the end of the line in terms of respect, who you are and what your future is. For our community—the gay, lesbian, bisexual, transgender and intersex community—that is the most important factor that there is.

We are an organisation that is totally voluntary at this stage. We are looking at working more closely with the government in terms of Outright Youth, and Scott will detail for you in a minute what we are doing. Our basis is four regional community liaison committees. We work very strongly with local government. We ask local government in those four regions—Greater Hobart, Kingborough-Huon, Greater Launceston, the north-west and the west coast—

ACTING CHAIR—Does that cover the whole state?

Mr Punch—Yes, it does. As I will explain later on, we are trying to reverse the Hobart-centric, Launceston-centric stuff. The problem for us—and I will show you the statistics in a minute—is in those regional local areas where homophobia is prevalent. Those community

liaison committees have been developing over the past four years. They are a fundamentally important part of our structure, particularly when we work with local government. We ask local government to endorse the program we put up to them. We provide terms of reference and we ask them to appoint a liaison councillor. That is now replicated, probably at the level of the social inclusion commissioner in Tasmania. They are also working very closely with local government. They are forums that people can come into. They may be people who are experiencing violence or they may be young people who are experiencing discrimination; a whole range of people can approach us. We have a strong connection to local police, health and human services, education and, interestingly, tourism. Our community is very involved in the pink dollar and pink tourism. There is a huge influx of gay people into this state, as there are into major population centres.

On top of that basic structure we have the League of Gentle Fellows, which is a very important structure. It all started in the sense that people got together to establish safe space and to have a social event—very simply, in somebody's house or garden and eventually in a commercial venue. They now have a database of about 1,500 people. It is very important in that people are coming together. Their motto is, 'You're not the only gay in the village'. It is a bit anarchistic, but it is very, very effective. They are also raising money, which is now the Coming Out Proud Program trust. There is a belief that our community needs to contribute to its welfare and to supporting members in need. The trust now has about $25,000 or $35,000, and we do not spend much of that; we are able to match it to local government dollars or state government dollars. The third wing is Outright Youth, and I will ask Scott to detail that for you.

Mr Ryan—Outright Youth is a youth group that started because of my coming out, which was hard. I found that there was not much support that I knew of, so I spoke to a counsellor at my school, who referred me on to Julian, and we went from there. Everything was fine, and a few months after I had seen Julian I thought 'There needs to be support out there,' so I formed Outright Youth. Initially it was just going to be a social group like the League of Gentle Fellows, but in this short period we have actually started working with schools, appointing one counsellor-teacher in each school in the state. We have gotten a fair way. We already have a database of teachers and counsellors who are willing to support us, and a lot of the colleges are supporting us big time as well.

Senator CAROL BROWN—When you say schools, do you mean colleges?

Mr Ryan—Colleges and high schools. We are going across the board. We are dealing with the youth bracket, which these days is 12 to 25. We are trying to deal with as much as can within that youth bracket.

Senator BILYK—How many schools do you have on board?

Mr Punch—At the moment we have 15. We have a database that I could provide to you which covers the whole state, and that is the aim eventually.

Senator CAROL BROWN—Are they all public schools?

Mr Punch—No, and it is interesting that at one school at Cygnet, St. James, which has come on board, the social worker there crosses over between the public schools and the private

schools. I would say about 15 schools at the moment, and we are just about to talk to the new minister for health. We are getting a very good reception because it is a big task. There is a difference between high school and college for a young person coming out. Primary school is difficult and high school is difficult, but once they have got to college it has settled down a bit, but that whole area of coming out is important. Scott could tell you about what happened prior to going to see a social worker.

Mr Ryan—Prior to going to see a social worker, I was at the stage where I was living a lie. I had the pretend girlfriend to keep the parents happy and all that, but I was at the suicidal stage.

ACTING CHAIR—How old were you?

Mr Ryan—I was 17 turning 18. I had known for a while, I just kind of thought it was a phase that was going to pass. It did not, so I was at the stage where, if I could not get help, I was going to do myself in. Looking back on it, I think how stupid I was to think like that, but that was the only option that I thought was available. Dad is a blokey bloke. He did not know how to handle it and we did not speak—we have just started speaking again. Mum was fine; she just turned around and said, ‘Are you sure?’ and I said, ‘Yep.’ The problem was more on my father’s side, because I was always ‘dad’s boy’. I did not know where to turn or where support was here in Tassie.

ACTING CHAIR—What did you do?

Mr Ryan—I went to see Cindy Barrier, a social worker at Rosny College. She said she would find the best person for me to speak to and she said she had had contact with Julian before so she organised for Julian and me to meet. We just sat down and had a good old talk and sorted everything out to make everything better. After that I was in contact with Julian a fair bit over the next few weeks. I was able to go on and get my life back on track. I contacted Julian again six months after our first meeting and everything was going fine. I was living at home and that was fine; it was not awkward anymore.

ACTING CHAIR—How long ago was that?

Mr Ryan—I am 20 now, so everything has been fine for a couple of years now.

Mr Punch—There are a couple more points I want to make. It is important to emphasis that there is nothing existing in schools, apart from in a couple. The government does fund some programs but they are too complex, they take something like eight weeks, and teachers do not have the time. So I emphasise that what we are doing is very simple and it has those very simple points that Scott has outlined. The first is a contact point in each school, either a teacher or social worker. Then the young people download Not Round Here, the Human Rights and Equal Opportunity Commission’s anti-homophobia program, which is a very good manual that young people can use and they can pull bits and pieces of it out. Then the young people act as mentors back to other young people. They are not social workers; it is simply that experience, that ‘You’re okay; I’m okay. I’m gay; you’re gay.’

Our contention is—and you will see it at the head of our submission—that we are a very vulnerable but hidden group within the community. We have compounding suicide issues. We

have very high rates of suicide. The easiest statistics to quote to you are those on same-sex-attracted young people from the La Trobe University study in our submission. It is very relevant for Tasmania. Tasmania has, I think, the second-highest rates of suicide in the nation. We are also, interestingly, the most homophobic state in Australia. That is according to the Australia Institute. I have got no doubt about that. Our rates of suicide in the urban areas are three times the national average and in rural areas they are six times the national average. We believe we have an understanding of why that is. Young people, in terms of being gay, as Scott has outlined, face conflict with parents and peers. You come out to your friend and you may get a punch in the face. Your parents very often kick you out of home. There are statistics that indicate that we are one-third of the homeless population in Australia.

ACTING CHAIR—It would be good if you could provide that.

Mr Punch—I can probably get you a reference for that.

ACTING CHAIR—At some stage, thank you, because that is another element we have not picked up on.

Mr Punch—What happens is that your parents discover you are gay, are totally confronted by it and young people leave home. I have seen a lot of this. The time I was a priest, I saw that young people, fairly innocent in a Tasmanian situation, would leave the state to get away from it and go to Sydney. I have actually buried some of those people when they have come back with HIV AIDS, because they go into a culture that they cannot cope with. You lose friends after coming out. You can become totally isolated unless you can make the connections back to your culture within that environment. Our community abuses alcohol and drugs. You become homeless and unemployed and you have unsafe sex.

I think it is really important to address the hidden part of our community. Our contention is that discrimination leads to suicide. There is a connection between discrimination and suicide. All of the statistics indicate that. If you look at suicide linked to bullying, as I note in the submission, 55 per cent of gay men and lesbians had contemplated self-harm as a direct result of bullying and rural same-sex-attracted young people are six times more likely to attempt suicide than the population as a whole. Those are in our submission, so you have the reference there. The Tasmanian experience of assault is that 46 per cent of 16- to 26-year-old Tasmanian gay men have experienced assault or verbal abuse based on sexual orientation. That is from the Menzies Centre for Health Policy on population and rural health. I can produce many statistics along those lines. Our contention is that discrimination leads to suicide and that if we are going to be effective in terms of reducing our suicide rates then we have got to find strategies that reduce that discrimination. That is for the wellbeing of the whole community.

There is, unfortunately, a huge amount of denial in our community of the statistics and incidence of suicide within our community. It is interesting: we have had a huge discussion with beyondblue because beyondblue is well known within our community, and we never got any assistance with beyondblue. People reflected on why this was happening. Now beyondblue is putting out the draft guidelines on depression in adolescents and young people. When they came to Hobart for a consultation, I was asked by the national organisation to go along. Totally left off the picture.

Senator BILYK—Can I clarify? Are you saying that the issue of gender was totally left off?

Mr Punch—Yes, sexual gender was left off. Indigenous people? Yes. Certain other areas are there consistently. I went to the consultation here in Hobart and got rudeness when trying to explain to them some of the statistics and our experience. I think that is changing—probably quite rapidly because our community has worked very hard on it. We went and made a presentation last year on our contention that discrimination leads to suicide. That night Dr Crawshaw came to present the state government's perspective, and of course we again got left off the picture.

Senator CAROL BROWN—Why do you think that is happening?

Mr Punch—I want to go on to that. I think it is a deep seated pressure in our community—certainly from churches and many organisations with a conservative viewpoint. We are considered to be immoral and decadent. That is the basic thing you always hear in Tasmania; it keeps coming up. There has been a whole trend in the welfare system moving towards outsourcing welfare services to church based organisations. I know from my own background that it is just too hard to face. I think it is changing, but we have to do a lot more to make sure that it does change. We have had long discussions with Dr Crawshaw. We were appalled that night. It took the wind out of our sails, because the next day we were presenting a submission to the national conference. We have had discussions with Dr Crawshaw, and I think we are starting to get there. I notice he is—

ACTING CHAIR—He is giving evidence this afternoon.

Mr Punch—Yes.

ACTING CHAIR—The question will be asked.

Mr Punch—Besides beyondblue, it is everywhere you go. With our relationship with local government we have had two significant complaints with the Anti-Discrimination Commissioner where either the mayor or certain other people have been very discriminatory. That has achieved substantial change for us. I do not think we are going to have any more. The process of conciliation is really important in terms of not making enemies and reaching an agreement that we are not immoral and decadent, that we are a significant part of the community, that we play a role in the community and that we are part of the rich diversity of the community.

It is difficult in terms of Tasmania. We haven't even started to look at the—well, we have started, but it is very difficult in the north-west and west coast. We have an agreement with the Cradle Coast Authority, which covers the nine councils of the north-west coast, but that is an agreement that we will work through the Cradle Coast Authority, because they know that, if we went through the councils, in terms of the endorsement of what I have explained, and the appointment of a liaison councillor, it would be very difficult to get 10 people to agree to that. So we have agreed that we will work through the Cradle Coast Authority and that will be our aim—to work through that gateway into the councils and it will be part of our role.

We are proposing a couple of things. One is the importance of cultural awareness training. There is very little cultural awareness training. There is antidiscrimination training in this state,

but we are just moving now towards cultural awareness training. This is the same for the Indigenous community, too: the special position of our community—our weaknesses, our strengths—are contained in cultural awareness training, which changes the culture. We have got good antidiscrimination legislation in this state, but the difficulty is that we need a culture change in terms of the community. The communities are the cause but also the solution.

Most professions do not have cultural awareness training. I provided cultural awareness training to second-year medical students two weeks ago. They were on a rural program—funded, I think, by the Commonwealth government, trying to attract doctors to rural areas—and went to Huonville for a week. It was really interesting. We started off with GLBTI, and the lack of awareness of those students in terms of that terminology—'gay' was okay, 'lesbian' was okay, 'bisexual' was difficult, 'transgender' was more difficult and they had no idea what 'intersex' was. These are medical students who, in a short period of time, could be making a fundamental decision about a person who is intersex and a determination about their sexuality for the rest of their life.

It is the same with lawyers and with police. Three-quarters of the police in this state are not trained in cultural awareness. They are dealing with large amounts of violence towards our community, and very often they are part of the problem. We have a hate-crimes group, a group of people who have been bashed, and there is no recording of the cause of that bashing. You can go right the way through the professions. So the introduction of cultural awareness training is really important. I think that in the Commonwealth public service it is probably very good. In the state service it is not good. But it is absolutely critical.

The other thing—and you touched on it in the previous session—is the whole issue of funding. We are a voluntary organisation. We have two significant groups in this state that are specially funded—Working It Out and TasCAHRD. The funding is probably about a million dollars. But I think one of the significant things the government could do is to ensure that no funding goes to an organisation until there is proper consultation with that community in terms of the efficient, effective and appropriate funding base for that. In other words, organisations that are funded have got to put up, in terms of consultation with the community, that they are talking this out with the community—that is No. 1—and, if they are going into programs, that those programs are effective and efficient. That is most important, because we find that many of the programs that go in are not effective.

There is a program called Pride and Prejudice, which is supposed to go into all the schools. It is too intense, and its implementation has not been discussed properly. It is eight weeks but, if you go into a school, there just is not the time to do an eight-week program. The Outright Youth model has emerged from that to do something very simple that the school can cope with.

Senator BILYK—When you say it is eight weeks, how many hours are we talking about?

Mr Punch—It is a program that people come outside to do. It does not create infrastructure in the school. It takes the teachers and students through a process. It might be about two hours over an eight-week period. I am not saying it is bad. The other difficulty is that it was launched in a blare of trumpets. When that program goes into a school, parents have to sign. You can imagine in Smithton, Dover or wherever that, if they have to sign a statement that their children can go to a Pride and Prejudice program, immediately the fundamentalists move in. They ensure that there

is a huge amount of pressure on the teachers and students. That is the difficulty of there not having been consultation with our community and the general community.

Senator CAROL BROWN—Who developed that program?

Mr Punch—It is an overseas program. It is a very good program, but we find that Not Round Here, which is the Australian Human Rights Commission antihomophobia program, is very practical. It has a manual which you can download. The Outright Youth download it, for instance.

Mr Ryan—It is a 150-page booklet on the whole discrimination area. Teachers can pick up the booklet and pull out anything they want to use. It can be used in high school and college. It has comic strips, worksheets, everything that a teacher needs. They can sit down and do it for an hour or for a whole day. It pretty much cuts across the board.

ACTING CHAIR—It is right across all areas of discrimination, so the gender issues do not jump out.

Mr Ryan—They do a little bit. There is one question that asks a straight male or female: how would you feel if you were gay?

Senator BILYK—But the program—and I think this is what Claire’s comment was about—does not isolate, which makes it more mainstream.

ACTING CHAIR—It is a very good program.

