LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON SOCIAL POLICY

(Reference: Inquiry into men's suicide rates)

Members:

MR T EMERSON (Chair)
MS C BARRY (Deputy Chair)
MISS L NUTTALL
MS C TOUGH

TRANSCRIPT OF EVIDENCE

CANBERRA

THURSDAY, 16 OCTOBER 2025

Secretary to the committee:
Ms K Langham (Ph: 620 75498)

By authority of the Legislative Assembly for the Australian Capital Territory

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WITNESSES

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Amended 20 May 2013

The committee met at 9.18 am.

LEAVENS, MS STACY, Chief Executive Officer, Capital Health Network

THE CHAIR: Good morning and welcome to the public hearings of the Standing Committee on Social Policy for its inquiry into men's suicide rates. The committee will today hear from a range of witnesses with expertise in risk factors, research and service delivery.

The committee wishes to acknowledge the traditional custodians of the lands we are meeting on, the Ngunnawal people. We wish to acknowledge and respect their continuing culture and the contribution they make to the life of this city and the region. We would also like to acknowledge and welcome any other Aboriginal and Torres Strait Islander people who may be attending or participating in today's event or listening in online.

This hearing is a legal proceeding of the Assembly and has the same standing as proceedings of the Assembly itself. Therefore, today's evidence attracts parliamentary privilege. Giving false or misleading evidence is a serious matter and may be regarded as contempt of the Assembly. The hearing is being recorded and transcribed by Hansard and will be published. The proceedings are also being broadcast and webstreamed live. When taking a question on notice, it would be useful if witnesses used the words, "I will take that question on notice". This will help the committee and witnesses to confirm questions taken on notice from the transcript.

As this hearing will touch on sensitive matters, some witnesses or people watching these proceedings might be impacted or even triggered by what is said or heard. Please take care of yourselves throughout this process, take it slowly, breathe deeply and take breaks when needed. Witnesses do not need to share traumatic details. We have a duty counsellor available on site if needed. For those in the room today, please indicate to the committee secretary for an introduction or pop into the small committee room in the corridor. The counsellor is there to support you if needed, even if you are just in need of a break or a cup of tea.

A support handout is available at the entrance of the committee room. We encourage witnesses to take a copy home, as unpredictable emotional reactions may occur in an extended window after leaving the hearing. The handout has tips and strategies for self-support and referral points in case of a crisis or more in-depth counselling support. For those attending remotely, an electronic copy is available from the secretariat.

We welcome the Capital Health Network. Please note, that as a witness, you are protected by parliamentary privilege and bound by its obligations. As indicated, you must tell the truth. Giving false or misleading evidence will be treated as a serious matter and may be considered contempt of the Assembly. Before we go to questions, would you like to make any kind of brief opening statement covering matters that are not addressed in your submission?

Ms Leavens: Yes; I do have a brief statement. Capital Health Network is funded by the commonwealth government under the PHN program to commission many of the mental health services, including suicide prevention services, delivered here in the ACT. We

do this through the Mental Health and Suicide Prevention Agreement funding that we receive from the commonwealth as well as in line with the national bilateral agreement between the commonwealth and the ACT.

We work really closely with the Canberra community, including service providers and people with lived experience, to understand, identify and fill gaps. The challenge of supporting older men in particular at risk of suicide is very clear from our stakeholders. This is supported by data indicating that the men in this age group may also be at higher risk of social isolation than other age groups or women in this age group. Yet many older men may not seek out support or respond to existing traditional services in this space.

Adding to our submission, which really addresses the proactive and formal and informal assessments by primary healthcare professionals, we believe that there are a lot of practical tools and models out there already available that are now only limited by time and training. For example, there is growing recognition of community benefits of mental health first aid courses for pharmacists. In our submission, we cover the pilot in Tasmania. However, we know this has also been rolled out broadly through South Australia, where the state government has commissioned mental health first aid training for pharmacists.

Likewise, giving general practitioners and other practise staff the time and tools to identify men at risk can make a real difference. Men may be more likely to take up formal support when recommended by a GP. What is really critical here—and what we hear from our stakeholders in the primary care space—is having the resources, supports and services available for those health practitioners to effectively and timely refer people on to.

Finally, I would really like to stress the importance of using the right language and programs to reach and support men in this age group. A one-size-fits-all approach will not work, and this means we need to identify approaches with an evidence base but tailor these with men for a local and responsive approach.

THE CHAIR: Thank you, Ms Leavens. Capital Health Network played a lead role in delivering the ACT Mental Health and Suicide Prevention Plan 2019-2024. I am curious why it is not mentioned in your submission.

Ms Leavens: We currently have a revised version of that in draft form that is currently being finalised—and so that will be coming through. In our submission, wanted to have a really targeted focus, rather than going broad and trying to cover off on everything. But suicide prevention is certainly going to be an ongoing focus under the renewed regional plan once that is finalised.

THE CHAIR: Do you have a timeline for when that will be finalised?

Ms Leavens: It is in final draft. We are going through the final approvals at the moment.

THE CHAIR: Okay, so that is—

Ms Leavens: It should be very, very soon.

THE CHAIR: The original plan was for annual reporting on implementation progress, including latest data, that is experienced in important case studies. Are those annual reports available somewhere?

Ms Leavens: I will have to take on notice where that information would be available. I do know as part of the drafting of the new plan, there has been a sort of a reflection piece done that I would be happy to share with the committee.

THE CHAIR: That would be great. Thank you. When exactly did the old plan expire?

Ms Leavens: I believe that was 2024. I would have to double-check that, though.

THE CHAIR: I was looking at the plan and it mentioned there would be a final report, including data and progress toward outcomes and reporting on the experiences of consumers, carers and the workforce under the plan. Do you know if that reflection document is the same document or if there is a separate final report?

Ms Leavens: I think there is a separate piece. There is a reflection piece that was done reviewing the whole plan with stakeholders.

THE CHAIR: Okay. Do you know if that final report has been completed?

Ms Leavens: I am not sure. I will have to double-check that.

THE CHAIR: You mentioned the bilateral schedule or agreement between the commonwealth and ACT governments in relation to the national agreement. I note in that schedule, it says that the parties agree to continue to support the ongoing review, implementation and monitoring of the ACT Regional Mental Health and Suicide Prevention Plan 2019-2024. What does that mean for us in this period where there is not a plan in place?

Ms Leavens: We continue to work very closely with the ACT Health and Community Services Directorate on progressing priorities in line with the regional plan. In this period, there has been a redrafting of that plan, but we continue to work really closely. Our teams are in touch regularly to ensure that those shared priorities continue to be addressed in partnership with ACT Health.

THE CHAIR: Does that mean in this interim period that the former plan is being delivered or there is a bit of a hiatus—that there is a continuation of whatever was already in place and then new initiatives will kick off with a new plan?

Ms Leavens: Yes. There is been no of things; it is a continuation of shared priorities and activities.

THE CHAIR: Do you know what level of federal funding is associated specifically with the delivery of that plan?

Ms Leavens: I do not know the full amount of funding, because the national bilateral agreement covers a number of priorities. What I can tell you is that one of the

components that the commonwealth funds through us with regard specifically to suicide prevention are aftercare services. We fund an element of aftercare services in the ACT, and that is just over $700,000 per year. I can get the exact figure to you, but we do fund aftercare services to that amount.

THE CHAIR: Okay. And that is federal funding that is basically delivered through you?

Ms Leavens: Yes, but that is really specifically the aftercare component—not the full.

THE CHAIR: Is that matched in any way by ACT government funding?

Ms Leavens: I believe it is.

THE CHAIR: So maybe it is $1.4 million in total.

Ms Leavens: Yes.

THE CHAIR: Okay. Obviously there is commitment in that schedule and support to the national agreement to the objective of achieving universal aftercare services to support individuals following a suicide attempt or a suicidal crisis. What is your assessment of progress on that commitment? Are we moving forward toward that being the case?

Ms Leavens: Yes. Through the Capital Health Network program, we have been funding the Way Back Support Service for a number of years and that has continued. Currently, the funding under this agreement ends this financial year. So we are just looking to the future of what that continuation will look forward to—there is definitely ongoing engagement around what the Way Back Support Service is delivering, but as well what else might be needed in this aftercare space.

THE CHAIR: Okay, so that is one element of aftercare services that perhaps is not quite yet fulfilling the promise of universal.

Ms Leavens: Right. It is really thinking about what the core program is and what other gaps might need to still be filled in that space.

THE CHAIR: Thank you.

MS BARRY: Thank you for appearing today. I wanted to drill down a bit more into the gaps that you see in the current suicide prevention services for men in the ACT and how your program is specifically adapting to men seeking help, especially around behaviours and preferences.

Ms Leavens: In addition to what we just spoke about in terms of the aftercare services that we fund and work with ACT Health on, we have also been running, through commonwealth funding, what we call the TRISP program, which is Targeted Regional Initiatives for Suicide Prevention. That work has a few different components. There is a suicide prevention collaborative that we run in collaboration with service providers, people with lived experience, health professionals and academia. That is about bringing

together a system-wide view and really looking at how we work effectively across sectors around this. We continue to hear from that group that this cohort, men and particularly older men, is an area where there are still some gaps.

I will speak about some of the things that we have done in this space. We ran a number of grants maybe two years ago—I would have to check the dates on that—where we funded, for example, The Men's Table, which is a specific initiative for men. We worked to establish three additional tables. They were already running one in the ACT, and we added three additional tables to that. What we heard from that was that there were positive outcomes around social connection, including relationships that were sustained outside of those specific initiatives; reduction in substance use; greater confidence in expressing emotions; less conflict; increasingly use of primary care services; and increasing activity around volunteering.

There have been challenges with that, particularly around short-term funding, because we were funding it as a grant, which is time limited. So there were some challenges in attracting volunteers to lead those tables and get them fully subscribed. But we think if we had longer-term funding—or programs like that had long-term sustainable funding—that some of those challenges could be more easily overcome once they get bedded down and embedded in the system.

MS BARRY: Thank you very much. Just for my benefit—and I guess for anyone who is watching—can you tell me a bit more about the aftercare service? What does the service involve?

Ms Leavens: If someone has attempted suicide, they are then connected with the support service, the Way Back Support Service, which really provides wraparound care in that immediate period following an attempt.

MS BARRY: Thank you very much.

MS TOUGH: Thank you for your submission—it was really insightful—and thank you for all the work you do in that mental health and health space. In the submission, you talk about engaging men in the 45 to 64 age group and the trial that was done by the pharmacists in Tasmania, and you have mentioned a similar program is running in South Australia. Can you just tell me more about that program and the mental health first aid for pharmacists, please?

Ms Leavens: Sure. Mental health first aid courses for pharmacy can equip pharmacists with the knowledge, skills and competence to recognise, understand and respond. That might be to coworkers, patients or other adults experiencing mental illness that are coming into the pharmacy. Standard mental health first aid courses teach recognition of suicidal thoughts and behaviours and how to provide that initial support and safety. These courses have gained international recognition. While studies are limited and there is more evaluation required, there is an indication that this really does improve confidence.

We have a number of pharmacy stakeholders that often talk to us about, particularly, the social isolation that they identify within the pharmacy. We have heard recently from the Pharmacy Guild that, on average, Australians visit a pharmacy about 18 times per

year. So it is a common touchpoint. We hear from pharmacists a lot that they see social isolation and mental health issues coming through their door. Many have taken up mental first aid training on their own, but there has not been available that kind of consistent training program offered to them. We think of this as an opportunity to really embed that throughout the community given the presence that pharmacy has.

MS TOUGH: Wonderful. I think you mentioned one of the barriers had been the public-facing nature of pharmacy. I know a lot of pharmacies are now moving to those treatment rooms, because the scope of practice has increased so much. Do you think that is one of the ways that we can get rid of some of the barriers for pharmacists?

Ms Leavens: Yes, absolutely. I think as we see pharmacists and pharmacies play this kind of greater role around scope of practice, that sort of one-on-one consultation is becoming much more common. So I think that breaks that down a little bit. But I think even just the infrastructure of now having a consultation room makes a big difference.

MS TOUGH: Yes; you can take them into the consultation room without being obvious why necessarily?

Ms Leavens: Yes; it is part of a breadth of services that are offered.

MS TOUGH: Are there any other programs similar to the pharmacy in Tasmania and South Australia that have been useful in the health space to engage with men in this age group that you are aware of?

Ms Leavens: Not that I am aware of, off the top of my head. I guess the other element here that I would highlight—while not a specific program or model—is thinking about that role of GPs as trusted health professionals. I think there is an opportunity for training and supporting GPs, nurses and other primary care professionals—even allied health in this space—around identifying suicide risk, building confidence and using the appropriate kind of language and engagement with men, in particular, around this. I think there are real challenges to that around the funding model. I think this requires a lot of time, and current general practice funding is a barrier for that. But I think there are ways to think about how we overcome that and engage with general practice in this space. We have a platform called Health Pathways, which is a place to have information and resources available for GPs to help with that. So I think there are a lot of existing components that could be drawn on to help support a response.

MS TOUGH: Wonderful. Thank you.

MISS NUTTALL: One of your recommendations talks about low-stigma language rather than explicitly mentioning mental health. In your experience or from what you have heard, what language tends to work well? How do you broach that discussion from a safer place for older men?

Ms Leavens: I have to admit that I am not sure I have a real answer for that. My response to that would be that, if we are going to look at developing resources to support men in this space, it is thinking about how we actually co-design that language with men rather than us thinking we know what the message is. I guess that would be my message at the moment—that it is thinking about how we engage and co-design around

identifying and developing that language.

MISS NUTTALL: Possibly relatedly, I know clinical settings provide a helpful opportunity to have those conversations with a trusted professional. Does it tend to matter who broaches the topic? For example, do you know if people have found men to be more receptive to mental health conversations when, say, the person initiating the discussion is also a man or is maybe of a similar age or has shared life experiences?

Ms Leavens: I do think that that matters. We often hear—and, again, this is coming from that perspective of we work in the primary care space—that having that advice and encouragement from a GP does matter. There is that kind of trusted relationship. I think that is the piece that matters—the trusted relationship. Whether that is man, woman, same age, different age, I think it is about the existing relationship that is there is what makes a difference.

MISS NUTTALL: That is helpful to know. You talked about a lot of pharmacists tending to opt-in to mental health first aid training on their own. Have you seen a similar thing where GPs have reached out to you directly after seeing those higher rates of loneliness and social isolation and things like that?

Ms Leavens: I think GPs see this day in and day out. With regard to mental health, I think GPs provide the most mental health care out of any health professional. We often hear from GPs specifically about the challenges in understanding the referral pathways and understanding what services are available. I think that is really a place where there are opportunities to improve the awareness of what services are available but also ensuring that that service and resource network is sustainable and secure, so that GPs know where to send them through. I think they often know how to have the conversation and know how to do that assessment, but it is that next bit that we often hear from GPs is where we need to do a little bit of work.

MISS NUTTALL: How to provide the warm referral and know where to go with it?

Ms Leavens: Yes.

MISS NUTTALL: Okay. Lastly, back on co-design, you have raised a really interesting point. Do you know of any programs right now that co-design mental health, first aid, referrals and things like that with older men?

Ms Leavens: Not specific to this cohort. I think there a lot of work has been happening around working with people with lived experience across mental health and suicide prevention. But, in terms of getting down to this kind of particular issue and co-designing that, I am not aware of anything. That is not to say that it is not there; I am just not aware of it.

MISS NUTTALL: Thank you.

THE CHAIR: I had a question, similar to what we were just discussing with GPs, in terms of gaps in referrals and services. One of the gaps that we have heard about is when someone has not yet made an attempt but they are really in an acute space, and perhaps beyond the scope of their regular psychologists, let's say. Is that a gap that you

are concerned about as well? Are there barriers to engaging with services based on that criterion of whether or not someone has actually attempted suicide?

Ms Leavens: In general in this space, I think there are a number of barriers around access. There is eligibility—that kind of "attempt requirement" to get into some of these aftercare programs. I think there are a number of issues. There is an awareness—just kind of knowing what is out there. It can be quite sporadic in terms of what programs are available, the eligibility requirements and then timely access. I think the gap is ensuring that consistent understanding of what is available in the community.

THE CHAIR: Is there something available in that exact kind of gap or space that I was just describing?

Ms Leavens: Not that I am aware of and not that we fund—although we fund a number of mental health services that engage with people who probably fall into that cohort. But, in terms of a specific program, not that I am aware of.

THE CHAIR: Are there other jurisdictions where there is something where, essentially, you are suicidal but you have not made an attempt yet?

Ms Leavens: I am not sure.

THE CHAIR: Would you be willing to take that question on notice, to have a look at what might be available and whether there is consideration been given to providing such a service in the ACT?

Ms Leavens: Yes.

MS BARRY: I want to ask one really quick question. Do you correlate your report on suicide prevention data specific to the ACT?

Ms Leavens: We would have some information available through our needs assessment on rates and things. Is there a specific type of data you are thinking about with that question?

MS BARRY: I guess generally just to inform services. The needs data is one of them. What would it tell us? What would the data say? What does it collect?

Ms Leavens: I would have to take that on notice as well.

MS BARRY: Okay; sure. Thank you.

MS TOUGH: I know you are the provider of the two Medicare mental health services here in Canberra.

Ms Leavens: Yes.

MS TOUGH: What do the people that come to you need support with? Is there support there for someone who is coming in who might be thinking about suicide or has had an attempt in the past?

Ms Leavens: Yes, absolutely. I think that is a really good point. That sort of goes to the question about specific services. Medicare mental health services are not specifically a service around suicide prevention exactly. But, absolutely, people come in. The benefit of that is that it is a walk-in service; so people can just drop in. What we often hear from the centres is that they do have people who come in to have a bit of a de-escalation, to debrief, to just get some immediate support.

The way that those services run is that people can walk in, they can make an appointment and they can call. There are a range of services. It is really multi-disciplinary—so whatever that person is coming in with. We know that people are accessing that who may be at risk of suicide or have made attempts in the past. Those are absolutely services that are available—again, more broad but open for people having that experience.

MS TOUGH: Wonderful. Thank you.