Mr Punch—That is the difficulty with our community. We can be incredibly separatist at one end and at the other end we can be part of the mainstream. We really need to be part of the mainstream, and we are becoming mainstream. There is a whole range of groups. When you get into a community that does not have a lot of resources, you get this silo mentality between mainstream programs and special programs, and there is no coordination. There should be a lot of discussion, and we are trying to initiate discussion between TASCARD, Working It Out and the Outright Youth. But it is very difficult to do that, because there is an inbuilt threat about funding, and it is too possessive.

The Auditor-General’s report about the proper management of community based programs talks about efficient, effective and appropriate benchmarks, and that is based on consultation and evaluation of programs. We are saying those two things are absolutely critical for cultural awareness training. That is not too hard, I do not think. We have got to the stage in Tasmania where the Anti-Discrimination Commissioner now has a mark 2 of the antidiscrimination training, which is GLBTI cultural awareness training, and that is having a major impact. Through one of our complaints to the Anti-Discrimination Commissioner, Huon council and Kingborough Council have initiated that training with their workers. It has had an amazing effect in terms of cultural change, from their road workers right through to the councillors. There are various areas they are working on in terms of young people. They are now cultural awareness trained, which is a start, whereas the doctors are not. So there is a very interesting situation in—

Senator CAROL BROWN—That is what I was going to ask about the cultural awareness training. What other sections of the community would you like to see this training occur in as a priority area?

Mr Punch—In terms of suicide prevention, certainly Indigenous people—who feature very highly—and our community. If you look at the attribute groups under the act you will see that a lot of people do not understand indirect discrimination. They understand direct discrimination but they do not understand indirect discrimination, and it is that area we need to change. The common thing is, and this happens very much to the Indigenous community, you are not going to get anything that the whole community does not get. You walk into a health centre and you say, 'Where are the signs that tell our people that they are welcome and safe? There is nothing. And they say, 'Look, your community is not going to be treated any differently to any other section of the community.' There is that homogenous lack of understanding about diversity.

It is like with a disabled person. For example, a meeting is held on the second floor and everybody is invited, so everybody is welcome. But the thing they have forgotten is that people with a disability cannot get to the meeting place. That is a good example of indirect discrimination. We suffer from that a lot. They look at our community and think 'Yeah, double income, no kids—well off.' They do not look at the social indicators that deny the reality of what has happened. So cultural awareness training helps people to understand some of those factors and some of the things that they need to build into their program. I will give you an example. We participated in a consultation at Kingborough, in the very early days, on youth policy by Kingborough Council. Kingborough Council spent $80,000 at that time. They outsourced youth policy and practice to Fusion. Fusion is a church based organisation. We stated where we were from, and all the heads in the room went down. It was the first time that many in our community—and it is a fairly strong Dutch Reformed/Sudanese based community—had really been confronted by gay and lesbian people putting their heads up. At morning tea time we went to the head of Fusion, who is in receipt of $80,000 to work with young people. We said, 'How do you deal with our community? How do you deal with the gay and lesbian community?' The report came back, 'It's an immoral and decadent lifestyle.' We have a conversion program called Exodus, which is an American program. If you look at Exodus you will see that the connection between Exodus and suicide in America is very significant. Here is an innocent council—unaware. Cultural awareness training can change that.

ACTING CHAIR—I just want to clarify one of your recommendations regarding people in receipt of government funding for those programs. Are you saying there should be something in the tender document or in the application process that makes sure there is no discrimination?

Mr Punch—No, I am saying more than it. The tendering government should ensure that coordination and cooperation take place through consultation with the community involved, regarding that community's special programs. I think it is also a factor in mainstream programs, which we are looking at a lot. It is the general principle. You were talking with the previous people about a lack of coordination across the board. It is a huge waste of money.

ACTING CHAIR—We have spoken a bit in this committee, and Senator Adams and I have been following it up, about the tender process. We have had significant feedback from people—not just in the health area but specifically for this inquiry—that tenders go out and they are often regionally based: 'Provide services to X'. The process of the tender seems to allow larger

organisations which have high skills in writing tender responses to win tenders, quite rightly on their proven delivery of service. But in terms of the absolute understanding that if you are going to provide services in a region you need to demonstrate your ability to cooperate with people in that region before you win the tender—and that is something that we have spoken about at length—you are also suggesting that for special groups in the community, including yours but generally, there needs to be something in the process to ensure that those issues have been considered and that they are part of the mainstream of their service delivery?

Mr Punch—Yes, absolutely. I can give you examples of working it out in TasCAHRD. It is probably a budget of at least a million dollars.

ACTING CHAIR—Can you help me with that acronym? I am not from Tasmania.

Mr Punch—TasCAHRD is the old AIDS council. It is the Tasmanian Council on AIDS, Hepatitis and Related Diseases.

ACTING CHAIR—Do you want to talk about that process? You have mentioned it twice.

Mr Punch—Yes. They are funded. They are very important for special programs in this state. We put a lot of importance on mainstream programs that we fit into in terms of the police, health and human services and education. We are involved in the mainstream programs, hence the Outright Youth involvement with a teacher and a social worker in each school—a simple thing but a big task, and we will be working with a minister, probably, to achieve that.

ACTING CHAIR—Mr Punch, you mentioned earlier that you are in liaison with the minister, and you mentioned the Minister for Health earlier. Is the liaison on this process also the Minister for Education and Skills?

Mr Punch—Yes.

ACTING CHAIR—I would think so. When you are talking with government, I would imagine that putting something for the school network would engage the minister for education as well.

Mr Punch—We have found the new minister, Lin Thorp, very attentive to us, very concerned. The previous minister was not sympathetic. She said: ‘We’re funding a program and you’re just an additional thing that we need to deal with. You’re complicating the scene.’ This current minister is totally different. We do not have a minister responsible for our community in the state. Every other group does.

ACTING CHAIR—Is there a minister anywhere?

Mr Punch—We get referred to Community Development.

ACTING CHAIR—In any jurisdiction is there a minister that is focused on your area? I am just wondering.

Mr Punch—No, I do not think there is, actually. It is interesting that when you go into DPAC here you have youth affairs—

ACTING CHAIR—DPAC?

Mr Punch—The Department of Premier and Cabinet. You have ministers responsible for youth affairs, children and families, ageing, Indigenous issues et cetera. We have no minister. We spent a lot of time yesterday talking to the Social Inclusion Commissioner about it. We have nobody at cabinet level who is really responsible for us. That is something we are trying to change. It is important at the federal level too.

One of the difficulties at the moment is marriage. It is significant that about 90 areas of Commonwealth legislation are changing to an antidiscrimination perspective, but the one thing in terms of stigma is the importance of marriage. I went to the Attorney-General to talk to him when he came for the cabinet meeting in Hobart, and he just did not want to know about it. There are lots of ways to do it.

ACTING CHAIR—It is an ongoing issue, Mr Punch. I can assure you that the discussion continues.

Mr Punch—It is critical for us in terms of stigma and self-respect.

ACTING CHAIR—I will go to Senator Adams first, and then we will go back to the Tasmanians. The gentlemen from this area had heard that because one of our witnesses is not able to come through illness we are letting the witnesses go on longer. For anyone who was not in the room: I am aware of the time, but we have the ability to move into a longer discussion with the witnesses.

Senator ADAMS—I have a question for Scott. When you approach the schools or whatever groups you want to go and talk to, how do you get on? Do they immediately shut the door and not want to know, or are they really starting to improve?

Mr Ryan—Mine was easy because although the person I went to see was not a teacher of mine we knew each other and we got along really well. That was the bonus with me—I knew her already. In some instances, in some schools, it may be that teachers do not want to know. I do know a friend of mine who went to XXXXXX. The college social worker there is very homophobic, and he did not want a bar of it when he came out.

Senator ADAMS—Just with your group, if you are trying to promote it.

Mr Ryan—Yes, when we are trying to promote it, we have not had a knock-back yet. They are all very willing to support us. The best one at the moment is Claremont College. We are at Claremont College now. We have just started there. I am at Claremont College now every Wednesday for two hours for the students as part of the group. We are working with the schools and trying to get at least one student that can be there as a recognised person for other students to talk to.

Senator ADAMS—What about the general community? I come from a rural community, and you have a lot of rural communities. Do you go as a guest speaker to Lions or Rotary?

Mr Ryan—Not as yet, but that is the bigger picture. We are not trying to bite off too much at one stage. We are all volunteers, and we do not all have a lot of time.

Mr Punch—We are using the social worker network, which is the safest.

Mr Ryan—Yes.

Mr Punch—What Scott is saying is true: we are getting a very good reception, because schools have a huge problem with bullying and they know that it is really important to set this up. They just do not have any resources to do it. If it is simple, as what we are doing is, they can cope with it. It is developing social capital in the sense that the young people coming out of that bullying situation are then, like Scott, the best people to be the peer support. Last week, we went up to Launceston and spoke to the council—we made an address to council—and then we went to meet the principal social workers. Now they have set up a network. We will now go up and talk to all their social workers and start to set the network up there. What we are trying to do, to back on with the minister, is to get the minister to endorse it so that teachers understand that it is something that they can do and it is endorsed by the government. We are not asking for a lot of resources, but we will ask the minister to endorse it and to then have somebody in the education department who will work to facilitate it. It is like the relationship with local government. That is important. But we are getting a very good reception because there is nothing there.

Senator ADAMS—Scott, as far as being a sort of counsellor is concerned, if a school has a problem and they want a younger person to come and talk to the student, are you asked to do that?

Mr Ryan—Yes. My policy is that my phone is always on, or there are emails. I do have the instance where a social worker can send me an email and say, ‘Can you please come in at this time and speak with this student?’ If I cannot make it myself there are other people within the group who can do that, go into the school or college and speak to the student. I cannot tackle all of that, but in the instance that Narelle is not contactable they can email me or they can call me at any time. It does not matter what time it is—one o’clock in the morning or whatever—I will answer the phone.

ACTING CHAIR—Does that need parental approval?

Mr Ryan—Yes, it does. That is a cautious side. I do try to stick to being cautious and abide by the book. I am at the moment doing work in children training. So I am doing all the training that I need to do this job, as well as having sufficient police checks so that when I go into schools I am police checked.

Mr Punch—It is a very narrow definition—and we talk a lot about it. It is not a counselling role. They are not trained as counsellors and it would be high risk—

ACTING CHAIR—For the duty of care stuff?

Mr Punch—Yes. It is simply, ‘I’m gay; you’re gay; it’s okay.’ It is a peer mentor role that they play. They do not play any role more than that. They play that role with the social worker. It is very high risk in a way, in the sense that I have been called to go in because there is nothing else there. I go in, with my training and background, but for teachers it can be very difficult.

The last time I went into Rosny a young person who had been away from school for three weeks came out. His parents kicked him out of home. He just left and he was in high moral danger, living with a group of people. He had been through unbelievable difficulties. He was suicidal. I went in. I then asked him if it was okay and made the introduction to the teacher, who was the contact teacher. She came in and we then talked about a program, support and a safe space for him. We called his teacher in. His teacher then sat down with us—so there were the three of us—and we worked out the program. As we walked out the door, here were his parents, because he had been away for three weeks. The parents said, ‘I hope you’ve got good news for us.’ His teacher had taken him back to get him back into the school situation. I said, ‘What good news do you need?’ I said, ‘Your son is an incredible person; he’s got so much respect. He’s been through a very difficult time. What’s good news?’ They said, ‘He’s not gay.’ I said, ‘Well, you need to have that conversation with him but you should be so proud of your son and who he is as a person.’ But it was a terribly difficult situation for the teachers. That is why I think that we need, with the minister, to get backing and safeguards for what is happening.

Senator ADAMS—In terms of drug and alcohol dependency amongst your members, do you find you have a situation in that respect?

Mr Punch—Yes, there are some statistics on it. Anecdotally—

Senator ADAMS—Statistics are fine, but I want to know from the point of view of your association how you deal with it. Is there a lot of it, or not?

Mr Punch—Again it relates to the mainstream programs that are there to deal with it—I was interested in the previous people you had here—and their acknowledging that gay and lesbian people exist and that they have special needs. They have a culture and that culture needs to be involved in rehabilitation of those people. It is understood that within our community there are increased problems with alcohol and drug taking, relating back to our position in the community.

Senator ADAMS—Is that true, Scott, amongst your peers?

Mr Ryan—It can be. I have not really come across many incidences of that. I work with the social workers at schools. So, pretty much, before I get there those problems have been fixed. I am called in after that, normally. But if I am called in before that then I go through the channels and see what help we can get to get them off the alcohol and drugs.

Senator ADAMS—But with your own age group—

Mr Ryan—Yes. It is a problem with alcohol and that. I admit that I steer clear of it because it is horrible stuff. I work in the industry. But, yes, there is a problem with it.

Senator ADAMS—How do you get into the coordination with the other areas to be able to help your friends or people that you are associated with, for them to get help to be able to run their lives a little bit better and not push themselves completely into a depressed state?

Mr Ryan—We use the mainframe groups that can help with support with that. I am not trained in any of that kind of stuff. I am not going to stand there and say that I am and preach about it. I am just going to go: ‘This is what you can do. These are your options. The world is your oyster. There are so many different choices you can make about which road you go down.’

The **Senator ADAMS**—We have had quite a lot of evidence about people self-harming and the way that they are being treated with emergency departments, especially with the triage area. If someone goes into an emergency department, do you have a special mental health or psychiatric area for that person or a triage person so that they can be helped straightaway rather than being taken out and then having to go off themselves later on? Is there any way that that works here?

Mr Punch—You are asking us questions probably beyond what we are doing in schools. We participated in the state consultation around 30 communities that the suicide prevention council initiated. It is a major problem. Young people and older people are going into, for example, the Royal Hobart. Their parents have had strategies to work with them and deal with them. They go into the Royal Hobart and a short time later they are released and then they may be off the bridge. It is just a horrendous story. I sat in on many of those consultations to represent our community, but it was horrendous, just a constant story of parents who—

Senator ADAMS—My question is: if you or one of your colleagues front up to an emergency department in a distressed state—affected with alcohol, drugs or whatever or just absolutely had enough with the discrimination that you are talking about—what happens right at the coalface there? How are they treated?

Mr Ryan—I am not so sure how to answer that question.

Senator ADAMS—Have you had any friends—

Mr Ryan—Not personally.