THE CHAIR: On behalf of the committee, I thank you for your attendance today. You have taken a couple of questions on notice. Could you please provide your answers to the committee secretary within five business days of receiving the uncorrected proof *Hansard*. Thanks again for taking the time to submit.

Short suspension.

MARTIN, DR SEAN, Program Lead, Ten to Men Study, Australian Institute of Family Studies
NEVILLE, MS ELIZABETH, Director, Australian Institute of Family Studies

THE CHAIR: We welcome witnesses from the Australian Institute of Family Studies. Please note that, as witnesses, you are protected by parliamentary privilege and bound by its obligations. As such, you must tell the truth. Giving false or misleading evidence will be treated as a serious matter and may be considered contempt of the Assembly.

The committee recognises that some of the issues raised in this inquiry are sensitive. We have a duty counsellor available on site to provide support if needed. The secretary also has a support handout, which includes tips and strategies for self-support and referral points, in case of a crisis or more in-depth counselling support.

Would either of you like to make a brief opening statement, covering any matters that are not addressed in your submission?

Ms Neville: Thank you, Chair. I will make a few brief comments and then give the floor to Sean to make some further comments. Sean is our male health expert and is a key witness, at least from my perspective. I will just make some preparatory comments.

I begin by acknowledging the traditional owners of the lands on which we are coming, in my case, I am coming from the lands of the Wurundjeri Woi Wurrung people of East Kurin Nation. I certainly pay my respects to Elders past and present as well as any Aboriginal or Torres Strait Islander people who may be present with us today.

The Australian Institute of Family Studies, or AIFS, which you may have heard us refer to ourselves as, is the Australian government's key research agency on family wellbeing. Our purpose is to create and communicate knowledge that informs government policy and accelerates positive outcomes for children, families and their communities.

With respect to the terms of reference for this inquiry, we believe that the health and wellbeing of Australian boys and men is directly tied to the wellbeing of Australian families and their communities. Our work shows that men's suicide cannot be understood in isolation from the broader social and relational contexts of men's lives and their roles as partners, fathers, friends, workers and community members. This view, working in collaboration with a variety of government research, community and service organisations, will continue to inform the research we conduct into the future on this critical issue which is fundamental to the wellbeing of Australian families.

A key source of data for building the evidence base in this area is Ten to Men, the Australian longitudinal study of male health, funded by the Australian government Department of Health and managed by AIFS. The study began in 2013 and generates findings to inform government policies, programs and services in male health. The National Men's Health Strategy 2020-2030 guides the study and sets out priority study areas, including in relation to male mental health. I will pause now and hand over to our male health expert, Dr Sean Martin.

Dr Martin: Thanks, Liz. I would like to thank the Chair and the committee members

for the opportunity to appear before you today. I also pay my respects to traditional owners and acknowledge any Indigenous colleagues that might be joining us today.

I am a researcher who has spent over 20 years working in the field of men's health to help improve the health and wellbeing of Australian boys and men. Over the past few years, it has been my privilege to act as the program lead for the Ten for Men Study at AIFS, our national longitudinal study of Australian boys and men and now the largest-ever study of male health worldwide.

Like many of my colleagues, I am all too familiar with the statistics around male suicide in Australia and across the world more generally. Equally, I am aware of the devastating and far-reaching consequences of male suicide for the friends, colleagues and families left behind. As our director has just stated our work at AIFS shows that men's suicide cannot be understood in isolation, in the broader social and relational context of men's lives. Across our research, we have identified that many men experience compounding risk, social disconnection, barrier against health seeking, challenging life transitions such as job loss, separation or aging, which can erode a sense of identity and purpose. These factors often operate long before a crisis point has been reached.

Our job moving forward is to make this evidence usable, helping policy and law makers, service providers and the broader community to target prevention efforts and tailor health systems to the real patterns of men's health and men's lives. We are committed to continuing to share our insights in support of the ACT's efforts to reduce male suicide and strengthen Australian families and communities.

THE CHAIR: Thank you. Your submission references adolescents as a particularly sensitive period. What is your understanding of that? Why is that a sensitive period? Is it because that is when that awareness of the traditional masculine norms and the kind of stigma can emerge in seeking supports? I am really keen to dig into that, if you have any additional insights.

Dr Martin: Thank you, Chair. I think there are probably two dynamics at play when we are talking about male suicides. There is suicide, lethal suicide and also non-lethal behaviours—so suicidal thoughts and behaviours. Particularly when it comes to adolescents, that is where we start to see those suicidal thoughts and behaviours really start to peek. Then, for males, the peak period of suicide breaks are in the 40s and 50s. To your specific question around why that is a particular area of concern in terms of adolescents, as you point out, this is where a lot of our foundational attitudes and beliefs are formed.

I should also say, particularly in my current capacity as Acting Research Director for Data and Life Course Study at AIFS, that we also have steerage of the LSAC studies, the Longitudinal Study of Australian Children. They have recently—just after our submission—published a report looking at suicidal thoughts and behaviours, showing that early on these sorts of behaviours peak in females but that, as you enter out of adolescents and start to get into the early 20s, that is where the male rates tend to catch up. From beyond there, we know from other datasets that it then starts to exceed those risks that we see in the female population and then extend, obviously, to a threefold increase around suicides in general in mid-life.

To your other question around what is going on with adolescents, a focus for us here at Ten to Men is to revisit that question. One thing we know is that the challenges that adolescents are facing are rapidly evolving. Unfortunately for Ten to Men—and just for context for you and the rest of the committee—we started by recruiting males aged 10 to 55 in around 2012 and 2013, as our director has pointed out, and so they have essentially aged out of that criteria or that group at the moment. We are very keen to revisit that, because we are aware that some of the online challenges, in particular, that young men face and are increasingly targets of has rapidly changed. So we want to revisit that and use our dataset to compare challenges that adolescents faced 10 or so years ago and the challenges they are facing now and what we, as both government researchers, working very closely with our other key stakeholders, can do to address that.

THE CHAIR: On that, does Ten to Men track any data relating to outcomes for men who have made a non-lethal suicide attempt?

Dr Martin: Yes, we certainly do. To a large extent, we are thankful for the previous managers of the study. University of Melbourne Professor Jane Pirkis established Ten to Men and then the study transferred over to us in late 2017-18. As you may well be aware, she is one of Australia's leading researchers when it comes to suicide, particularly male suicide. As a result of that, we have a quite a large footprint of suicide-related measures—suicidal ideation, thoughts about suicide, suicide plans and suicide attempts—and we have that both in the past 12 months and also lifetime. That is data that we have been able to utilise through some of our research, some of which was included in our submission. Certainly we plan to continue to use that going forward.

THE CHAIR: Do you have a sense of the level of provision of aftercare services for those who have attempted suicide? How many of them are connecting in with the service and not attempting again? What are the insights you might be able to share with us there?

Dr Martin: That is a great question. One of the big challenges for us going forward is to dig deeper into not just the health service provision but also a broader range of the care and supports that our cohort, including those who make attempts, are attempting to connect with. What we can say is that there is a gap around health service provision in the first instance—and I will get to your point around after service care shortly. Again, and I will just refer to my notes here, being mindful this is going into *Hansard*. We see a significant proportion of men who have clinically significant depressive symptoms—noting that that still remains the strongest predictor of suicidality—not attempting to engage with the health system. We really feel that there is a strong effort that we and others require to try to develop a gender responsive healthcare system.

To your specific question around what services people are engaging with after they have disclosed that they have made an attempt, that is something that we have, frankly, have not had the opportunity to look at as yet. We are commissioned, through the Department of Health, as the director mentioned, for one report per year. That is in terms of AIFS research. One of our primary jobs is to put the data into the hands of experts. As part of that, we are doing a lot of effort on the front end to directly engage with subject matter experts to try to encourage them to look at these sorts of issues and other issues related to male suicide.

THE CHAIR: Okay. Thank you, Dr Martin.

MS BARRY: Thank you for attending today. I have a question around your data. I think you noted that about three in 10 Australian men accessed Medicare-funded mental health services in recent years. Do you know what proportion of men with high risk did not access services? What were the barriers reported?

Dr Martin: That is a great question. That particular report that you are referring to dates back to 2020. It was one of the first issues that we looked at when the study transferred over to AIFS. In relation to your first question, one thing that we saw is that, whilst we do see regular engagement of men in general with GPs, only 40 per cent of those who had clinically significant depressive symptoms were actually seeing a mental health professional. So there is a significant gap there between demand and behaviour that we see with our men.

Moving forward to today, as we mentioned, we are very much involved in trying to work with colleagues in the sector to create a gender responsive healthcare system. I think part of that relates to how we actually measure and detect depression, so that there is an evolving view of what male-type depression looks like. That is something that we hope could help to address some of those issues.

In terms of specific barriers that we looked at, particularly during that earlier report, we saw that there was a strong statistically significant influence of stigma associated with mental health. So, for those men who had not accessed services who had demonstrated a clinical need, there was a low level of health literacy, particularly literacy around mental health issues. We also saw that there was some association with masculine or some particular domains of masculine norms discouraging from seeking help when they need it.