Senator ADAMS—What I am trying to do is really not getting into representation. It is just practical issues. We want to know how people who perhaps are looking at committing suicide or have self-harmed here in Tasmania get to that next place after that cry for help.

Mr Punch—I think I have explained to you. They go out of control of their support group, and the hospital deals with it.

ACTING CHAIR—Have people raised with you their concerns? You can only tell us what you are aware of.

Mr Ryan—I am not, but Julian has been doing it longer. I have only been in the position now for—

Senator BILYK—Maybe I could ask the question that I asked the previous people with regard to the recent media releases, where it has been stated that it would be good if people who had been released from hospital who had attempted suicide or self-harm could be handed back to the police or that sort of thing. I am just wondering what your views on that are.

Mr Punch—Police cannot deal with it appropriately. I have already explained that, from our communities' perspectives, many of the police are not culturally awareness trained and are not aware of it. I think it is around that issue, and we said it right at the start. A supportive community, and parents, is the most important point. Many of our people are separate from their parents—there has been that break. I can tell you in terms of participating in the consultations that, once you go to the triage situation in the hospitals, you lose that break with whatever support group you have. And then the law is deficient—and it is being talked about in this instance. The person loses their break with their community, their parents or their support group, and then they are in a legal situation where there is no way of dealing with it and they exit the hospital. That is the way the law deals with it. All the communities are experiencing about. It is the same for rehabilitation. There is very little rehabilitation around. I have a nephew in Sydney who is addicted to drugs, he is dependent on marijuana, and he cannot get any rehabilitation. There is nothing for him. His brother suicided. He is in a very vulnerable position. We are encouraging him to come to Tasmania. There is very little rehabilitation for people.

Senator BILYK—That leads me in to a question about support for families and those close to people who have suicided. Obviously, your second nephew has other issues besides the fact that his brother suicided.

Mr Punch—The whole family gets affected.

Senator BILYK—That is right. Do you think there are enough support programs out there for families and those who are close to the people? If not, do you have any suggestions?

Mr Punch—I am talking significantly about our community. I know that, when my nephew suicided, the community provided basic support. The main theme was that Joel was depressed and had some sort of mental health problem. That divided my family. Part of the family understood that, as a gay member of the family, he had been excluded in a lot of ways. That had been passed down from some of my brothers and sisters to their children, who then bullied Joel. Joel used to go home to the seat of the family, where my mother was. Every Christmas Day he had to face the prospect that he would not fit into the family and was going to be excluded. That is why he chose Christmas Day. There were about 300 people at Joel's funeral. My brother and sister had no idea that he was so popular in the community. At home he was very depressed and very withdrawn and very difficult to deal with. But they loved him. They really cared for him in a great way.

There was a grieving in the whole community. There were 300 people at Joel's funeral. They came and had a barbecue at our place after he died. The whole community talked about the frustration felt by so many of the gay and lesbian people he was friendly with. Joel had a very interesting relationship with women. He was a secure person for women to be involved with. They had all experienced suicidal thoughts themselves, as mentioned in the statistics I told you about. They all had friends they were trying to support. In our community, that is the most important support, but it is not backed up by mainstream or specialised assistance. So, somehow,

you have to strengthen that capacity within the community. Family support or community support has to be supported. Most of the programs, including the CORES program in Tasmania, are developing resilience capacity within the community, and that is where has got to be. There is a specialised need for rehabilitation, where people move out. One of the reasons we are talking about my nephew coming to Tasmania is that he needs to get away from his peer group.

Senator BILYK—I was also interested in the support offered to the immediate family from the emergency service personnel and that sort of thing. Because you have had firsthand experience of this within your own family I just wonder if you have any comments to make about that? We have heard varying stories where people have been handed things by ambulance officers—basically at the time—and they have got lost in the pile of things and not found until months later. That is not always the case, of course, and I suppose it depends on the individual community and how much time people within those services may have as well, but I am interested in your feedback on that question.

Mr Punch—I think it is a really important area. Again, it is part of that community. A lot of the people who came to my brother's house with food were people who had lost their children. But they also needed counselling. We sat down on New Year's Eve and around the table were a whole lot of parents who had lost their children. Again, I would put a lot of emphasis of that being within the community.

I think it is informal—

Senator BILYK—When you talk about it being within the community, are you talking about within the broader community or within the GLBTI community?

Mr Punch—You need your geographic community or a cultural community.

Senator BILYK—You would find that not all people would have a strong sense of community around them either.

Mr Punch—That is one of the things we are trying to do, and that is why I said that the structure of what we are doing is really critical. Those forums that we are establishing are creating community. The League of Gentlefellows, who are telling people they are not the only gay in the village, is absolutely critical for our community. It is a very real bulwark against discrimination and, eventually, against depression, alcohol taking and whatever. It is a very important base. A lot of it does need to be supported, but not by taking it away from the community.

Senator BILYK—Your submission had an example—Laurence's story—which was quite moving, and I will quote:

The coronial inquiry and investigation gave no reason or motivation about the suicide.

You mention that later on in your submission. I am quite concerned with the accuracy of reporting of suicide with regard to coronial inquiries. What ways can you suggest to ensure that sort of evidence is able to be gathered? I think we need to get better statistics. We have got statistics, but I think there are gaps in them.

Mr Punch—Absolutely.

Senator BILYK—What comments have you got to make?

Mr Punch—That is an absolutely crucial question and I am grateful to you for asking it. It is absolutely critical, and it is part of that cultural awareness training. The police do not ask about sexuality, and the statistics are flawed in relation to our community. The first step in a coronial inquiry is the questioning by the police, and the question is not addressed as to sexuality being a cause. It is difficult, because there is a lot of denial in the community anyway. You are right—the statistics are fundamentally flawed. It also relates to violence against gays in the state—it is just not recorded.

Senator BILYK—Even the issue of whether it is actually a suicide or not is often not accurately recorded either.

Mr Punch—Yes.

Senator BILYK—I understand that there is a variety of reasons for that—family dealing with the issue anyway at the time and things—but it is a concern to me that we are never going to get a complete handle on it if we cannot get the true facts.

Mr Punch—It is absolutely critical, yes. You are absolutely correct. Please do not—

Senator ADAMS—If I can interrupt—with all the travelling around that we have done, we have got some excellent evidence from coroners and from the Australian Bureau of Statistics, so if you read our transcripts from the other inquiries I think you will find that there is a lot of work being done in this area. It is all there.

Senator BILYK—Yes. Obviously I was aware that the work was being done, but I think it our job to make sure it keeps being done.

Senator ADAMS—Well, we have certainly done it. If you look at the transcript, you will see that.

Mr Punch—It is a particular problem for our community, though, because there is denial. Parents do not want to admit, number one, that their kids are gay.

ACTING CHAIR—It is not on the form. The form that the police fill out does not have information on lots of specialised groups, and all the stats go back to the police form. It is a core issue.

Senator CAROL BROWN—I want to follow up on a question that Senator Bilyk asked about the media reporting and whether there should be greater powers for detaining people who are at risk of suicide. Obviously, when such people present at an emergency department they are having an episode. Some are admitted and, as I understand from the evidence that has been given, some are not admitted and are released, and not to a referral service—they are out by themselves. I want to know your view on the situation where people who are in that position, that state, have been assessed as being at risk of harming themselves and are released.

Mr Punch—I think it is disastrous in this state.

Senator CAROL BROWN—What I am asking is: do you believe that those powers to compulsorily detain people that have been—

Mr Punch—Yes, they need to be strengthened.

Senator BILYK—And the police need to have appropriate training.

Mr Punch—Absolutely.

Senator CAROL BROWN—Senator Bilyk, I am talking about medical personnel—I do not know about the police—they do not have the proper training.

Mr Punch—I think there is a connection between the police and the triage at, say, the Royal Hobart Hospital. But your question is simple, and it is not being addressed. Parent after parent talked in the consultations about how they had worked with their child and, as soon as they went into hospital, they lost control—for want of better words. The next thing they knew, their child had exited the hospital and suicided. Does that answer your question?

Senator CAROL BROWN—In some respects, yes. I have to say that my sister became one of those statistics when she was admitted and left, and questions were asked about why she was not secure at that hospital.

Mr Punch—Yes, that is very valid.

Senator CAROL BROWN—You do have that sense that they are in the hospital so they are going to be looked after for the period of time in which they are having this acute episode. My other question is: what is available after they get out?

Mr Punch—I was going to say that this is the problem—there is no rehabilitation. I think we are seeing that residential rehabilitation for a long period of time is critical in many ways.

Senator CAROL BROWN—It is not easy, because you are not always working with willing patients and clients.

ACTING CHAIR—Absolutely.

Mr Punch—I worked with homeless young people for 10 or 15 years, and it was just consistently disastrous. There are lots of funny but tragic stories. You are looking after people, you have ways of helping them, it comes to a crisis and they go into the hospital, and it is disastrous. It is just not being dealt with at all, short term or long term.

ACTING CHAIR—I have two last questions. Firstly, are you in the UnitingCare booklet that we heard about from the previous witnesses?

Mr Punch—I suspect not, but I cannot say. We probably are not, and that relates to my point about coordination.

ACTING CHAIR—Coordination is an ongoing issue. Do you know about the Open Doors project in Queensland?

Mr Punch—No.

ACTING CHAIR—It might be useful for you to see, as it is a process in Queensland that is working with young people and does get funding but is constantly under threat. This is a more general question for both of you: in terms of the staff working with kids, do you receive criticism that in working with young people you are actually encouraging the lifestyle?

Mr Punch—Yes.

ACTING CHAIR—How do you handle that allocation?

Mr Punch—There are also accusations of paedophilia.

ACTING CHAIR—Absolutely. It would just be good to get something on record in relation to the people who have different views on this issue, just to have something about your response to the allegations that funding programs that look at allowing engagement and discussion about these issues is actually encouraging those issues and works against people's value base.

Mr Punch—It is a real problem for us. You are automatically identified as a paedophile. I also have the unfortunate background of having been a Catholic priest and having been gay.

ACTING CHAIR—Lots of industries share that issue.

Mr Punch—Yes. It is the quality of what you do, the quality of care and the way you approach it. I think there have to be protocols and you have to have regard for the protocols. That is why we are very careful about the young people we get involved with and the limitation of their peer responsibilities. I think it is part of that cultural change that has to take place. It is trying to explain the facts. Paedophilia, in fact, is not a gay problem. There are just as many paedophiles among opposite-sex-attracted people. I think it is the facts that are important—trying to get those out. It is part of that culture of bigotry that is used against us.

ACTING CHAIR—We have had evidence from the GLBTI health network in Sydney, so the issues have been raised with our committee and the need for inclusion has been raised.

Mr Punch—We are a member of that group.

Senator CAROL BROWN—I would like to mention the comments that are running in the media today, attributed to an AFL footballer.

ACTING CHAIR—He used to play in Queensland.

Senator CAROL BROWN—He said that if you are gay and play AFL then you should stay in the closet, because people feel uncomfortable.

Mr Ryan—I can talk on that personally, because I worked with the Australian Army Cadets and I was told, 'If you're gay, stay in the closet.' I did not. I came out and it caused a ruckus. I am only a civilian working with them. There was one person who had a problem with it. I thought, 'Okay, I'm going to get booted now.' I did not get booted. That person got dealt with.

ACTING CHAIR—Good.

Mr Ryan—They would rather have me there, because I am willing to work, and they would fix the problem rather than have me leave.

Mr Punch—Again, it is a very important question. The difficulty for our community is that our community does stay in the closet—three-quarters of them do. The hardest thing in our community, in terms of our voluntary capacity, is to get people involved. So it is a double whammy for us in terms of trying to get volunteers, which is hard enough anyway. People do not see the connection. I said to Scott when I saw Scott, 'Yes, it's a difficult situation being bullied in a school, but one of the most important things is to have the courage to be part of the solution.' It took Scott nine months. Then he rang me up one day and said, 'I want to do something about it,' and I said, 'Good.' It is really sad. Everybody in our community knows about the AFL and rugby league and how you just do not come out. We wish they would, because they are then role models. There is only one player in Australia I know of who came out, and that is Roberts in rugby. They are enormously important role models for us, but it does not happen. Role models are absolutely critical with the stigmatisation that goes on for us. It is very sad.

ACTING CHAIR—I think a positive thing today, Mr Punch, and it really impressed me, was the response to Mr Akermanis's comments—and he should be named. It was from the mainstream commentators and they all disagreed. Every single mainstream commentary this morning, across the various media outlets, was from people who were saying it was an outdated comment and that it belonged to a past series of values and that people should now be open. In many ways, having that mainstream response is probably more reinforcing than going back to your community and asking them to be the natural responders to that. I think that is a different response from the response 10 years ago, so we can be positive. If there is anything that you think we have not covered this morning, could you please be in contact with the secretariat. We do appreciate your time and we can assure you that the issues you have raised today have been raised in other areas.

Mr Punch—The only other thing I would like to add is that we have looked at a lot of young people, but the problem of positive ageing for our community and suicide is very basic. One of the best things that has been produced, courageously by the Alzheimer's Association—I am afraid I do not have a copy of it—is *Gay men, lesbians*—

ACTING CHAIR—We will follow that up with the Alzheimer's Association. Is it a national production?

Mr Punch—It is a national production. I think it is paper No. 16. Again, it involves the whole cultural awareness training within aged-care facilities. Again, there is a strong link to discrimination in that industry. It is under great stress and there are ageing gay and lesbian

people in those facilities. That is a major production and a major mainstream production and that will lead to a whole new area of cultural awareness training of carers.

ACTING CHAIR—That is very important.

Proceedings suspended from 11.15 am to 11.26 am

SWALLOW, Ms Michelle, Executive Officer, Mental Health Council of Tasmania

ACTING CHAIR—Welcome, Ms Swallow. It is always great to talk with you when we come to Tasmania. You have information on parliamentary privilege and the protection of witnesses. We have your submission. Thank you very much, as always. Would you like to make an opening statement, then we will go to questions.

Ms Swallow—In 2009 the Mental Health Council of Tasmania hosted a suicide prevention conference, funded by the Department of Health and Ageing. You will have noted from our submission that there were a number of people who attended. I also sit on the Tasmanian Suicide Prevention Committee, so it was exciting to see some of the recommendations that came out of the conference. Despite the diversity of the stakeholders who were present, the overwhelming recommendation that was put forward was the need for there to be a whole-of-government response. It is a good thing to see that, while you are doing this inquiry, the Tasmanian government is also working on a Tasmanian suicide prevention strategy. The recommendations that we have made to this committee will be the same ones we will be putting, and have put, through the Suicide Prevention Strategy, at a state level. As well as our own submission to this committee, we also contributed to the Mental Health Council of Australia's submission and the big one—the collective.

ACTING CHAIR—With SPA.

Ms Swallow—Yes, exactly. Sadly, I missed the first speaker today, but listening to Julian and Scott speak there were a number of issues that they raised that have come up for us as an organisation. I am happy to talk to those issues as we go through.

ACTING CHAIR—Thank you, Ms Swallow. I want to talk about the coordination aspect. It is one of our issues. Can you talk about the coordination of services and the awareness of what is available. I know it is an issue that your organisation has mentioned many times. On record, from a Tasmanian perspective, knowing what is available, can you talk about what the services are, where the gaps are and who is responsible for telling people what is available.

Ms Swallow—One of the success stories is the postvention intervention in Tasmania, with the standby response and having emergency services give people that information at the time of crisis. One of the things that is not so good is what you were talking about earlier—that is, when people are discharged from the emergency department without any immediate support. We absolutely have to invest in evidence based programs and coordination at that point. It is not just that it does not happen; it is almost that there is no-one there to do that. So it often relies on emergency services and triage staff to say, 'Off you go.' That is still an issue. At a local community level, which I will talk about later, I think that works a lot better than perhaps it does in some of the bigger centres.

ACTING CHAIR—So if I was wanting to find out what was available in Tasmania, as someone from outside the state, where would I go?

Ms Swallow—I think, like most of us, you would probably try one of the services. For example, you might ring Lifeline Hobart or Lifeline in the northwest and they might tell you everybody that is around and available. You might be lucky and get the state Mental Health Services Helpline on a day when they are not very busy, and they might tell you. I think it is probably a little person-dependent at the moment

Senator ADAMS—In terms of the triage, I have been asking a question wherever we have gone as to the frontline emergency situation, when a person is brought in or has self-harmed. We have had some horrific evidence about people who have self-harmed and just been abandoned because it is their fault or have been stuck in an emergency department—not for four hours but for eight hours and then not really given any help. So I have been trying to find out—more from the large and regional hospitals—how many hospitals have someone, whether they be a social worker, psychologist, psychiatrist or someone in the triage area, who can take that person aside or find a separate place for them.

Ms Swallow—I do not know enough of the machinations of what goes on in each of the different hospitals in Tasmania, but I do know that there has been an increased presence of psych registrars. I guess you have to be triaged to the point of someone thinking you have a mental illness to have access to them. So for people who have attempted to take their life, and/or who have self-harmed, I do not know that they often get picked up through that system. I do not feel I have enough knowledge to make any definitive statement about it. I do not know if there is a time-out space.

I also have heard of horrific stories of people waiting for very long times, often by themselves, because the police have had to go out on another call-out. Certainly, there have been some media reports in Tasmania this week asking: 'Is it appropriate for the police even to be involved sitting and waiting? Then what happens? Do they take the person, and where to?' Not everybody has the support systems or the family to support them through it.

Senator ADAMS—With the dual diagnosis, can you step us through that?

Ms Swallow—In terms of alcohol and other drugs with mental health?

Senator ADAMS—Yes.

Ms Swallow—There has been some significant work, as you would be aware, where the Commonwealth has funded some programs to look at dual diagnosis and how organisations, particular not-for-profits, can work to support people. But you have to be referred through in the first place. There is a lot of reliance on the primary health framework, so it is good if GPs are involved. Often it is the GPs who provide the bulk amount of care to somebody who has co-morbid issues. But at the acute end, where somebody might present in an emergency department with a psychosis, there has been a lot of conversation, particularly by psychiatrist in the north of the state, Dr Mani Maharaj, who says, 'If we keep somebody in overnight, then if it is a drug induced psychosis the drugs will start to wear out of their system by the morning and we are then able to do a full assessment as to whether it is a mental illness.' I think that is fantastic practice. It actually gives somebody a bed for the evening, and some food. They are then linked into a system of information so that when they are discharged from hospital they are able to get that support.

That has been a significant shift in the north of this state at what was 1E, which was notoriously badly represented—and managed, perhaps. It is now called Northside and they have this new clinical infrastructure which is making a very big difference for people in the Launceston area. It is probably a good model to be used and rolled out, not just here but across Australia.

Senator ADAMS—That is some good news. With respect to the group that presented before, were they invited to the suicide prevention conference?

Ms Swallow—Yes, they were, and they did a presentation.

Senator ADAMS—I could not see them on the list.

Ms Swallow—They should be there.

Senator ADAMS—You had the Gay and Lesbian Switchboard but I just cannot see the others.

Ms Swallow—They were called Coming Out Proud, then.

Senator ADAMS—They were there.

Senator CAROL BROWN—One of the recommendations that came out of your conference was about looking at the gaps and the duplication. You have these recommendations; how are you moving forward on them?

Ms Swallow—Since the conference, was invited to sit on the Tasmanian Suicide Prevention Committee. So they would have put forward those recommendations through that and have been asked by Dr John Crawshaw, who is presenting later, to sit on the interagency committee—who is also driving the promotion, prevention and early intervention strategy which the suicide prevention strategy will sit under. So we are probably best placed at the moment to be able to get some of those recommendations through at a state level and, through being a member of the Mental Health Council of Australia, able to get them through at that level.

Senator CAROL BROWN—So that work about looking at where there is duplication and gaps has not been done by government?

Ms Swallow—No, and certainly the MHCA's submission, as well as ours, talks about the need to invest a lot more in research. That is true across the mental health and well being and mental illness spectrum, but it is particularly the case in suicide prevention. We know that, and I could just go on and on about it, but there is an absolute lack of funding into any sort of research—longitudinal and what might work. That is connected to data collection and it is connected to the quality improvement of the programs we have got on the ground. In a state like Tasmania we have some really innovative things happening, like the CORES program, but they are not necessarily being funded from the Australian government down; it is sort of grassroots and growing up and so—

Senator BILYK—At local government?

Ms Swallow—Yes. And I think those are the sorts of things where we need to say, 'All right; well, they have filled a gap but they did not necessarily do that by developing a big evidence base.' At what point does research link in with them to support that so that it can be funded more thoroughly and taken to other jurisdictions as well?

Senator CAROL BROWN—We talked about comorbidity, and one of the things that people have said to me over the years is that if you take drugs but you also abuse alcohol, and vice versa, and you try to get into a service, they will not take you. Is that still the case?

Ms Swallow—There is definitely a lot of stigma associated with intoxication as a result of drug use or misuse—and I count alcohol in that as well—and there is that sort of sense that it is the self who makes those decisions so really you should deal with it. Without understanding the social determinants of health, we are making decisions about whether or not you provide intervention to somebody. It is still an issue. It is very much an issue about what we should do and who we should treat—is it the alcohol, the drug dependency, or the mental illness? Well, how about that it is a human being who has got a complex range of needs?

Some of the programs that have been funded recently to look at comorbidity, and point of entry and no wrongdoer, are really important but they have been very much focused on the alcohol and other drug end and not so much on the mental health end. In Tasmania, particularly in the sector I represent, there are a lot more people working in the mental health sector than there are in the alcohol and other drugs sector and so you have got different assessment tools, different treatment tools and different ways of working with people. There are pros and cons about training people up to have specialty in both, but perhaps it is about working as a coordinated team to ensure that the human being gets the best care and support they can.

Senator CAROL BROWN—But you can understand the frustration of a family that is trying to find assistance and a safe place for a family member who has had an acute episode. They are having difficulty finding those places as well.

Ms Swallow—In the mental health area we have Carers Tasmania, who do a lot of work with families. They provide a six-week free support program and group work. In addition, ARAFMI, the Association of Relatives and Friends of the Mentally Ill, also do some fantastic support work for families, carers and others peripheral to them.

There are not really similar programs across the state in Tasmania. Certainly Holyoake provides support for family members of someone who has an addiction, but you are right: there are not a lot of places for someone who has comorbidity to go. There are a few programs across the state. They are often church based programs—for example, the Bridge Program, run by the Salvation Army, and Missiondale, run by City Mission.

Senator BILYK—In your submission you talk about the need for more research into suicide prevention and you mention that there are several gaps in the research area. Could you expand on that by talking to us about the areas you think are lacking and whether you have any recommendations as to how we might solve those gaps.

Ms Swallow—I think I mentioned earlier that I do not think research on suicide prevention has been well funded at all, and that is across a range of different areas. I mentioned some of the

programs that had been set up from a local point of view. The research is more an evaluative research: is it best practice? Is it actually making any difference? What are the long-term outcomes? That is also about reducing the medicalisation of suicide. Often mental health and wellbeing sit in a medical model rather than in a social model. You hear people talk about suicide prevention being a community's responsibility; it is everyone's responsibility. If it sits in that medicalised model, it is easy to pass the buck.

The other piece of investment in research has to be about health literacy: how people can understand what is happening to them and how they can seek assistance sooner. Christopher John from Lifeline Hobart and I are both alumni members of the Tasmanian Leaders Program. Just last weekend we ran a workshop where we asked people to provide input into recommendations for the suicide prevention strategy in Tasmania. One of the suggestions was that we really need to do some research into what is and what is not working in schools—that is, really making an investment in early intervention. Part of that is the health literacy stuff as well.

ACTING CHAIR—Was the MindMatters program mentioned at that?

Ms Swallow—Absolutely. It talked about KidsMatters and MindMatters as well. People in the room came from private business, the three tiers of government and the community sector, and a lot of people had never heard of them. So people only know about it if they are in the sector of if their child has gone through that training. The other piece of research that came from our conference was about investing in art and research.

Senator BILYK—I was going to ask you about that.

Ms Swallow—It was fascinating, and it was not just from one person. It came up a few times. I do not profess to be an authority on that at all, but it said that, for perhaps the 50 per cent of people who attempt to take their own life and do have a diagnosed mental illness, it is about providing opportunities for people to be creative in that space. We focus on having to get people jobs and get them into education, but really the comments were: if we invest in arts programs it can increase people's health literacy as well by saying, 'We all have things that we're good and bad at and perhaps for some people creativity in music and art is one of them.'

Senator BILYK—You mentioned that you thought there should be more research into suicide and suicide attempts and motor vehicle accidents. Are you able to expand on that for us?

Ms Swallow—As we know, often coroners err on the side of caution. We believe—and, again, there is not enough research into it—that a number of single vehicle accidents are perhaps attempts at suicide. Really, it was a statement that before we make that assumption we should find out. That is why it is not an easy thing. Again, at the Tasmanian Leaders Program retreat one of the suggestions that came up, which I thought was a fantastic suggestion, was that at the point of a single vehicle accident the emergency services people could be giving the people who survived information such as: 'Are you feeling suicidal? This is somewhere to ring and these are some people you could get some support from.' It is a point of intervention that we would not have otherwise thought of, so it was pretty exciting to have somebody come up with that idea.

Senator ADAMS—That could backfire badly, though.

Ms Swallow—Possibly.

Senator ADAMS—Especially at the scene.

Senator BILYK—One presumes you would train people in how to do it.

ACTING CHAIR—It is a concept for discussion which is really to bring all those issues together so that people think about it.

Ms Swallow—Yes.

Senator BILYK—You also mentioned the role of the media in reporting suicides and attempted suicide. Would you like to expand on that for us?

Ms Swallow—I will have to have a quick peak at what we submitted, so excuse me.

ACTING CHAIR—You do not have to say the same thing.

Senator BILYK—I would like you to expand on the views of the conference.

Ms Swallow—We had done some work earlier in 2009 by bringing Jeff Cheverton from Queensland Alliance and Minerals Council of Australia to Tasmania to look at his Churchill Fellowship around anti-stigma campaigns.

ACTING CHAIR—Jeff Cheverton has submitted to this inquiry and giving evidence, as you would expect.

Ms Swallow—Yes, as I would expect. It was saying that, if we are going to focus on any national campaign utilising the media, there needs to be an aspect of that which specifically targets suicide prevention. We often have them all separate but it is about saying that all of those campaigns, in using the media, have to be about health promotion, intervening and prevention at a much earlier point than downstream. That was one of the things that came up about having a media campaign. The other thing which has happened in this state is that, through Dr John Crawshaw, Statewide and Medical Health Services have sponsored a media award, again about the celebrating and supporting the media and journalists to report positively around mental health and wellbeing and not just focusing on the suicide story. I believe there has been a significant shift in our media in the last probably five years. Last year that award was the most contested media ward in the state, more than all the others combined. There is some competition and it has had a great effect, with people wanting good news mental health stories.

ACTING CHAIR—Ms Swallow, thank you very much, as always. Is there anything we have not drawn out from you which you think is particularly important to put on the record?

Ms Swallow—Julian Punch mentioned working through and using local councils. I mentioned earlier that there has been a lot of work done through Rural Alive and Well in this state and Cause. Even the OzHelp Foundation is another program but Cause and Rural Alive and Well have I think being highly successful because they have come from local councils initially. The uniqueness of Tasmania in terms of our dispersed population means that the Australian

government and the state government have an opportunity to absolutely invest in those programs, as well as in the evidence based ones like ASIST, and to make great gains in preventing suicide in the state by continuing to get local governments involved from their leadership teams down to using some of those infrastructures. We have that happening here; we need to build upon it.

ACTING CHAIR—You raised your engagement with the leadership program, which is at state based program looking at people and community and so on. The immense value of having two people with a mental health focus in that team lead to wider discussion. How was that handled by the other people on that team? The people engaged are from all different areas—I know that. Having a mental health focus, what was the reaction from the other people who came onto that team—and for future reference for such groups?

Ms Swallow—It was mixed. I was contacted by some of the participants before and one person had given me permission to speak about him. Both his brother and his father completed suicide and he said, ‘I cannot be there, but I want to participate.’ So he did and he provided input and information which we were able to use on the weekend as well. Many others came along who just went, ‘Wow, we had no idea.’ I will let Christopher John talk to you about a specific example of what a huge difference just the two of us speaking for a few hours has made. He can give you specifics of that. It was very well received. The feedback was, ‘We would never have thought about this, let alone had the opportunity to put in our ideas.’ It was not just lecturing at somebody saying, ‘This is what suicide prevent is and this is how you help.’ It was more about, ‘If somebody talks to you about potentially suiciding, these are some skills you can use.’