MS BARRY: You also mentioned your data captures trajectory of psychological distress over time. Are there are identifiable turning points or windows of opportunities where interventions could especially be effective, according to your findings?

Dr Martin: It is a really great question. Again, as our director has just kind of pointed out, we are increasingly taking a view of being very targeted or trying to work with others to be very targeted during those prevention windows. We think that there are particular issues around family dissolution—obviously, that is a key focus for us at AIFS—and where there are relationship challenges. More broadly, if you look at risk periods over the life course, there is a particular risk period that emerges for young men, for adolescents and there is also—it is sort of a u-shaped curve—an emerging awareness of the issues that are around for particularly older men. That is something that we are also looking at for our study.

But very broadly, when we looked at this in, I think, 2022, the broad kind of drivers for men in general. For younger men—that is, essentially men aged under 50—and a lot of the key intervention points relate to economic factors; for example, loss of employment. That is not only through financial reasons but often, for a lot of men, there is a loss of social connection that is associated with employment. For our older guys, it more maps to familial-related issues—so, again, relationship breakdowns or issues related to direct

family members, including obviously people who unfortunately lose their life partner. That is also another peak period around suicide risk.

MS BARRY: You mentioned masculinity as one factor that is a barrier to men accessing mental health. I just wanted to tease that out a little bit. What does that mean? We hear that a lot in society.

Dr Martin: I assure you that we do as well. I think it is a topic in which there is an evolving view of masculinity. I am sure as you have also heard, we speak a lot now about healthy masculinities. The initial measure that we ran in 2020 relates to self-identified masculine norms using an older measure that was developed in the early 90s, which is called Conformity of Masculine Norms Inventory. Our view now is that that perhaps has a view of masculinity that does not resonate with how men see themselves now.

There is an emerging view—which, frankly, comes from some our learnings that we have taken from Indigenous men's health—around the limitations of using deficit space language with your key target population. For a lot of our colleagues, we initially spoke—many decades ago now—about flexible masculinity, noting that masculinity is not a fixed trait. I think some of the things that we see, particularly recently, demonstrate that masculinity is susceptible to change for a variety of influences. But, likewise, men are able to exercise their agency as men to sometimes be vulnerable, to sometimes demonstrate resilience et cetera—and, frankly, that is something we see across the gender divide.

One thing that we are working on very closely—both ourselves and others—is to develop measures that better capture masculinity. We are involved with some conversations that will hopefully lead to a measure around positive masculinity that we are able to run at our next wave of data. For your reference, as of Monday, we will be releasing our wave 5 data, and we are already starting to think towards our next wave of data, which is due to be collected as of August next year. Hopefully, if we get things right, we will have a measure that we can run around positive masculinity. I think that might help create a more productive way of how we have both encapsulate and measure masculinity in a way that can ultimately help men who might be at risk of suicide and a range of other health-related and general wellbeing measures.

MS BARRY: Thank you.

MS TOUGH: I just want to, firstly, piggyback a bit off the masculinity stuff. In breaking down those barriers around masculinity and what is masculinity, do you see, a role for masculine men with influence—particularly in that younger age group of men—to talk about mental health and to use language that does start to destigmatise?

Dr Martin: You are exactly right, and I think we are starting to see that more and more. Our report spoke to an issue around stigma and mental health and that preventing men who had a genuine clinical need from accessing health services. That is something we increasingly see. I think the way forward really from here is to adapt this positive role model approach. That is something we increasingly see not just with our study or our intention for future studies but also with other stakeholders, and that extends not just to young or adolescent boys but also right through the age course—that modelling kind of

behaviour that we feel will lead to a better outcome. So, yes, in short, I think that is part of the solution moving forward.

MS TOUGH: Wonderful. I now want to switch up to a different part of your submission. The submission talks about men from culturally and linguistically diverse backgrounds were found to be at a 69 per cent reduced risk of suicide or ideation compared to men not from culturally or linguistically diverse backgrounds. Can you provide some insight into this? We have also heard some submissions from people of CALD backgrounds that they are at an exposed risk, with experiencing linguistic difficulties, in being in the community and with accessing healthcare. Then there is stressful cultural adaptation and there is potential separation from family. I am interested in how that plays out in the data you have collected and the research you have done.

Dr Martin: It is a great question. It is one that, frankly, caught our eye as well. If I am honest, we probably expected the relationship to go the other way, given some of those issues that you just sort of pointed to. I guess part of this points to the limitation of examining data at a population level, in that there are lots of stories that are there. One of the things that we have recently done for Ten to Men is engage in a sample top-up. That is adding an additional 10,000 participants to the existing 13,000 or 14,000 we already had. They were included in part of the main study for wave 5. Part of that was to over-sample what, for one of a better term, we will call CALD communities, to dig into some of those issues.

I am very much aware that the notion of CALD communities is not necessarily a topic or nomenclature that many people enjoy—so I am speaking very generally here. I know, through some of the qualitative evidence that I am aware of, there is an issue where some people feel like they cannot disclose mental health issues. So that might be what we would call a measurement error. There are certainly other factors at play to talk about. Some of the health literacy effects we spoke about earlier, particularly around mental health literacy, were particularly acute for CALD communities. So that is something that we would like to look at either directly ourselves or in working with others in the future.

A report that we are due to release in about 12 days talks about some of the challenges that CALD communities face in relation to things like discrimination and how that has a direct effect on their mental health. So if you follow that thought line through, then that should increase the risk of suicide as well. But this is a kind of a pattern we see elsewhere, where sometimes we have a headline figure, or headline statistics, that we then really need to sort of unpack. That will hopefully be a feature of what we do in the future, particularly, as I say, now having increased the overall sample size, which gives us capacity to look at a range of these issues that underline those broader headline figures.

MS TOUGH: Wonderful. Thank you.

MISS NUTTALL: When you talk about those specific risk points in time when it comes to employment for younger men and relationship breakdown, retirement and things like that, what have you found to be the best ways to make men aware of services that explicitly address and help in those instances—as part of the issue awareness—and

how do you make people aware of what works?

Dr Martin: I think that is another great point. I feel like we are at the start of that conversation. There is a tendency, particularly in mental health circles, to talk about "the stigma issue has gone", because it has been our experience that 10 years or15 years ago there was that erosion of not being willing to talk about mental health issues. But I still feel in the broader community that that still needs to play out a little bit. Going directly to your question around which services and under which circumstances should be recommended to men, I feel like your question still has a little bit of time to unpack until we start to see some of those benefits on the ground.

I will say, though—and I think this is particularly related to AIFS—that, whilst there is a lot of focus on the health system, I think much more broadly we as society need to improve out mental health literacy in relation to men's health. That is why we are doing a lot of work with colleagues at the moment looking at male-type depression—just to gain a general recognition of what depression presents as, so that we have opportunities as friends, as colleagues and as the general community to do a better job at capturing people who might be at risk through various stages of life or following a variety of social life events and to sort of help herd people who do need help in the right direction.

One of the things that we have been able to examine within the study is a specific question around who men turn to when they have an emotional behavioural problem. Very clearly, the health system is a third, fourth or fifth order priority. A lot of people, particularly men, will seek advice and emotional support from partners, from friends and sometimes also from some of the community services that they are involved in. So I think, as a study, again working with others, we need to do a better job at understanding what people who are experiencing significant mental health issues and ultimately at risk of suicide look like and how we respond to that as a general community in order to make sure that they receive appropriate care.

MISS NUTTALL: Absolutely.

Ms Neville: I was just going to build on a point—and Sean may be able to elaborate here. We recently produced a report on fathers of newly-born babies and the extent to which they experienced depression. One of the things that was quite interesting to me, in my reading of that report, was that there is really good community awareness about postnatal depression for women. It would be my sense that there is quite strong awareness about the issue of postnatal depression for women and the fact that a pre-existing mental health condition or a history of mental illness in the family can be a risk factor for postnatal depression in women. It is not radically different from men, but it is not really a thing we are talking about. This is what the research highlighted.

From my perspective, as the leader of the Institute of Family Studies, that to me really highlights that we need to have a much more family-oriented approach to antenatal services. Albeit there are obviously very significant concerns for women's health during that period, I think we need to be careful that we are bringing fathers into the equation very early and that we have a gender responsive approach at that point and know the many other points in the intervention kind of continuum. That recent report was kind of eye-opening for me.

THE CHAIR: On behalf of the committee, I really thank you for your attendance today. Thank you so much for contributing, for making the submission and for the work that you are doing in this area.

Ms Neville: Thank you.

Dr Martin: Thank you.

Short suspension.

SANKAR KUMARA SURIYAR, MS NIRMIDHA, Undergraduate Researcher, South Asian Research and Advocacy Hub, Australian National University
SRIHARAN, MS SAHANA, Undergraduate Researcher, South Asian Research and Advocacy Hub, Australian National University
SYED, MR SHANEEQ, Undergraduate Researcher, South Asian Research and Advocacy Hub, Australian National University

THE CHAIR: We welcome witnesses from the South Asian Research and Advocacy Hub. We will use the acronym SARAH. Thank you very much for your submission and for being here today. Please note that, as witnesses, you are protected by parliamentary privilege and bound by its obligations. You must tell the truth. Giving false or misleading evidence will be treated as a serious matter and may be considered contempt of the Assembly.