Senator ADAMS—That is what leadership is about.

Ms Swallow—Yes.

ACTING CHAIR—Not in this inquiry but in a previous one we had evidence about a similar experience with the National Youth Roundtable, where all those young people come together. At times a couple of the kids identified mental health as the issue they were going to follow up, and then there was the impact on the whole group, because they may not have looked at those issues if it had not happened. I was keen to get that on record, and that is fine.

Mr John—One of the projects in Tasmania, in another year of the leadership program, is working with the OzHelp foundation to do some specific work in a different sort of industry than the current one. We are looking at, ‘How can we roll out those interventions across Tasmania?’ So there is some exciting stuff.

ACTING CHAIR—Thank you very much. We will see you again.

Ms Swallow—Thank you.

[11.51 am]

JOHN, Mr Christopher, Chief Executive Officer, Lifeline Hobart

WOODWARD, Mr Alan, General Manager, Social Policy, Innovation, Research and Evaluation, Lifeline Australia

ACTING CHAIR—Thank you very much for talking to us as part of this process. You are so much engaged as Lifeline, and we thought that since we had half an hour we would like to hear from you. We are, as we have put on record as a committee, going to visit your Tasmanian centre this afternoon. I invite you to make an opening comment, and then we will go into questions.

Mr John—Thank you very much. This gives me an opportunity to introduce you to Lifeline Hobart so that we do not need to do so this afternoon, and that will give you more time to talk with the volunteers and the staff members there. Lifeline Hobart has been around for 36 years, and we have been heavily focused on telephone counselling. That has been the traditional part of our work, but we are doing a number of other programs in the suicide prevention area and also in loneliness and isolation, particularly in older people.

A couple of years ago we revisited our strategy as an organisation to really focus on three areas. We wanted to focus on that continuum of care from people who are calling us in distress and despair or at the point of considering suicide right through to the preventative ends and the resilient ends where people have the skills not to get to the place where they need to be in distress and despair. So our focus is on catching people at the safety net end, on the education and awareness that equips people who may be at risk or could possibly come into contract with those at risk and on the resilience end—that is, making sure that people are not isolated or lonely and are connected with the opportunities so that they know what to do if they come across life's challenges and can handle them without having to access the service.

So our focus is really on that continuum of care. That has been a major focus for our organisation over the last couple of years to the point where the board is investing its own funds into certain areas of support. We have really broken up the particular areas that we focus on—suicide prevention, intervention and postvention—specifically because we know that people at different ends of the interaction with the thought or the effects of suicide are at increased risk. For example, we know that those in postvention are at significantly increased risk of suicide themselves, whereas those who are considering suicide need a different type of support. So we are really trying to focus our efforts on different populations in that area. We currently run two postvention services. One is a standby response service, which was mentioned earlier, and that has been going for nearly 12 months now.

ACTING CHAIR—That is the national one, is it?

Mr John—It is part of the national model. Tasmania is fortunate in that we are the only state that is geographically covered completely by the standby response service. All of the other services that are run—in the Pilbara region, in Queensland and, I think, in Canberra—are all in a smaller geographic area. Tasmania is actually the first state that is covered completely by that.

Lifeline Hobart runs that in the southern part of the state and Choose Life Services, formerly Parakeleo, runs in the north and north-west of the state.

ACTING CHAIR—That is a specifically Tasmanian service?

Mr John—It is a specifically Tasmanian organisation, yes. They run ASIST programs and awareness and EAP programs for organisations and have some face-to-face residential support services that they have offered from, I think, Sheffield originally. That is where it originated.

ACTING CHAIR—If I can follow up on that, is that one of the services that was originally funded for three years and has now been funded for another two?

Mr John—I cannot be completely sure on Parakeleo.

ACTING CHAIR—But for yours?

Mr John—It has been going, I understand, as part of a national trial for the last three years, but Tasmania and the Pilbara were only brought on last year as part of extending that trial, and it was 2½ years funding for that.

ACTING CHAIR—We had evidence about that particular trial in Canberra. I think that is one of the ones that was part of that overall process, but we will follow up on that. You have only been operating your part of the standby for the last 12 months?

Mr John—Yes, coming up to 12 months.

ACTING CHAIR—And now you are funded for another two years?

Mr John—We are funded for another year and a bit from now.

ACTING CHAIR—Funding cycles.

Mr John—Yes. I understand they did a mid-term report on that and had some very positive outcomes which they are building on as well.

The other part of Lifeline Hobart's postvention area is a suicide bereavement support group, which we call Support After Suicide Group. That is being built on some of the recommendations and the pilot work that was done through Lifeline Australia to develop the best practice standards in delivery of suicide bereavement support services. We were part of that pilot, which was almost two years ago, and the board has now self-invested, with our own funds, to keep that support service going.

ACTING CHAIR—Is that only in Hobart?

Mr John—Yes, we only deliver that in Hobart. We do that in partnership with Relationships Australia.

ACTING CHAIR—Are you aware whether there are services similar to that in other parts of Tasmania?

Mr John—I understand that the Samaritans in Launceston have a suicide bereavement service and there might be some others, but I am not quite sure about the north-west. So those are basically our postvention areas.

We also run both ASIST and safeTALK on a regular basis. SafeTALK is run on a monthly basis and is free to the community. We run ASIST, which is the intervention based program, two to three times a year free to the community and anyone can come along, from business or community or government. Where an organisation wants to do in-house training on that we do charge, and that helps fund the free ones that we do have the community. We made that as a strategic point of difference, because we know that sometimes the barrier to getting into those services can be a cost, but since we have done that we have been able to increase the number of people we have been delivering that training to. Last year about 360 people received that training through those services.

ACTING CHAIR—Mr Woodward, is there anything you want to add?

Mr Woodward—I come to this from the national perspective. Lifeline is a national organisation, as you would be aware, so my colleague's presentation has shown some of the strengths of the model where a national non-government organisation has, through its outreach work on the ground, the ability to connect with communities. That has been historically a feature of Lifeline.

From a national perspective, one of the reforms we believe needs to be made around suicide prevention in Australia is for there to be a truly national approach in a policy, strategy and structural sense. Some of the discussion in the presentations at the hearing this morning has raised issues around coordination and issues around how suicide is perceived and therefore addressed. I noted the mention of the difficulties where suicide is perceived simply as an illness or a mental health issue that therefore requires a medical treatment.

The other aspect we see in that is the need to look at how government policy at all tiers of government is shaped and funded to support action at a range of levels commensurate with the roles of government. I can expand on some of that. We particularly believe that suicide prevention, in a policy and strategy sense, needs to be addressed by government on a cross-portfolio basis—in a similar way to how many other major social issues have been addressed—and that it needs to be recognised that there is in fact a mix of health and social determinants around the causes of suicidal behaviour and therefore the action that needs to be taken for its prevention.

ACTING CHAIR—Which portfolios do you think would be involved? It is one thing to say 'cross-portfolios' but when you say that do you have any particular portfolios in mind?

Mr Woodward—We think that there are some portfolios that would need to have further engagement. What we mean by 'cross-portfolio' is that the structure should reflect a central agency or authority created with the purpose of working across government so that it takes it

outside of any single portfolio area. A comparative model would be the treatment to do with road safety.

We also believe that there is the potential for structures outside of government that receive funding and support from government to be very effective. We see that the beyondblue model has been very effective around depression awareness and encouraging access to services around depression. Conceivably, a similar construct could be used around suicide prevention—where governments play a role but feed into an established authority.

The portfolio areas that we believe are particularly important would relate to the social policy arenas around individual support, and certainly areas around family support and community engagement. These are likely to be relevant areas for suicide prevention and where greater coordination and attention could be given. Again, I think some of the presentations this morning have highlighted the importance of equipping community based action.

This also entails looking at a range of communities that can be defined in differing ways—perhaps along the lines of geographic communities but also along the lines of culture, age and gender communities; also looking at the ways in which income support and other social policy areas might be addressed with the knowledge that issues such as employment, participation in the community and disability can also result in issues around suicidality. There have been studies undertaken which show a relationship, for example, between suicide rates experienced and economic downturn. We would say that there is broad range of portfolio interests around suicide prevention and there is a need to harness a national strategy around a multifaceted approach.

Senator ADAMS—I would just like a practical example. If someone rings up from Dover while they are absolutely distressed and contemplating suicide but wanting to talk, what happens when the phone is put down or the connection is lost? What does your organisation do as far as connecting Dover to that person?

Mr John—We do not actually have the capacity to do community based development in regional areas at this point. That is certainly one of the areas that we do want to focus on. The resilience end of our strategic plan is really about trying to work out ways in which people can live and contribute and have more meaning and purpose in their own communities. At this point in time most of our services are delivered at the safety net end and the awareness end when it comes to suicide prevention. The challenge, and this is consistent for all of the telephone counselling service delivery through the 131114 service, is for all the volunteers actually doing the risk assessment of what is actually happening for that person and then linking them with the appropriate services in their region or closest area.

We have a national database which is locally updated. We employ someone on a regular basis to go through and update all of the services that are relevant to our area so that when a volunteer—anywhere, right across Australia—takes a call from Tasmania, they have a live database of services which has been updated regularly by the local area. So we would be able to say whether there was a self-help group in Dover that covered relationship issues or drug and alcohol issues or whatever it might be.

The actual list of services that are focused on suicide prevention or suicide intervention activities are predominantly Hobart-centric, with outreach to those areas. That is simply part of

the economies of scale. But also it is part of the logistics of delivering services. If you are located down in Dover, it is a three-hour drive back around to the Tasman. So being Hobart-centric really is a logistical approach to it. But it is not necessarily the best community approach to it, and I think that is one of the challenges. The reason is: I think local councils have the opportunity to have some local connection to a greater extent. We certainly see the social inclusion strategy that Tasmania is focused on as really having its legs, in its implementation, through local councils more than through state or federal departments, because they really are the places where people interface with their local community.

Senator ADAMS—So would there be a number that your counsellor could give to that person to say, 'This person is in your community,' or 'This service is there; go and talk to them,' so that they would be actually given a phone number so that they were not just cut off?

Mr John—They are given what we call a 'cold referral'. What that means is that we give them the number so that they actually make the contact locally. We do not have the capacity to do that warm referral—'I'll get someone to give you a call in the morning,' or the next day, or whatever it might be—because the database and our system are structured around that level of anonymity for the people who are calling. That does not mean that a service like a warm referral could not be suitable, particularly in the area of suicide prevention, and that certainly—

ACTING CHAIR—What does 'warm' mean?

Mr John—'Warm' means that we will take their contact details and we will contact the service provider the next morning and get them to directly contact that person.

ACTING CHAIR—And that is an industry term?

Mr John—It is an industry term. A 'hot' referral would be: 'Hang on—we'll get them on the line for you.'

Senator ADAMS—That was going to be my next question: if the counsellor was not able to calm that person down and they were still quite determined that they were going to go and complete, what would you do then?

Mr John—We have a process: the infrastructure has an ability to identify a particular number and do a trace on that number so that we can intervene by engaging the police or the ambulance service. That sounds quite strong—

Senator ADAMS—No.

Mr John—but we will have approximately, on a monthly basis in our region, 30 to 50 interventions where what we call the MCID button—that is just the terminology they use—has been activated. That is activated where there is the suspicion of a suicide in progress, harm to others or a potential child-protection issue. So those things are activated on those points by the volunteer at that point in time. And there is a whole process and protocol: our volunteers have to engage with a supervisor, and that supervisor will then engage with the emergency services where they need to be engaged.

ACTING CHAIR—And this is a national process?

Mr John—This is a national process.

ACTING CHAIR—So Lifeline everywhere operates on the same protocol?

Mr John—Yes, exactly the same: they have got exactly the same phones and exactly the same systems.

ACTING CHAIR—And the same training?

Mr John—Yes, that is right. Probably the key point to make on intervention through that tracing device is that, even when we have a suicide in progress, the volunteer will still go through the process of engaging with that person, keeping on building the rapport. And, in the majority of cases, they are able to get the person's name and address so that they do not actually need to do the trace and they can actually engage the emergency services, just through holding that rapport and getting the details for the emergency services to get there. But my understanding is that the activation of the trace from a person who does not want to give those details is relatively minor in suicides in progress.

Senator ADAMS—Would the counsellor keep talking while—

Mr John—Yes, they engage with them until the emergency providers are there—and then part of our follow-up with those volunteers is that they have debriefing and get support after taking such a call. As you can imagine, it is quite a distressing situation, particularly at two o'clock in the morning. It is important that they do have that follow-up and debriefing.

Senator ADAMS—That is very interesting. It is the practical part of it. It is fine to read about it, but it is good to know just how it works in real life. Thank you.

ACTING CHAIR—Mr John, I am really interested in what is available in each community. My understanding is that over many years Lifeline has built a reasonably up-to-date database.

Mr John—Yes.

ACTING CHAIR—My understanding also is that it is not public; it is a Lifeline resource.

Mr John—There is a Lifeline Service Finder, which you can find on the website. You can type in whatever service you want and the geographical region, and it will give you a list of those services in that area. That is the database that sits behind it. My understanding is that it is not a browsable database; it is a searchable database. That is where the information that goes into the service finder comes from.

ACTING CHAIR—When you say 'searchable'—I have talked to Queensland about this but I want to get on the record—does that mean that when I key in 'suicide' it will bring up all the agencies that can provide that support, or do I have to key in 'Lifeline'? Is it searchable by issue or by organisation?

Mr Woodward—It is searchable by organisation and location, primarily, although there is some capacity along issues, so there is a menu of issues offered. But it is not quite as user friendly as your example, Senator. The service finder directory is, however, scheduled for further enhancements and redevelopment in the next 12 months, and we want to work on that search capacity. It is a publicly available directory through our website. Also, anyone who phones the 131114 service can have someone assist them with finding services.

ACTING CHAIR—Does it also provide information about the organisation and what they do?

Mr Woodward—Yes. It includes basic information about the organisation; and, in putting those organisations into the database, we also make a few inquiries about their origins and their stated purpose, and we keep it to low- or no-cost community based services that are broadly accessible by all.

ACTING CHAIR—The first people we saw this morning were from the Time-Out project. Would they be in the database?

Mr John—I am quite sure they are, but I would have to double-check that.

ACTING CHAIR—One of the things happening in the national program is the need to know what is available. My understanding is that we have two nationally funded organisations. One is for research and that is through Griffith University. If there is published research on the issue of suicide, my understanding—from the evidence we have got—is that Griffith University's Australian Institute for Suicide Research and Prevention will have information about that. The other is Crisis Support Services in Melbourne, which is also supposed to be a central repository of all services that are available. I am wondering a couple of things. First is whether CSS, with their capacity, has been able to pick up all the available services. Some of the interviews we have had indicate that people do not know about it. Second, I am wondering what Lifeline offers that CSS does not. If Lifeline is already maintaining a database of these organisations, from your understanding, working in the industry, what does CSS do that Lifeline does not? I know that is a big question but I am trying to work out what the focus of the national project is.

Mr Woodward—In some respects, you would need to ask CSS and possibly DOHA. The Lifeline Service Finder is very much oriented to what services someone might access as part of seeking help. It is a database that specialises in mental health and crisis oriented services, so we aim to include locally based services such as suicide bereavement support groups or local services around suicide prevention. One of the difficulties with that is always that local groups can change frequently—

ACTING CHAIR—And do.

Mr Woodward—but at present about 95 per cent of the records in the database have been reviewed and updated in the last 12 months.

ACTING CHAIR—And does Lifeline fund that database out of its own funding?

Mr Woodward—We receive funding from the Department of Health and Ageing for that.

ACTING CHAIR—And do you receive it for each local area?

Mr Woodward—We administer the updating centrally in the national office, with liaison from our network of Lifeline centres.

ACTING CHAIR—For instance, the Tasmanian Council for Sexual and Gender Diverse People Incorporated now operates under that name and a couple of years ago operated under a different name. Would my expectation be that the Lifeline database would have the new name?

Mr John—We employ to update those details on a regular basis. We spend more than we get in doing that updating.

ACTING CHAIR—It is a huge task.

Mr John—It is a huge task. Initially we had 3,500 entries. We have culled it down to make sure it is specific to—

ACTING CHAIR—3,500 in Tasmania?

Mr John—Yes, 3,500 in Tasmania. That covered everything from drug and alcohol to accommodation and right through to support services and self-help groups et cetera. A lot of that has been streamlined with some of the major organisations now having a single point of access. That has helped to delineate one point of contact around some of those things.

ACTING CHAIR—Ho would that operating with the Uniting Care book?

Mr John—To be honest, I have not seen the Uniting Care book, but that does not mean that people in our organisation who work in the suicide and bereavement area have not seen it. It is quite possible, but they have not shown me that one.

ACTING CHAIR—Do other senators have questions?

Senator BILYK—I am looking forward to the site visit.

ACTING CHAIR—Is there anything you want to put on record which we have not asked you?

Mr John—Two things. Recently, in partnership with the LifeForce in Wesley Mission we ran a memorial service here in Tasmania, which is the first time we have run such an event. That was a really good engagement event for a lot of people. One of the strong learnings from that process was that that event was focused around providing an opportunity for those who have been bereaved to do something without necessarily having to do something through a service or through an organisation. The feedback we got from that event was very much about the fact that it was great to create that opportunity. Those sorts of events or opportunities where people can come together and do what they need to do, rather than something a service is providing, is a really important strategy for engaging people who are contemplating suicide or have been bereaved by suicide. The key learnings are that it has to be where the people are at and it has to

provide the opportunity for them to do what they need to do in that process. That is a really strong approach to that resilience based thing.

To follow up on Michelle's comment about the Tasmanian leaders program which we went through recently, on Saturday night we did a 45-minute presentation on some of the key issues around suicide in the state and some of the key things you may look at doing. The next morning we did a workshop for two hours. As a result of that workshop, I have had calls from two people in that group. One of them was yesterday morning when a gentleman in one of the local councils rang me and was in the process saying, 'I've got a bloke in my office here who—' and I asked the question, considering what he was saying, ' Are you thinking of killing yourself?' He said yes and I said, 'I need to get Christopher on the phone to follow it up.' We had a bit of the talk through what he needed to do at that time in terms of setting a safe plan for him, making sure he had a contract so that he would be engaged with this bloke and engaged in that relationship. He rang me back about 15 minutes later and said, 'Thank you so much. I never thought I would get to the stage where I would ask that and it was only as a result of that opportunity that I had the confidence to do it. I am really glad I had the chance to do it.'

That was a key learning. One of our objectives in doing that workshop with the alumni was to make sure that this is not only a topical issue but that they are equipped on how to do that. I have now been invited to present to the whole leadership team of that council, 45 of those managers, in July to have a talk about suicide prevention and what they can do and local level in intervening and supporting people. Again it is about trying to get to where people are at and making it important for them so that they can do something in the process. That is where I see the community-end to focus. It really does need to be where they are at and what they need out of it.

If I can just follow up on the crisis support stuff, I think one of the really important things for Lifeline in Tasmania is that we have an incredibly strong brand. We do biannual surveys on brand, and Lifeline has always been at 100 per cent recognition in every one of those surveys that we have done in the last decade, I think, in Tasmania. Nationally it is about 96 per cent. So I think that brand is a really important thing, because people associate us with where they need to go for help. If we were to do a survey on crisis support services, I think a lot of people probably would not know about it, but the men's helpline which is run by Crisis Support Services would be something that they would have an understanding of.

ACTING CHAIR—Very much so.

Mr John—It is that affinity and what the name means to people that create that opportunity for them to get that support and access.

Senator ADAMS—I have a question on your community event. How did you advertise it? Was it just in the paper? What did you do?

Mr John—We went through a lot of the networks that we have for service providers, but we also advertised in each of the three major papers 10 days out, and we had quite a large uptake of people who had simply seen it through the newspaper. The newspaper advertising is where we got the majority of the people who wanted to come along and just be engaged with the activity rather than coming along through their involvement with a service or engagement with a—

Senator ADAMS—How many did you have?

Mr John—We had about 95 people turn up at the event. Speaking of media, *Stateline Tasmania* did a story on that, which is available on the *Stateline Tasmania* website, and Airlie Ward was our MC for the event, so she was very engaged with that process and also did a wonderful job in making sure that the story was representative of the needs and the issues and respected the privacy of those at the event, which was a key issue for us in that we did not want people to have their face on the news if they had been bereaved by suicide. It is still a difficult issue for people to talk about in their local workplace or community.

ACTING CHAIR—Could you send us a copy of the advert.

Mr John—Yes, absolutely. Certainly.

Senator ADAMS—Could you talk about suicide rates and the road toll for Tasmania.

Mr John—I think that in Tasmania last year it was about 65 people who died on the roads. The annual average for suicide—I do not know what the actual figures for last year were—is about 75, which is what the Tasmanian Suicide Prevention Committee has been regularly reporting. There is talk in our sector. We had a horrific day last year when nine people died on the roads in one day, and there was a lot of talk about one of those events being associated with a suicide or being thought by our networks to be a suicide. Again, trying to find the evidence on that is really difficult.

There is one interesting thing I will allude to, because I think this is the important part of the issue of accessing people with support that Michelle alluded to. One of the Tasmanian leaders was talking to their sister, who does reissuing of licences following an accident. At times, when she has read through the police reports and all of the evidence seemed to indicate that something could have been an attempted suicide, she thought, ‘Is there a way that we can make sure that people get help at that point in time?’ It is sensitive ground. How do you get someone to the point where you can get them to get help or even have the question asked at that point? I think that is a really important thing. We know that often when people are asked the question, ‘Are you thinking of killing yourself?’ or, ‘Are you considering suicide?’ it makes them state what it is that they are intending to do or not. Often we find that people who are asked that question are relieved that someone has come to the point of asking them that question, and that is the first point in getting them to further help. It is getting over that squeamishness about being able to talk about suicide as an issue or a concern. She was asking, ‘Is there a way that we can somehow look at that question?’ because she had a concern about reissuing the licence as a result of that concern.

Senator ADAMS—I suppose there is no process within the department that can alert people to it, because of the privacy issue.

Mr John—Yes. I do not know of any process, but it was a really interesting thing that came out of that discussion that I had not considered before, and I am not sure that it has been considered in other forums before. It would be interesting to see what opportunities could come from having the opportunity to get people to seek help at that point in time if there are suspicions.

Senator ADAMS—That person could be flagged somewhere in some system to indicate that they may need supervision or just someone to talk to.

Mr John—Yes. It is how you get across that question.

ACTING CHAIR—Thank you very much for giving your time. We will be visiting the centre this afternoon.

Proceedings suspended from 12.25 pm to 1.18 pm

CRAWSHAW, Dr John Adrian, Chief Executive Officer, Statewide and Mental Health Services, Department of Health and Human Services Tasmania

ACTING CHAIR—We appreciate the fact that you have come from the department to talk with us. You have information about parliamentary privilege and the protection of witnesses and also about your role as a public servant—that you will not be asked to give detailed answers on policy, though discussion around policy can be had. Is there anything you would like to add about the capacity in which you appear today?

Dr Crawshaw—I am also the Chief Forensic Psychiatrist, and the chair of the Tasmanian Suicide Prevention Committee and the Inter Agency Working Group for Mental Health, as well as the chair of the Inter Agency Working Group on Drugs.

ACTING CHAIR—Thank you very much. I invite you to make an opening statement, and then we will go into questions.

Dr Crawshaw—Thank you for the opportunity to speak to the committee in relation to the Tasmanian perspective on suicide. My aim today is to give a broad overview of suicide and suicide prevention in Tasmania and to discuss some of the unique characteristics of Tasmania that are relevant to any inquiry into suicide and, finally, to share Tasmanians' vision for the future in terms of suicide prevention. Can I just say that the submission that you have received—I hope—

ACTING CHAIR—Yes.

Dr Crawshaw—has been endorsed by both the Suicide Prevention Committee and the Tasmanian Inter Agency Working Group for Mental Health. Much of what I am going to say in my introductory remarks is already detailed in the submission, but I would like to just draw your attention to some key issues which I think are worthy of discussion.

Tasmania, as you will see from the presentation, has a small population—just over half a million people. It is one of the most regionally dispersed populations of any Australian jurisdiction and one that is ageing at a faster rate than those of other states and territories. The majority of Tasmania's population, just over 64 per cent, live in inner regional areas, and just over 33 per cent live in outer regional areas. As you would have seen, we do not have a 'major city'—as defined by the ABS.

It is known that, compared to those living in major cities, people in inner regional and outer regional areas have 20 per cent higher reported rates of fair or poor health. In 2006, more Tasmanians lived below the poverty line than in any other jurisdiction, and Tasmania had the highest proportion of households dependent on welfare. After the Northern Territory, Tasmania has the second-highest proportion of people living in disadvantaged communities. While I am not very keen to paint such a negative picture of such a beautiful state as Tasmania, it is really done to illustrate some of the unique social and demographic characteristics that impact on the broader health and wellbeing of the population, which clearly also has impact in terms of the prevalence of mental ill-health and suicide.

As you may have heard, last month we had Tasmania's first suicide memorial service, in Campbell Town, organised by Wesley LifeForce and Lifeline. I attended that, and it was a very powerful and emotionally challenging service, attended by close to 100 Tasmanians of all ages. The service gave us all an opportunity to stand together to reflect on the impact of suicide on family, friends, workplaces and communities. It also gave us an opportunity to talk with Tasmanians who have provided support services to people at risk of suicide and those bereaved by suicide.

What is clear is that there are many Tasmanians working hard every day to prevent suicide. But we also know that service providers within our communities are often challenged by the apparent lack of coordination of suicide prevention services and the nature of time-limited funding for services. Better coordination and sustained funding for services that achieve positive results for Tasmanians is needed.

There is strong evidence of the link between mental illness and suicide, and the Tasmanian government, through Statewide and Mental Health Services and the funded community sector organisations, provides a range of specialist mental health services and recovery and rehabilitation programs for Tasmanians with mental illness. Services are also provided by the private sector and the not-for-profit organisations.

One of the most significant challenges faced by all governments today is encouraging people in need of mental health care to seek help early. But feelings of shame, and stigma and discrimination stand in the way. There are no shortcuts here, but an increasing emphasis on improving mental health literacy and mental health promotion is the first important step, as is increasing our communities' understanding of what help and where help is available.

Consideration needs to be given, at both a state and a national level, to the most appropriate messages to deliver to our communities to encourage better help-seeking. In addition, it is incumbent on our state to have an appropriate mix of clinical services focused on early intervention, recovery and relapse prevention. In October last year, the Tasmanian government released the first mental health promotion, prevention and early intervention framework for Tasmania, Building the Foundations for Mental Health and Wellbeing. I believe that was supplied to you.

ACTING CHAIR—It was.

Dr Crawshaw—This framework provides Tasmania with a whole-of-government and whole-of-community approach to the promotion of mental health and the prevention of mental ill-health. Further to this, by June this year we will have received Tasmania's first suicide prevention strategy. The strategy will build on a significant community consultation that took place across Tasmania in 2008 and culminated in the release of a report, *Voices of Tasmanians on suicide prevention*. This work is crucial to shaping the direction of Tasmania's collaborative effort in mental health and wellbeing and suicide prevention over coming years. The collaborative approach across all levels of government to achieve better mental health outcomes is also a clear direction in the Fourth National Mental Health Plan.

At a national level, the Living is for Everyone—LIFE—framework has been affirmed as the agreed national policy framework for suicide prevention in Australia. Tasmania's suicide

prevention strategy has been developed in line with the LIFE framework and the Building the Foundations for Mental Health and Wellbeing framework. In Tasmania, there is still much work to be done identifying appropriate levels of funding to support suicide prevention activity, and the establishment of clear mechanisms for coordination and communication across all levels of government and within the Tasmanian community is critical.

At a national level, I trust that the current national health reform does not overlook the significant and ongoing needs of mental health, but I am optimistic and look forward to working across all levels of government, the community and business and industry to strengthen the mental health and wellbeing of Tasmanians and to reduce the impact and prevalence of suicide. I thank you again for your invitation to be here today.