The committee recognises that some of the issues raised in this inquiry are sensitive. If anyone is finding this hearing difficult, we can take a break. A duty counsellor is available on site to provide support if needed. A support handout is available at the entrance to the committee room which includes tips and strategies for self-support and referral points in case of a crisis or if more in-depth counselling support is needed.

We do not have much time. Would any of you like to make a very brief opening statement in addition to what has been said in your submissions? It is okay if the answer is no.

Miss Sriharan: I can. As part of this group, I, alongside my peers, advocate for the South Asian diaspora in Australia by writing submissions to parliamentary inquiries based on our experiences and our undertaking of research. I am the co-author of the submissions. I wrote submission 1, which discusses the lack of culturally sensitive counsellors in the ACT. Submission 2 highlights the academic pressure faced by South Asian children. And submission 3 is about alcohol and substance abuse issues faced by South Asian men. In the submission, I have provided a general overview and elaborated on recommendations aimed at improving the health and wellbeing of South Asian men. I would like to thank you all for this opportunity.

THE CHAIR: Thank you very much. My question is about services like multicultural youth services and how reliance on mental health programs for culturally and linguistically diverse people and volunteer efforts can impact the capacity of those services to actually serve the community? Is that something you have concerns about?

Miss Sankar Kumara Suriyar: I could speak on this. I wrote submission 6, which discusses the lack of safe spaces that allow South Asian youths to discuss mental health. Many of the multicultural organisations are underfunded because they are all community organisations. Many of them are run by volunteers and rely on grants. Because many of them are multiculturally run, a lot of people do not know that they can apply for grants or do not know how the grant system works. There is also a lack of multicultural-specific mental health grants that could be awarded or grants that support multicultural youth services, at least in the ACT. That is one of barriers that we identified.

In terms of South Asian communities, discussions around mental health are still very

limited due to stigma. Stigma is one of the main reasons. It is of one of the reasons you do not see many organisations trying to target these sorts of mental health safe spaces or allowing community groups to discuss mental health in a safe way. It is a funding issue, but, also, the community needs to mature enough to actually want to discuss these issues in a safe way.

THE CHAIR: With respect to the funding issue, does that mean that maybe the answer is that there is not a sufficient number of services or there is no capacity to communicate the services that do exist?

Miss Sankar Kumara Suriyar: It is a two-way street. There may not be enough services that provide the sort of specific funding that can be taken by these communities, but, also, communities themselves do not know how to advocate for themselves or they do not know how to ask for the funding that they need.

THE CHAIR: Thank you.

MS BARRY: Thank you for appearing today. I have a couple of questions around parents and the supports that parents need. Your submission noted parents in Canberra noticing changes in their son's behaviour—withdrawal, aggression and substance use—but not knowing how to respond. What specific signs do parents report often missing, and what culturally safe guidance could help them act before the crisis occurs?

Mr Syed: Usually parents report stress, isolation and guilt among children. In our study, we saw that it is usually based on cultural differences—cultural distortion, between the culture in the home and the culture outside of the home. There is discontent in that, and that may lead to some parents missing signs of possible stress, or possibly playing it down or maybe not accepting it as an actual issue—that it is a temporary stage in their life, and so on. We saw a lot of that. I did submissions 4 and 5, particularly on the parents, demonstrating the emotional toll on the children of migrant parents—the discontent between the two.

MS BARRY: Are there any examples in the ACT where parent-led early intervention prevented escalation? Do you have anything on that? It is okay if there is not.

Mr Syed: In my recommendations in submission 4, I mainly looked at how some migrant communities can have community-led support networks. Having those support networks can help parents and maybe help parents understand their children. In a community-led support network, you are with migrants of the same community background and you can discuss: "My children feel like this. What are some of the strategies going forward?" You can discuss certain issues, like mental health or stress. I cited a few in Victoria. VICSEG is non-profit and provides training, early childhood programs and health support for migrants and refuges. I also cited how community-led support groups can demonstrate improved migrant wellbeing. What I am trying to say is that, when you improve the wellbeing of the parents, in turn it can be transferable and improve the wellbeing of the child as well.

MS BARRY: Thank you.

MS TOUGH: I am interested in the experience of younger South Asian people—

students moving to high school and college and then post-school life. The submission talks about current school counsellors and youth workers. I am interested in the services they are offering or the services that might be missing in that space. Also how that plays into university being seen as the be-all and end-all of post-school life. What is missing in showing that maybe TAFE and CIT are just as wonderful as going to university—that there are other pathways for a future career? How does that all fit together? How do young people experience that?

Miss Sriharan: Thank you for the question. I did research and read about the academic and career pressures on South Asian people. This originated from my personal experience of hailing from a South Asian background. From many people in my family and the community in Melbourne, I have heard stories of young people pressuring themselves to do well, but it also comes back to repaying parents. It is a sort of debt repayment. Many children honour parental sacrifice, particularly migrants who travelled from war-stricken places to live in a better country like Australia. We all put a lot of pressure on ourselves to do well academically to repay our parents, and that creates a moral obligation that goes beyond just academic pressure.

In my research, I also found migrant youth experiencing conflict around education due to pressure. Because of the pressure we place on ourselves, some young people, particularly from CALD and South Asian backgrounds, fear talking to their parents about it. During my research to find potential recommendations, I found two great school programs in Canberra. One was run by St Edmund's College. It runs a careers expo. At the careers expo, they work with former students. They arrange alumni sessions to get former students to come to the school and provide information to students. Likewise, Mary Mackillop College provides a learning alumni program that does a similar thing.

Reflecting on the initiatives that are currently run, it made me think of the potential of having alumni students from various cultural backgrounds coming to schools and providing information for current students as a way to tackle the pressure they place on themselves—sometimes it is parental pressure—and also how to bridge the gap between them and their parents so they can have healthy conversations. Go8 universities do not have to be the end goal. Encouraging South Asian students and CALD students to TAFE and other great avenues for tertiary education can also help our community as there is currently a skills shortage in nursing, hospitality, construction and IT. Having alumni programs in schools would be a great way to tackle this problem.

MS TOUGH: Wonderful. Thank you.

MISS NUTTALL: So you think alumni are the best people to communicate and essentially provide peer support for young people. Do you see a role for career development professionals within schools—people who facilitate work experience and make industry pathways? Do you think there is a role for them to play in support for young people too?

Miss Sriharan: Yes. I think it would be great to also have career development professionals giving their expertise in career development. Alumni students may not have that same level of expertise. In high school, our career development program was very beneficial. It helped me plan out options and consider other pathways, other than

the Go8 universities. With that is a caveat. It is really important that career development programs are also culturally competent. That could possibly be achieved by employing career development staff and experts from various backgrounds or maybe having virtual or hybrid sessions with mentors from other states. It may be infeasible in some circumstances to have a wide range of staff from various backgrounds, so perhaps virtual programs or hybrid programs given to students would also be beneficial.

MISS NUTTALL: Thank you. When it comes to exploring pathways outside of university and academia, do you see a role for anyone in the school to essentially broach the topic with students' parents, when it could be difficult sometimes, given the moral obligation that you have to repay your parents? Do you think someone in a school might be well placed to have that conversation with parents and advocate on a young person's behalf?

Miss Sriharan: That is a great question. Coming back to my experience and my community, in many South Asian families I see that educational success and achievement is emblematic of a family's social status. Coming back to your question and with that in mind, there are alumni who have done exceptionally well and have not taken the traditional route that parents expect of their children or children place on themselves, such as attending the Go8 universities to study law, medicine, engineering and those types of degrees. Perhaps alumni students who went to TAFE or made use of other avenues to do exceptionally well in their tertiary education could go to schools and give parents more information, perhaps in an informal seminar, to break down misconceptions and misinformation that is prevalent in South Asian communities.

MISS NUTTALL: Thank you.

MS BARRY: You talk about culturally-competent psychologists. I want to explore that a bit. How do you see that fitting in? And what is the role?

Miss Sriharan: It is really important to have culturally-competent psychologists, especially in schools and also for young men in Canberra, and Australia more widely as well. There are special considerations from a cultural standpoint. In my research, I found that CALD groups in Australia experience a higher degree of mental health problems compared to other demographics. When considering why, I realised—and this goes to Shaneeq's point—that there is a high prevalence of isolation. Children and young people are quite isolated from their parents. Also, there is stigma. Stigma is quite prevalent around mental health in South Asian communities. It emerges as a major barrier to seeking help, which compromises the young individual's quality of life.

In some research that I uncovered, I found instances where counsellors blamed the family around the individual for putting on pressure, without recognising the role culture plays in shaping South Asian parents and children. This perhaps stems from their expertise as well as a fundamental lack of understanding of why families are unwilling to understand or fail to understand the impact of poor or untreated mental health problems. Going to the point about masculinity that was raised earlier, culture plays a role in masculinity. In many South Asian families and those from other CALD backgrounds, men typically play the role of the provider and the protector for the family, and this shapes strong cultural expectations for them to be the primary breadwinners. There is also emotional stoicism. Traditional masculinity norms often

discourage showing weaknesses, leading to the suppression of emotions like sadness and vulnerability, and this in turn leads to an increased stigmatisation of mental health. The stigmatisation then results in young men and families failing to treat mental health problems.