Senator ADAMS—I am from Western Australia, so I am very aware of these small rural communities that you mentioned you have to deal with in describing Tasmania the way you did. We have had a number of discussions about the road toll and the amount of money that is spent on the advertising and all the other pieces of prevention and so on. Also, we were discussing the suicide rate with Lifeline just before you came. There has been possible under reporting of suicides in single vehicle accidents, and I know that Tasmania has had several very nasty incidences of single drivers running into trucks. Could you comment on how we can identify suicide as a problem and deal with that so that the public is really aware of the problems associated with those numbers? It has been sort of a taboo subject, but it is finally starting to be talked about a lot more.

Dr Crawshaw—I will answer that first in general terms. I am a clinician and have also been involved in teaching about suicide and suicide assessment for many, many years. In the 80s and 90s, part of our concern was that media publication around suicide was actually serving to increase the chances, particularly in young people, of what we call copycat suicides. This was because it was almost glamorising suicide as an option when you are distressed, and unfortunately young people are inclined sometimes to take impulsive actions and not think through the consequences.

In some respects, this then generalised to ‘we don’t talk about suicide’, and that causes significant distress for people who have suffered the loss of loved ones through suicide or near-suicide. It also means that people do not see it as a very significant issue. Mindframe and other organisations have been trying to work towards how you positively talk about mental health issues without glamorising the options and choices with respect to how you might end it and instead encourage help-seeking behaviour rather than suicide actions or parasuicidal behaviour.

The other problem is that there is a need to draw distinctions, in terms of motivation and so forth, between those people who self harm and those people who are serious about committing suicide. Sometimes that is a really difficult thing for clinicians to make decisions about when people present, and while we would like to get it right 100 per cent of the time, no matter how carefully you assess someone, it is not always easy.

The other problem is that people assume when they hear of events, such as the single motor vehicle accidents, that they might be a suicide. In Tasmania we work quite closely with the coroner’s office—in fact, we have a representative on our suicide prevention committee—so that we can start to get a handle on what is coming through the stats.

We are somewhere in the low- to mid-70s in terms of our suicide rates here in Tasmania, as indicated in our report, which means it is actually a very low frequency phenomenon. So you get the other, problematic part, which is what I call pseudoclusters due to small numbers. If it is a low-frequency event you can seem to see clusters, whereas in fact it is really because the baseline is just blipping up and down, and what looks like a cluster is not a cluster. But in some cases it is a cluster, because there has been media coverage which has fostered the intention of certain individuals to join the club in terms of risk-taking behaviour.

So how the media report is a very difficult thing, in terms of the importance for the community of suicide events but not reporting them in such a way that glamorises them or makes suicide seem a way out for people to take. We are getting from the initial response in the seventies and eighties, where it was almost glamorised and sensationalised, through to a period where it was not well reported, through to a period where we are starting to have a more mature debate in the media about what the issues are. Often issues are around the social determinants of mental health and wellbeing.

Senator ADAMS—As you are probably aware, we have had a lot of hearings. I have been trying to get an idea from each area we go to about how it is being dealt with, and of course the media has been raised at every inquiry. We have been given some really good, positive health promotion media examples.

Dr Crawshaw—What we need to foster is a focus on how we help the community to think about how they look after their mental health and wellbeing. We need to look at how we reduce the stigma of saying, 'I need some help. I'm not travelling so well,' at an early stage rather than at a late stage. I have been involved in mental health long enough to know that there was a period when no-one wanted to know. It was out of sight, out of mind. That was very devastating for people who wanted to signify that they wanted help and then very devastating when they wanted to get back into the community and re-engage with the community. My view is that there is no health without mental health and mental health is everyone's business.

Senator ADAMS—I would agree with that. I was just looking at the statistics that you have in your submission on prisons. It is quite frightening to read page 10 of your submission, which deals with the prison population.

Dr Crawshaw—Yes. Unfortunately we have seen an increasing number of people who end up in prison. I do not think that Tasmania is any worse or any better than other parts of Australia in that regard. Australia is actually doing better in some respects, if you look at imprisonment rates, than other countries. But it is still a very worrying statistic.

Senator ADAMS—There are some samples of the number of people that have exhibited suicide and self-harm behaviour. Could you comment on the support that is available for people in prison and when they leave, in terms of rehabilitation and case management?

Dr Crawshaw—Some of it is more to do with what corrections do, but one of my areas of specific responsibility is correctional primary health. I am responsible in part for the other side of what we deliver within the prisons in terms of primary health. What we have structured is what we call a tier 1 assessment. For everyone who comes into the prison, has a significant change in their sentencing or returns from court—after a significant event—we conduct a tier 1

assessment, and that is an assessment which looks at their general health but more specifically looks for specific factors which we know are related to issues to do with psychological ill health or factors which may be related to suicide or suicide gestures within prisons.

ACTING CHAIR—Who does that?

Dr Crawshaw—That is done by our primary health nurses.

ACTING CHAIR—And they have psychological or psychiatric training?

Dr Crawshaw—We have trained all of our nurses in how to do it.

ACTING CHAIR—So they have mental health training.

Dr Crawshaw—We have both mental health nurses and general nurses. All of our nurses are trained in how to do the tier 1. If the tier 1 shows flags in terms of issues that need to be addressed either immediately or in the longer term, we have agreements with the prison service in terms of how we move people into special needs areas where they can be managed more safely and an escalation path. We work quite closely with the therapeutic services and the justice side of the equation, so we try to address it. That is not to say that people do not get distressed within prisons or do not sometimes act out in harmful ways, but nevertheless it means that we are able to do a comprehensive and graduated assessment of risk and then introduce risk management processes.

We also have a Forensic Mental Health Service which goes into the prison and will provide specific clinics. As you may be aware, prisoners have a higher rate of mental illness than the general population, so part of our requirement is to provide good mental health care for our prisoners when they are in prison. As chief forensic psychiatrist I am responsible—either me or one of my delegates—for moving people from the prison service into our Secure Mental Health Unit should they require hospital-type care because of their mental illness. So we have a graduated series of responses within the health profession within the prison.

We are also working with our Prison Service colleagues to develop what we call a healthy prisons approach, which is similar to what has been developed in the UK. We take a view that while people are in prison we have an opportunity to try to address their general health needs and provide them with base-level assessments, because they often may not have received those when they were outside prison. Where possible, we try to target people who we know have higher risks so that we can address those risks and seek to reduce them. That does not mean that they will always take up our offers, because of course they have the right to make decisions, but it does mean that we are trying to provide a comprehensive pattern and package of care for them.

In terms of when they go, that is sometimes a challenge for us. We try to provide advice to GPs on what has happened to them if we have provided health services within the prison, particularly around any medications which we may have started or changed. Sometimes, of course, that is quite challenging, because they go to court and the court decides to release them then and there, which means that we are scrambling to do a bit of catch-up because we were not expecting them to be released. Where people have very significant mental health problems, the

Correctional Primary Health Service will make referrals to appropriate agencies. Usually our mental health services will follow up.

Senator ADAMS—Just as an aside to your tier 1 assessment, this committee has been doing another inquiry into hearing services. We have found in evidence that 90 per cent of Indigenous prisoners have some sort of hearing defect. Is hearing part of that particular assessment?

Dr Crawshaw—If we were alerted to the fact that they had a hearing problem. One of the issues for Tasmania is that, while it probably has more prisoners than we would like, it also has a very small number of prisoners, and we have to cover the entire board. We will refer either to private services or within the general health services for specific issues. If they have hearing needs we would attempt to address those on an individual case-by-case basis.

Senator ADAMS—The reason I was asking is that the link with mental health, especially with some of the Indigenous people living in more remote areas, is the frustration which starts as a child, and becoming isolated and then coming up with a mental health issue later and then ending up going through the justice system.

Dr Crawshaw—I understand what you are saying. The other thing which is linked to that is literacy rates. We have made special efforts to ensure that the lack of literacy is not a barrier to them being able to get help within the prison service. A lot of our information is in visual form either simple diagrams or pictures, to try to overcome what we do know are barriers. The correctional primary health service also tries to work with key informants within the prison—that is more challenging than you might think because it is crossing some of the issues as to why prisoners are there—to try to get a sense of how they perceive necessary health services within the prison. As I said, we take quite seriously our opportunity while there are within the prison to actually address health needs and health issues.

Senator ADAMS—We have had a lot of evidence about people presenting at the emergency department with either self-harming or in a very agitated state. In Tasmania what services are available when they do present to triage? Do you have a special mental health section or an area where they can be examined in that way. I ask mainly because we have heard that a number of people who are self-harming are told, ‘You’ve done it, it’s your problem, go and sit over there’, and eight hours later they are still sitting there or they have gone.

Dr Crawshaw—We have within the state a 1800 number for our mental health helpline. That is a first port of call in terms of being able to access services. We have trained psychiatric mental health nurses who triage the call and the nature of the urgency and the response time to actually see the person either who has made contact or who another person has made contact about. Within Hobart for some time we have had a psychiatric or dual trained nurse who has actually been working within the DEM environment not 24 hours a day but most day shifts.

As a result of funding through a national partnership agreement around emergency department services we are actually now expanding that to a 24-hour nurse within the DEM. Once we move outside Hobart—and this comes back to the challenges I have in terms of providing services across the state—it is apparent that we need to actually modify some of that process in terms of how best to provide it. We also are in the process of implementing what we call extended CAT services which are able to respond much more responsively to people and also to provide inreach

services into the emergency departments with easy referral from the emergency staff. We do recognise that emergency departments are not necessarily always attuned to the needs of our clientele and it is better that we try to get them assessed by trained mental health professionals rather than relying upon emergency staff.

That is in the process of being rolled out over the next few months. We are still trying to work on what the most appropriate model will be for the north-west because we have got two essentially emergency type departments up there—one at La Trobe and one at Burnie. The numbers are low, so it is a matter of how we actually provide those services in a sensible way to meet the needs. It is not simply about doing the assessment but also being able to ensure that there are the pathways other than just an admission pathway.

We have challenges sometimes, and it is part of the stigma. Health professionals are not necessarily free of the stigmatising views of the general public. One of the experiences I have had over the years that I have worked as a psychiatrist is that my clientele are not always perceived as being most liked within hospitals. We are constantly trying to break that down, which is part of why we are working with our emergency department colleagues to provide improved resources and improved governance around what actually happens within emergency departments so that people who have got significant psychological distress and who present to the emergency departments are not seen as a pain but are seen as someone who is really needing help, and we then provide the help for them. That is in the process of being rolled out as we talk.

Senator BILYK—You just mentioned the 1800 help line—is that 24 hours, seven days a week?

Dr Crawshaw—Yes. I can leave you a brochure if you wish.

Senator BILYK—That would be good, because we heard evidence earlier from an organisation that was saying how hard it was for people to access a help line from a mobile phone, with the extra costs. But an 1800 number is a standard cost?

Dr Crawshaw—I am not sure what—

Senator BILYK—I am happy to talk to that organisation and just let them know about it. Maybe it is something which they are just not aware of.

Dr Crawshaw—It depends upon when they were talking about their experiences. There used to be a CAT number, which was not necessarily an 1800 number I think. But this has been rolled out over the last two years, so it should not have been a—

Senator BILYK—Okay. I will just make sure that they know about that. I want to ask about reporting and interpreting of statistical data with regard to suicide and what your views on it are. Correct me if I am wrong, but as I understand it the Tasmanian government do their statistical collections differently to the ABS? Is that right? There is a time—

Dr Crawshaw—We have a different way of reporting. One of my tasks is to sign off the reports. It used to be on a biennial basis, but we are now trying to provide data on a yearly basis. Our view is that you really should not be reporting statistics until such time as you have closed

off the inquest events for the year that you are actually reporting on. While people get upset with me, we tend to report our results two years in arrears for the simple reason that it gives us time to collate all of the information from the coroners as to their events and how they found them.

Senator BILYK—Have you got any comments to make with regard to the way that coroners might report or not report whether it was a suicide or not?

Dr Crawshaw—I am aware there is now a national process going within the coroners grouping to actually try to get a more systematic and standardised approach. One of the issues is that a coroner has to be certain as to what the finding that they are making is. If there is not sufficient evidence, or on the balance of probability, they may deliver an open verdict. In the past there have been concerns that coroners underreport for the protection of family members who did not want other family members to be said to have suffered suicide. In the past there also used to be stigmatisation around that in terms of claiming for insurance and so forth.

Senator BILYK—Sure.

Dr Crawshaw—So, no matter how good we are at working with our coroners I suspect there will still be some level of underreporting. As I understand it, specific research projects have occurred in New Zealand, Australia, the UK and other countries, where you actually do much more in-depth analysis. It is not able to be done on a general basis but you try to do a much more in-depth analysis, including what is called a psychological post mortem where you actually take a cohort of cases and do an in-depth drilling down and look for all psychological factors. That is obviously not something you can do on a regular basis, nor is it something that all family members of people who have potentially committed suicide wish to engage with. But that is where we get some of the information about what the motivating factors around suicide are. I am sure you must have had experts who have done that sort of research present to the committee.

Senator BILYK—That leads me to one of my other questions for you. Are there any groups or subgroups which you think currently lack programs to target services to them in relation to suicide specifically in Tasmania?

Dr Crawshaw—It is interesting in terms of population health measures that generally speaking, if you want to change health status, in particular we are talking about mental health and wellbeing status, broad population health measures are the ones that actually get you the best benefit. Having said that, as you would have read in our submission, there are groups that we recognise as being more at-risk groups. They are generally groups who have a combination of the social determinants of health occurring together. They are also groups who suffer from potential stigmatisation and specific problems in terms of how they fit within society. That has been well known since the 1890s, when Emile Durkheim reported about the suicide stats in France and about people who fell out of society or were not included in society as being a significant group—what he termed anomie or a lack of fit within society. Groups like that will have—

Senator BILYK—Can you tell us what those groups are?

Dr Crawshaw—For instance, people who are homeless, people who are suffering disadvantage, the Aboriginal group, which we talked about before, people who have significant

mental health issues and people who have alcohol and drug issues. There are particular ages that have issues. There is also the CALD group, particularly people who are recent migrants. It is not all migrant groups. Some groups migrate reasonably successfully; other groups find the dislocation much more problematic. Groups who have migrated because of trauma or associated issues can often have specific issues which make it more difficult for them to adjust and they bring with them some of the psychological distress that they suffered on the way. It may be interesting that Tasmania seems to have the highest proportion of humanitarian program settlers.

ACTING CHAIR—I do not know whether it is the highest, but they do have a large number.

Senator BILYK—I think it is. It is because we are such nice people!