MS BARRY: One issue that has been raised with me a couple of times around the barriers to men seeking help, especially young boys or men from South Asian communities, is the lack of understanding of psychologists and psychiatrists around the culturally sensitive issues you mentioned. One recommendation that was raised was that these cultural competence issues should be incorporated in units offered as part of the psychology degree, for example. Have you seen that? Is there anywhere in Australia where that is currently happening? If there is not, what do you see that looking like? What are some of the elements you would like to see in such curriculum efforts?

Miss Sankar Kumara Suriyar: In Sahana's submission, she talks about the multicultural youth services that are in the ACT already. Could you expand on that?

Miss Sriharan: Yes. In my submission, I listed multicultural youth services. They provide a one-off interactive session that addresses a range of topics, including mental health. This is done in schools. From my current knowledge and the research I have undertaken, I am not sure about any current courses that are provided—for example, tertiary degrees or psychology degrees. I would like to take this question on notice, if that is okay. I would be happy to do some research and get back to you.

MS BARRY: Thank you. That would be awesome. Include what it would look like.

Miss Sriharan: Yes.

THE CHAIR: You mentioned stoicism and the challenges in seeking help. What do you think is the role for the government in addressing that? Is it more support for peer-led programs? What are one or two things that the government could do to help? What would that look like?

Ms Suriya: That is the thing: mental health permeates everywhere. If you address it in school, if it is not addressed in the home, how far can it go? One thing that we have identified is that counsellors can be a really good avenue, especially in schools, because that is where the kids are. It is a great place for those sorts of services to take place. It is about encouraging the training of counsellors in schools to be more culturally competent. One thing that we should raise is that, throughout the submission, it may sound like we are almost blaming South Asian communities for having the stigma. That is not the intention of the submission; it is just raising that an issue. There are many reasons behind it. Having counsellors who understand the psychology of parents acting that way and being able to provide services would be a good recommendation.

Another would be to encourage more community organisations to support the mental health of both parents and kids. A lot of parents, especially migrant parents in CALD communities, rely heavily on multicultural organisations when they first come to the country and settle into the community. They rely on a lot of these organisations because they have been here for so long and can show them the ropes. It is about encouraging those sorts of cultural organisations to have more conversations around mental health,

and that can be through funding organisations to run youth initiatives that allow kids to talk with each other about mental health or, as Shaneeq mentioned, letting parents meet each other and discuss any signs that they notice in their kids. Those two would be the best recommendations, but those are just two.

THE CHAIR: Thank you.

MISS NUTTALL: When it comes to community-led workshops and pamphlets to teach parenting skills and things like that, do you have a vision of what they look like in practice? Do you think there are clear things that would make it work well?

Mr Syed: I am happy to take that question. In submission 4, on community-led support groups, two that I mention are in Victoria. They run on a sense of trust as well—trust that it is a safe space, that you will be understood within the community, and that these problems are not exclusively about you. A lot of CALD communities will think that certain issues in their family or certain mental health stigmas relate solely to their family—that they are the only ones facing it; that they are the only ones going through potential financial difficulty or issues related to migrating to Australia and the different culture.

In terms of those models, I listed two in Victoria. Under those models, they provide community educators from within the ethnic groups to deliver services. These services are curtailed towards CALD community individuals. There is potential for these community groups to be replicated in the ACT. They can effectively reach South Asian families in a more efficient way. I echo Nirmidha's point regarding more emphasis on already established community-led groups that have built-in trust with the South Asian community. The government could support those community-led groups.

MISS NUTTALL: Do you think it would work if ACT communities consulted with those Victorian community-led groups—for example, getting them here for a few days to set up a program initially? Do you think something like that would work or does it need to be tailored to the community and the place? Would it need to be ACT-specific?

Mr Syed: To say that, broadly, all CALD communities in different cities have the same experiences would be a bit reductionistic. I am not the one to speak on behalf of the community support groups. They will have their own procedure on how to potentially implement it in the ACT. I would leave the processing to the community groups because I am sure they are doing a really good job in Victoria right now.

MISS NUTTALL: Thank you. That is really helpful.

THE CHAIR: We will have to leave it there. On behalf of the committee, thank you for your attendance today. You took one question on notice. Please provide your answer to the committee secretary within five business days of receiving the uncorrected proof *Hansard*. Thank you very much.

Short suspension.

HERBERT, MS AMY, Manager, Policy and Engagement, Alcohol and Drug Foundation
REID, MRS ALLISON, State Manager for NSW/ACT, Alcohol and Drug Foundation

THE CHAIR: We welcome witnesses from the Alcohol and Drug Foundation. Please note that, as witnesses, you are protected by parliamentary privilege and bound by its obligations. You must tell the truth. Giving false or misleading evidence will be treated as a serious matter and may be considered contempt of the Assembly.

The committee recognises that some of the issues raised in this inquiry are sensitive. If anyone is finding this hearing difficult, we could take a break. A duty counsellor is also available on site to provide support if needed. A support handout is available at the entrance to the committee room, which includes tips and strategies for self-support and referral points.

Would perhaps one of you like to make a brief opening statement covering any matters not addressed in your submission?

Mrs Reid: I will make brief opening statement. The Alcohol and Drug Foundation is Australia's leading organisation committed to inspiring positive change and delivering evidence-based approaches to prevent alcohol and other drug harms. We provide up-to-date evidence-based information and run two large prevention programs—the Good Sports Program with community sporting clubs, and place-based community-led local drug action teams. We are an alcohol and other drug prevention organisation, rather than a suicide prevention organisation, but our work is related to this inquiry as alcohol and drug harm is a common risk factor to suicide death.

Evidence shows that alcohol and drug prevention can lower the risk of both alcohol and drug harm and suicide risks at an individual at a population level. Men continue to be over-represented in suicide mortality rates and alcohol and other drug mortality. There are some cohorts, such as trans men, who are over-represented at a greater extent. Alcohol and other drugs prevention targets the use and harmful effects of substances and protective factors. Though suicide prevention and alcohol and other drug prevention are distinct, they have a two-way relationship, and attention to one pays dividends to the other.

Most suicide prevention strategies in Australia recognise the need for collaboration but they actually do not identify priorities. At the Alcohol and Drug Foundation, we would like to see suicide prevention strategies support four key areas: one, addressing the increase in accessible alcohol and drug treatments and supports, including digital supports, as alcohol and drug use is a factor in many suicides; two, a reduction in alcohol and drug stigma, as we know isolation is not good for anyone; three, more investment in alcohol and drug prevention and harm reduction, because alcohol and drug harm has implications for suicide risk; and, four, adoption of policy measures to reduce alcohol consumption, because evidence shows us the link between population, alcohol consumption and suicide risk.

THE CHAIR: Are your Local Drug Action Team Programs available in the ACT currently?

Mrs Reid: Yes. We currently have six in the ACT specifically. They cover a range of, I guess, prevention programs. We have one currently with Lifeline that deals specifically in this space. That is dealing with first responders—for example, the Federal Police and state emergency services. That has actually been delivered and we are in the reporting stage of that, so we can analyse how effective it has been.

THE CHAIR: Great. You mentioned in your submission that we would benefit from some targeted programs for young men in this space. Is that a gap? If I said you can roll out another six programs, where you be aiming those towards?

Mrs Reid: Amy, do you want to take that?

Ms Herbert: Sure. Alcohol and other drug prevention is really ripe for targeted information and advice, like information awareness campaigns and then also more community-led place-based initiatives. One example is the Good Sports Program. We did not include that in the submission, but it is also a nationally delivered prevention program. It works with sporting clubs to decrease AOD-related risks and help clubs get great healthy cultures around alcohol and other drug use but also build their capacity to engage on mental health issues.

We know from that program that we get a boost in awareness of mental health issues among the clubs when we do that sort of dedicated work. It is quite useful because it is a mix of online and in-person supports and they are very self-paced. It really works for sporting clubs that are volunteer based, as they can do it at their own pace. It is kind of a graded sort of thing where, the more progressed you are through the modules, you can get gold accredited and they show really good results in terms of awareness and capacity. That is one thing. When we talk about boosting supports for the Good Sports Program, what that means is you get more dedicated in-person supports with clubs. When we create really good cultures around AOD use in clubs there have been health impacts as well as mental health impacts.

The other thing that we have done recently—I cannot recall if we mentioned this in the submission—is focusing targeted information and advice for at-risk young people in high-risk occupations. We know that young men in the construction industry are at risk of alcohol and other drug harm. I understand that has a similar sort of profile in the suicide stats as well, but I do not have those to hand. We worked with HALT, which are focused on tradies, and we developed a campaign that talks to people about alcohol and other drug-related risks, including what happens when you mix drugs and that sort of thing. There is a dedicated website. It got great buy-in from the people who were involved in the program. The website is up there still. We are not actively promoting it, but it still gets quite a lot of traffic—and that is really useful as well. For young people, if you are thinking about what we want to do to lift awareness around AOD-related help and harm, that is a great avenue. You can really dig into your cohorts and do targeted messaging.

Also, we have been trialling since January an AI-assisted chatbot called "dib". You can jump on the website and have a look, but basically it provides non-judgmental evidence-based advice using human curated content from the Alcohol and other Drug Foundation. It is kind of like ring-fenced against some of the wilder and woolly sort of information that is on the web that we know that can provide misinformation. That has

really great engagement with young people, as you could expect, and we are finding that people are engaged on the AI tool for longer, and with some detailed questions, more so than they would on web-based services. We think that is really important.

We know that the phone is where you shop for alcohol but it is also where you look for advice and information, increasingly, and it reaches people that might not get information and advice in a face-to-face way through, for example, their GP. It is realistic; it is free; it is private; and it is confidential. Boosting that would look like more targeted information, evidence for young people to access and then supporting the development of the program and promoting it within different groups or across the ACT.

THE CHAIR: I have a quick follow-up on the Good Sports Program. Are you aware of the level of uptake that is happening in the ACT and how many clubs are involved? Also, how is that funded?

Mrs Reid: It is funded through the federal Department of Health. Across the ACT, we currently have about 250 clubs, but there is definitely potential for more. We have them in community sporting clubs—everything from darts to rugby, football, gymnastics and pickleball. We really have the capacity to take on more sporting clubs and pass that message out to more sporting clubs. On those that have joined the program, the response has been nothing but positive. We actually only have two staff members in the ACT specifically dedicated to Good Sports and the Local Drug Action Team Program.

THE CHAIR: Are they equitably distributed across Australia, jurisdiction by jurisdiction?

Mrs Reid: Yes; we have national coverage. I have probably nine staff in New South Wales and then two in the ACT.

Ms Herbert: I would add, if I may, that, while it is federally funded, state and territory governments can support the program through increasing on-the-ground supports to do things like lifting the accreditation status—so working a bit more intensively to get the engagement up and deepen the awareness and knowledge within each club.

THE CHAIR: Thank you.

MS BARRY: Thank you for attending today. Mrs Reid, you mentioned that there is a risk that increased consumption could also increase suicide risk factors. I know that the jury is currently out on decriminalising drugs in the ACT and whether there is an increase or a decrease. We are still waiting on data for that. Are there any things that you are doing currently to monitor or mitigate a potential increase in suicide rates due to that decriminalisation of drugs, and are there any trends that are coming through?

Mrs Reid: Amy, would you like to speak to that?

Ms Herbert: Yes. Thank you, Ms Barry. On the link between increased AOD use and suicide risk, the evidence talks more about the intensity of use, if you are dependent on substances or if you have acute chronic alcohol and other drug use and what that means in terms of your risk factor for suicide. I am not aware of any data around the ACT

decriminalisation and any impact that it has had on the intensity of use or, indeed, casual use and how that changed. We will be interested to look at that, but I think, whether or not use is changing, the Alcohol and Drug Foundation's position is always to take a health-focused approach to alcohol and other drug use and reducing harms. So we prioritise investment in health-based services rather than a criminal justice response. We are keenly looking at demands in trends, but we tend to approach that from a treatment access lens and prevention services lens.

MS BARRY: Thank you for that. How effective are current harm reduction programs at reducing that risk of an increase in the intensity of use from a health response?

Ms Herbert: Generally speaking, with harm minimisation, there are different indicators in terms of effectiveness, whether you are looking at prevention, treatment or harm reduction services. We know, for example, if you are looking at opioid use disorder, opioid-based pharmacotherapy is gold standard treatment. It is a rolled-gold option. Not many people have access to that; so access is, of course, a barrier. Prevention shows really great return on investment, alcohol and other drug treatment shows really good return on investment and so does harm reduction, because you see impacts on reduced chronic health conditions and so on.

Alcohol and other drug use, no matter what the intervention—whether it is a law enforcement or a health intervention—is often relapsing. The idea of how effective it is at reducing the risk of substance use really is dependent on a range of factors, but we do know that it offers a really great return on investment. For example, there was a study in 2017 that showed a $14 to $1 return on investment for prevention, which is really compelling.

MS TOUGH: In the foundation's research, it seems that men are more likely to use alcohol and other drugs as coping mechanisms compared to women. Do we know why?

Ms Herbert: It is a really interesting question. It is a complex issue. I think the research tends to look at the common risk factors. Relationship breakdown, social isolation and all of those things are relevant. There is a lot of research to suggest that men are less likely to seek help, and that will increase the intensity of distress and/or alcohol use. I think that is a really important factor. Stigma and the idea of gender norms have been posited as reasons as well.

MS TOUGH: It sounds like a really complex thing. How should alcohol and other drugs be considered when creating ways of approaching suicide prevention strategies? If men are using it more as a coping mechanism, how do we then factor that into suicide prevention strategies?

Ms Herbert: Suicide prevention strategies across Australia always mention alcohol and other drugs.

MS TOUGH: Yes, they mention that.

Ms Herbert: They mention it and then they move on. In terms of coping strategies, obviously alcohol and other drugs prevention, treatment and harm reduction are very trauma-informed. So experience of trauma, child abuse and neglect is obviously a factor

for most suicide distress and is often a factor in alcohol and other drug use. When we are looking at AOD prevention, treatment or harm reduction services, we need to make sure they are trauma-informed.

But, generally speaking, I think paying attention to AOD prevention to achieve a reduction in suicide risk means more than general commitments to collaborate. We really need to see an increase in accessible trauma-informed AOD treatment and supports, including the digital supports that I was mentioning before. We know pharmacotherapy for opioid use, as I was saying before, is really impactful but difficult to access—so that is really important—and making sure that the model is holistic; so it is not just about going to the GP and getting a script but also about whether there are other social and health supports around.

We also think that evidence-based alcohol and other drug education, including in the school setting, can make a real difference. That is around building confidence in making choices, being connected and those kinds of things—those types of school education supports. Then there are the community-led, place-based initiatives that do that building of protective environments so that, if I am a young man and I go to Good Sports and my club is confident in talking about mental health, I feel a bit more inclined to open up. It is creating more doorways. Then, of course, there is primary care and support.

But I do not think we can ignore those population level policies that go towards reducing risk. We know the World Health Organisation has recommended alcohol pricing policies. We know alcohol is everywhere in the suicide data and in the health harm data across Australia and in the ACT. There was one recent study this year that showed that, when you reduce population level consumption of alcohol by a litre, you get these reductions in suicide risk at a population level. It is really compelling data.

So it is about the individual factors but also the population level health policies and making them quite tangible and distinct in our suicide prevention strategies, rather than just leaving the door open.

MS TOUGH: Thank you. That is really helpful.

MISS NUTTALL: I am interested in asking specifically about the Screening, Brief Intervention and Referral to Treatment model, SBIRT. I would love to hear more about the program and how widely it is currently being used in the ACT. I think your submission also mentioned that its shows promises as a cost-effective intervention digitally?

Ms Herbert: Screening, Brief Intervention and Referral to Treatment is basically a sort of light-touch intervention that you can deliver in primary care settings or you can deliver integrated in other treatment services. It is basically screening, assessing whether somebody is at risk for risky drinking alcohol or other drug use, and then there are different types of structured interventions that you can offer to help people sort of assess their interest and willingness to change and the sort of measures to undertake change. I do not have the information on the extent to which it is offered in the ACT. I suspect that is quite a complicated question, because it can be delivered in multiple settings.

What we have been exploring lately at the Alcohol and Drug Foundation is the opportunity to integrate that into things like our AOD chatbot or other ways of accessing that screening. We offer a screening tool on our website which allows you to complete a questionnaire that sort of says, "I want to know if the way I drink, is that risky and in what way is that risky?", and then if you are concerned about it get that access to, for example, a digital referral. But there would be opportunities for creating more referral pathways and linking up that brief intervention to treatment service pathways. There are lots of different ways you can do it, but the evidence really supports the use of screening, brief intervention tools and processes, whether that is in-person, digitally or a mix.

MISS NUTTALL: Is that across all demographics?

Ms Herbert: That is a good question. I do not have that information but I would be very happy to return to you on that one.

MISS NUTTALL: If that is okay, yes, please. I am also interested in whether, especially if it is the kind of thing you can do digitally, that is helping us reach a cohort of the more rural and even just geographically isolated men in the process.

Ms Herbert: Exactly. We know that regionality really affects alcohol and drug-related harm, risk as well as suicide distress risk. So models that are adaptable and confidential and also can be delivered at scale, while still being able to be targeted, are really important. But I will return to you on the demographic impacts with screening and brief intervention.

MISS NUTTALL: Thank you.

THE CHAIR: I have a quick question about the local drug health teams. What kind of connections are there that could be created, especially between police and service provision? We are hearing all the time from people who are concerned about drug-related behaviour and they report those incidents to the police. Thankfully, a lot of the time it is not treated as a policing matter; it is a health matter—but still the police might be the first to respond. What is that kind of connection like and is there an opportunity for improvements there?

Ms Herbert: Specifically in the sporting clubs or generally?

THE CHAIR: More generally.