Dr Crawshaw—That is a particular group and we have got particular programs for the CALD group here. There is also the gay, lesbian, bisexual, transgender and intersex population group. It is interesting because the stats do not necessarily show it but we know from first principles that they are more likely to suffer more disadvantages and social stigma.

Senator BILYK—How do those groups get involved or included in helping to develop programs, for example, to reduce the number of suicides? Take the GLBTI group, how would they be involved in suicide prevention strategies specifically for that group?

Dr Crawshaw—It comes back to what I was going to speak about in terms of what you need to do to address suicide issues. We have a suicide prevention committee, which is a high-level group. We also have a reference group sitting underneath that, which is a wide range of people who have specific interests, such as what you were just talking about. In this case, the GLBTI group has made strong representations on what they perceive as the needs for their group. It really illustrates for me some of the issues of how we address that. We have got small rural groups who are equally saying they need specific programs within their areas. It can be very small numbers of people that you need to think about how to do it for. We decided to do a structured suicide prevention strategy so that we developed a strategy that addressed the fact that in Tasmania we have communities who are quite scattered, sometimes small and sometimes large, and often need specific ways of addressing some of the things around social resilience and decreasing the factors that lead to suicide. That is going to come to me hopefully within the next month so that we can then release it. Following on from that, we would be seeking to engage not just with the GLBTI group but with a large number of communities.

Senator BILYK—Would you be looking at something like workshops?

Dr Crawshaw—Workshops are one thing. I guess I am more interested in addressing some of the factors which we know may make communities stronger—increasing the resilience within communities and building the community development type approach within communities and trying to address that. As I am sure the GLBTI would have said to you, part of their problem is around individuals who are just struggling to come out. They are much more problematic to reach because they are suffering the double disadvantage of putting their hand up and saying: ‘I don’t fit. I also have psychological problems and I might not be of the right sexual orientation.’ That creates much more challenging aspects for them.

Senator BILYK—Can you tell us what you think might be priority areas for future research into suicide?

Dr Crawshaw—I am not a researcher, so you may have to actually speak to the researchers on that. Looking at it from a Tasmanian perspective, I am particularly interested in research or field studies that tell me how to address small distributed populations rather than focusing on major cities. We know from the stats in Australia that outer and remote communities have higher suicide rates and we know that the programs that worked within large cities like Melbourne and Sydney may not necessarily be the programs that are going to be successful in Tasmania or some of our rural communities. So I am interested in work which actually helps us identify how we can do that. We were very fortunate when we did our promotion, prevention and early intervention framework—

Senator BILYK—Can you just remind me when that was?

Dr Crawshaw—That was released last year. In fact, there are three volumes. You got the framework. We also had a companion volume, which was a summary of the best evidence-based practice in this arena so that we have got a strong research base on which to draw as well as the government's response. If you want, I can get that for you.

ACTING CHAIR—We collect those in the secretariat, but I think the offices of Senator Bilyk and Senator Carol Brown would also like to get the whole kit and caboodle.

Dr Crawshaw—It is available on our website, but to save you scrambling around we can send the link to your secretariat and they can distribute it around.

ACTING CHAIR—That would be great. I know that, particularly for the local senators, that local knowledge is so important.

Dr Crawshaw—We have actually got an evidence based set of volumes that says, 'This works or this might work or this has not been shown to work.'

ACTING CHAIR—Which you have assessed?

Dr Crawshaw—We paid an external consultancy to do the assessment for us.

ACTING CHAIR—Can you remember who you used? You can give it to us on notice. It is just really important because the Commonwealth has funded a couple of different national programs and Griffith University has got the responsibility for looking at research. I am just interested to make sure they are talking to each other. If we find out who you used, we can make sure Griffith knows about it.

Dr Crawshaw—This was done by Auseinet, who unfortunately have folded since then.

ACTING CHAIR—So they did the assessment basis for you.

Dr Crawshaw—Yes. I have to say they did a very good job for us. We were very pleased with the work that they did. I guess that is why I am answering your question in that way—unless you

have a PPEI framework, it is very hard to think about how you do suicide prevention. Promotion, prevention and early intervention are part of the whole capsule in terms of mental health and wellbeing.

Senator BILYK—I am not sure if you will be able to answer this, but what sort of programs are there to support family members and those close to people that have either attempted or completed suicide?

Dr Crawshaw—Standby response has been working in Tasmania. There are a number of home-grown agencies. I refer you to pages 21 and 22 of our submission. You will see that we have listed a number of the programs that are operating here in Tasmania. We are very fortunate that some of our initiatives that have grown up in Tasmania have grown out of some of the small rural communities and are focusing on precisely what you are talking about. We also have, and I will leave it with you, the freely available kit *Sudden Loss Support*.

Senator BILYK—Where would someone get something like that? Say I come from a household that has had a parent, sibling or child suicide, how would I access that and when would I get it?

Dr Crawshaw—It depends upon whether you put your hand up to access it. We have distributed quite widely another—

ACTING CHAIR—I think what we would like to know exactly is: what is the system in Tasmania for when there is an event?

Dr Crawshaw—The StandBy Response Service actually go out with the police and ambulance. But why I am saying we have produced a number of these information things is that my experience tells me that you have to have multiple mechanisms for ensuring information is available. The consumer and family guide for services which are offered in Tasmania is well distributed in various community—

ACTING CHAIR—So the government produces that?

Dr Crawshaw—Yes.

ACTING CHAIR—How does that link with the Lifeline register of services and the Uniting Church booklet? How do they all work together?

Dr Crawshaw—When we put that booklet together we went to all of the community sector and private agencies that we knew of and we worked through all the peak bodies to get the lists. We try to keep that updated. We believed it was our responsibility to provide a guide for the state that people could use to access different types of mental health services. It includes Commonwealth as well as state provided programs.

ACTING CHAIR—Is that available on the net?

Dr Crawshaw—Yes.

ACTING CHAIR—Is that automatically be updated? The printed one would be updated every 12 months or two years?

Dr Crawshaw—It will be updated as people let us know, but we would plan to revise that on a semi-regular basis in a systematic way.

ACTING CHAIR—We have not seen such a document in other states like that state produced kit of services.

Dr Crawshaw—It is a full guide. For instance, it talks about what mental illness is, with simple descriptions that anyone can access, what types of therapy and treatment options are available and rights and responsibilities. At the end, it has a listing of all of the services that we know of within the mental health space within Tasmania.

Senator BILYK—Do you think the training and support of the front-line emergency personnel in Tassie is adequate or that they need some more help? Sorry, I did not word that very well. I do not want you to have to appear to say that the staff are not doing a good job, because I am sure that within all parameters they are and it is certainly not a job I would like to be doing. Having clarified that, do you have any views on whether they could do with some more support or training?

CHAIR—Can you tell us what the current police training is, Doctor, and then whether there are any plans for gaps in the future?

Dr Crawshaw—Police recruits, for instance, have basic mental health training and also aspects around how to access services and so forth. The ambulance service is increasingly moving to paramedic type services with much higher levels of training. We are talking with the ambulance service here in Tasmania about the level of training they would need if we were to make them what we call ‘authorised officers’ or ‘mental health officers’ so that they could actively respond more appropriately. The short answer is that I believe that we probably should and could be doing more training, but the problem is that these front-line staff have a lot of other people who would like to get into their training programs as well. It is a matter of how quickly you can get in. By and large, despite some of the media recently, we would say that there is a good working relationship between mental health services and the police. We have particular MOUs and particular ways of working through issues. They are engaged in working through the new legislation, which we are in the process of drafting. Yes, there could be more. You may be aware that within the fourth National Mental Health Plan one of the specific action items is around the improvement of the education and orientation of the first-line emergency services. So it is part of a national push.

Senator BILYK—Can you explain to me what a mental health officer would do?

Dr Crawshaw—In the new legislation they are like the authorised officers: they are the people, if someone is really unwilling to come to the services and obviously needing it because they might fit within the Mental Health Act, who would facilitate the action of the act.

Senator BILYK—Thank you.

Senator ADAMS—When the GLBTI group were here they were very concerned about the fact that they did not fit in anywhere. They were saying, 'We are not represented within the government by any ministers.' I was trying to think where they would fit. You have people with disabilities that are in the disability section. Where would you think in the government area they would fit? They are not really disadvantaged; they are members of the community.

Dr Crawshaw—I am not sure that I can speak on behalf of government as to how they would want to structure their ministries and ministerial portfolios—

CHAIR—Everybody else does, Doctor, so—

Dr Crawshaw—However, we certainly do recognise that they are a particular group that we need to engage with. That is partly why we have put it in our submission. I am not sure that they would necessarily feel they were well engaged with, given some of the strong debate we have had with them, but they are a group which do need to be recognised because they do have aspects that need to be addressed in terms of their mental health and wellbeing. Having said that, I do not want to see a return to a stigmatising type response which somehow defines people because of their sexual orientation as having some sort of mental illness or something like that. That was a problem in the past. It is, again, one of these difficult issues. Yes, they are a group that has particular issues which we need to think about, but I do not want to contribute to a stigmatisation or an inappropriate definition of people who have different gender orientations as being ill, if I could put it like that.

Senator ADAMS—Yes, it is hard. I have just been going through our federal departments trying to work out where they would fit.

Dr Crawshaw—Any group can be discriminated against—because they look different, they are different from the mainstream, they speak a different language, or they are a group that parts of society do not like. We see that where people have different religious views or where people have a different colour. You might be talking about people who cannot hear properly. That is why most jurisdictions—certainly all jurisdictions in Australia—have antidiscrimination legislation so that that does not occur. That is why I am being careful about how to respond to you. The last thing we want to do is to actually have an approach which discriminates rather than includes.

Senator ADAMS—I think their reasoning is that someone with a disability can go to Disability Services and get to the parl sec or the minister or someone like that, and this is what they are saying—that we really do not have that person up here that we can go to or be represented by or engage with. That was really the way they put the issue this morning.

Dr Crawshaw—I understand the issue they are putting, but I think it is an issue which can cut both ways. All I can say is that we certainly do recognise that for some people within that group they do have challenges and do perceive discrimination against them, and in fact often have overt discrimination against them. That can lead, as with anyone who suffers discrimination, to significant issues in terms of their psychological wellbeing. It is not that we want to exclude them; we will indeed engage with them but there are other community groups who make equally strong views about needing to be included. My task is to make sure that we do have a process of engaging with all of these various groups.

ACTING CHAIR—There are two specific further issues I wish to raise. I know it is not your portfolio, but in terms of getting the police form that the police fill out in Tasmania for the coroner's information—

Dr Crawshaw—I can certainly take that on notice and see what we can get.

ACTING CHAIR—That would be really useful. What we are finding is that the data is impacted by the quality of the form, and the form is not national. We would like to get a look at what is happening around the place.

Dr Crawshaw—That is also one of the reasons why we have police as well as the coroners on our suicide prevention committee.

ACTING CHAIR—They are so important. The other issue is that today we heard from the group called Time Out, in Launceston, and they were talking about their funding issues, which of course you know about and which go to the process. They did receive a $2,000 amount out of one of the boxes of money, but one of the links to that was that by getting the $2,000 grant they had to put the state crest on every piece of promotional information they had. I am wanting to find out where through the government we can ask about that. Is that standard process? It does seem to be a particularly onerous linkage to an amount of money which is not very high. Perhaps if they got the $60,000 they had asked for it might have been another thing, but they put on record the point that they were getting two grand but then would have to change all their leaflets to include the government crest. Whenever we have something like that we always go back to source and look at it. So it is probably not your department, again, but you are actually here as the only Tasmanian government person in front of us so I thought I would put that on notice for you to take up as well.

Dr Crawshaw—I think I will have to take it on notice.

ACTING CHAIR—I would think so, but you have that example as a basis. I know you will get the *Hansard*, but the other thing they said was that this was a third party process but when they were looking at putting information together about grants, the information they received from other organisations was that their title originally included the terms suicide and self-harm, but they were told they would do better in looking for funding if they dropped those terms off.

Senator BILYK—That did not come from the government, though.

ACTING CHAIR—No. We actually asked them to take it up with the government as well. I do not want to verbal them but perhaps when you have a look at the *Hansard* for today—

Senator BILYK—That could have been someone making sure they got funding instead of this group.

ACTING CHAIR—If you could have a look at that, because it comes down to an issue base, it would be valuable.

Dr Crawshaw—I will get someone to have a look at it but I am not aware that the title of an organisation would be relevant, necessarily, to any of the grants which we go through. In

Tasmania, we have Treasury guidelines on how we go through applications. We have to ensure that we address the criteria that are in the tender rather than other factors which, to me, would seem somewhat remote from it.

ACTING CHAIR—I have one other question—and this is in your department—in relation to people who are discharged from hospital for any reason, but particularly when they have had a traumatic event. Does the government have a standard discharge policy that requires that when a person is released they have someone to go to or they have a referral point? When you are released from hospital, if you have been in hospital for a suicide or self harm issue, is there a discharge process that means you are referred to someone to take care of you from then on?

Dr Crawshaw—We are in the process of revising our clinical policies and procedures because we are going through a new clinical governance process. Part of what you are raising is related to the clinical assessment by clinicians as to what is the perceived need for the person once they are discharged. Sometimes patients will say to us they do not want follow up and we have to accept that. Sometimes they will be seen as already engaged with services and we need to respect that. At other times we will have an issue whereby we do believe they need follow up, and one of the things which we have been working on quite closely with our inpatient and community teams in relation to mental health is to ensure that there is good transfer of information and good referral between them. From my perspective, it is more to do with the standard of clinical care and people doing the appropriate assessment as to what the need is. I suspect there is also the need to make a distinction between when people get within the mental health services versus people who may be triaged within the emergency department. Sometimes that is quite problematic because some of these individuals do not necessarily wish to accept assistance. Having said that, part of why we have been introducing the extended CAT team response—the psychiatric and nurse and the emergency—is to try and improve the standards of care within the space.

ACTING CHAIR—Dr Crawshaw, I am not sure whether there are things we have missed. Sometimes when we do our checklist of things to cover there is something obvious that we did not raise. If there is anything, the secretariat will be in contact with you.

Dr Crawshaw—Can I just check in relation to the matters which are on notice whether your secretariat will formally write to us?

ACTING CHAIR—Absolutely. We will formally be in contact with you. Again, thank you very much for your visit. It was very important.

Committee adjourned at 2.18 pm