Ms Herbert: That is a good question. As I mentioned earlier, in the Alcohol and Drug Foundation, we take a health-based approach to alcohol and other drug use, but that does not mean that you do not work with law enforcement at all. Law enforcement have been critical over the years for achieving really great results in alcohol and other drug access to services. For example, they collaborate on making sure that needle and syringe programs operate well. They are a part of the community and they are engaged as part of a whole-of-community approach.

I think sometimes there are opportunities to engage with police to do education on alcohol and other drug-related risk and what that looks like. Alcohol and other

drug-related stigma is an issue across the community broadly and it is also an issue with first responders as well. So working with police on understanding alcohol and other drug use impacts is also really important, because, as you say, they are there in the community and they are engaging with people with AOD-related issues. So, yes, there is definitely a connection and opportunity to work.

One thing at a national level that used to be in place was the Ministerial Drug and Alcohol Forum, which was the body responsible for managing the National Drug Strategy. On that forum, there was police and health ministers, and they were able to talk about strategies that worked for states, territories and nationally across the board. That forum is no longer in place, which is a real shame. There is nothing that has really replaced it; so we do not get that sort of level of collaborative formal engagement at that sort of whole-of-government level, which would be great to see.

THE CHAIR: I suppose I am thinking about when they see someone who needs support. If they are affected by AOD and they call the police, because that is just who they call, and the police may not know who to call for that person to get support—"We are seeing drug-related behaviours but what you need is support, but I don't know how to get you that support." So potentially there is a missing link there where they call the police and we are taking a health-related response but then there is a disconnect in actually engaging with services.

Mrs Reid: I would just add to that and actually give you a really good example. How our Local Drug Action Teams work is we work with a lead organisation. That could be a PCYC, it could be a council, it could be Lifeline or it could be, in some instances, the police. So we have a lead organisation and then they have community partners. That is how our place-based community-led Local Drug Action Teams work. In quite a few of our Local Drug Action Teams, the local police are community partners. It has actually been a win-win, because it is breaking down those barriers. We are learning things about the local community from the police and they are learning things from us as well. It is building up that trust within the local community as well. That is definitely working in quite a few of our Local Drug Action Teams in New South Wales. We would like to see it work more across the ACT as well.

THE CHAIR: So there are not any teams in the ACT where ACT Policing are a lead partner?

Mrs Reid: I think the closest one we probably have at the moment is in Wagga.

THE CHAIR: So that is a real opportunity then.

Mrs Reid: Our Lifeline Local Drug Action Team involved the Federal Police, but they are not currently an identified community partner. They were just a recipient of the prevention program.

THE CHAIR: Understood. That is really helpful; thank you.

MS BARRY: There have been submissions that indicate that men from culturally and linguistically diverse backgrounds are at a higher risk of suicide. I just wanted to understand from your perspective whether there is a higher risk or a high indication that

men from CALD backgrounds—noting that that word is quite broad—will use alcohol and other drugs and whether there is any trend you are seeing in your data.

Ms Herbert: Great question. It is one of those areas we do not know enough about. Generally speaking, the evidence suggests that the use of alcohol and other drugs is lower among CALD communities. But, as you say, that is a very blanket group of people. There are different trends within cultural groups about not only usage generally—are people using alcohol more or drugs more?—and what types of drugs. So it is quite a complex question. My sense would be that it would change quite a bit depending on what jurisdiction you are in and also the profile of the community within each of the jurisdictions. We know that socialisation is a real driver of alcohol and other drug use, and having a really thriving community might be a protective factor for some groups.

I am sorry I cannot answer the question with greater specificity. But, generally speaking, AOD use is lower, but it really depends on cultural groups, the setting and age. The age trends among different cultural groups with AOD use would be very different.

MS BARRY: That is correct. I would make one point. Some of the research I have seen is that, for older men, for example, there is a bit more tolerance to alcohol and that, for the younger cohort, that tolerance is less because of the level of alcohol—that the older men are used to the intensity of it. It would be interesting to monitor that space in terms of younger male CALD men and whether that trend changes in terms of lower use, for example.

Ms Herbert: Yes. We know that, for any young person, the risk of AOD use can be associated with developmental delay. So we really emphasise the need to invest in policies and programs that lower the age of initiation for alcohol and other drug-regulated uses, so that people are older when they first try alcohol and other drugs. That is really important as well with, as you say, the sort of micro trends that are happening within the populations.

Mrs Reid: I would quickly add to that. One of our Local Drug Action Teams is with the ACT Multicultural Hub. That prevention program is a little two-pronged, because we know that a lot of CALD communities do not acknowledge the alcohol and drug issues within their communities. So it is a little two-pronged. We are working with community leaders to get through to parents but also on the flipside getting through to young people as well about that education piece.

THE CHAIR: Thank you for your insight. Thank you so much for taking the time. On behalf of the committee, I thank you for your attendance today. You have taken some questions on notice. Please provide your answers to the committee secretary within five business days of received the uncorrected proof *Hansard*.

Ms Herbert: Thank you so much.

Short suspension.

GIALLO, PROFESSOR REBECCA, Co-Deputy Director, SEED Centre for Lifespan Research, Deakin University

THE CHAIR: Welcome back to this public hearing for the inquiry into men's suicide rates. We welcome a witness from the SEED Centre for Lifespan Research. Thank you for being here. Please note that, as a witness, you are protected by parliamentary privilege and bound by its obligations. You must tell the truth. Giving false or misleading evidence will be treated as a serious matter and may be considered contempt of the Assembly.

The committee recognises that some of the issues raised in this inquiry are, of course, sensitive. If anyone is finding this hearing difficult, we can take a break. We have a duty councillor available on site to provide support if needed. The secretariat also has a support handout which includes tips and strategies for self-support and referral points in case of a crisis or need for more in-depth counselling support. Before we go to questions, would you like to make a brief opening statement covering any matters that are not included in your submission?

Prof. Giallo: I would like to open with a brief statement. I am a psychologist and researcher who has been conducting research for over a decade into men's mental health and suicide in early fatherhood. I would also like to share that I am the partner of a man with lived experience of family violence in childhood and mental health difficulties in the early years of parenting, so I have lived experience of supporting someone who has struggled with mental health issues in the early parenting period. Also, I have recently experienced the recent loss of a friend who died by suicide. At the time, he was the father of two children, one aged two and the other three months of age. This is an important area of research for all members of our team who have lived experience, including me.

We wanted to make a submission to the inquiry that recognises that early fatherhood is an opportune time for the prevention of poor mental health and early intervention in suicidality among men. We wanted to draw attention to the opportunities to support men in early fatherhood and hopefully prevent suicide. Our intention was to propose evidence informed recommendations for policy, research and practice that would promote the mental health of men and reduce their risk of death by suicide at this critical life stage.

THE CHAIR: Thank you for sharing that, Professor Giallo. Thank you also for your submission and for being here. Your submission highlights that, although there is a perception that men do not want to talk about mental health, often that is not actually the case. We are looking for recommendations we can make to government. What can governments do to address that misunderstanding but also encourage men to seek help where it is available and make sure it actually is available when they seek help?

Prof. Giallo: I can speak to opportunities within the context of the early parenting period. You are right: there is a prevailing assumption that fathers do not want to engage with services, that they do not want to talk about their mental health issues and that they do not want to be approached about mental health concerns. There is stigma and there are cultural norms that discourage help-seeking among men. Our research has shown that there are negative attitudes towards help-seeking among fathers that can be

obstacles to seeking support. There are also structural barriers for fathers to access support in the early years. Fathers who work full time or have inflexible work hours—usually fathers who are in lower quality jobs—do not have the opportunity to attend health services with their children and families. This is an opportune time when they could be engaged by health services or health professionals, just to check in with them about how they are going.

Even when fathers do attend appointments with their partners and families—this might be in perinatal services, early childhood services or maternal and child health services—fathers in our studies have reported that they feel invisible, that they are in the background, and that they are rarely engaged about their experiences of fatherhood and mental health, even when their partners are being asked about those in the healthcare system. Currently in the healthcare system, there is no standard of care for fathers accessing perinatal and early childhood services, because they have been designed with women and children in mind. So we are missing critical opportunities to engage fathers about their mental health, link them to support and hopefully prevent death by suicide.

In terms of recommendations to overcome those challenges, there are certainly opportunities for policy to have fathers explicitly acknowledged and recognised as a priority population in key policies at the state, territory and national levels, including the National Mental Health and Suicide Prevention Plan and other relevant strategies. Strengthening the visibility of fathers in policy will create a policy imperative to ensure that there is provision of services that are more inclusive and responsive to the needs of fathers and their mental health care needs at the time. So it is definitely around policy. As a researcher, I think there are many opportunities to further investigate some of the risks factors in suicide among fathers in the early parenting period and to better understand which fathers are at most risk, and also when they might be at heightened risk, which is also important when thinking about how we tailor our health services to be more attuned to the experiences of fathers across the life course, as well as opportunities to engage with them about their mental health.

I have lots to say about research opportunities. You might have some questions around that, so I can always come back to it. I think we are missing an opportunity in the use of our data linkages. I can talk a bit more about that later. There are also lots of practical things that can be done in the service sector around redesigning universal health services to ensure that they are more inclusive and responsive to the needs of fathers, as well as the availability of targeted interventions for fathers experiencing mental health difficulties and support services for fathers at critical transition points, particularly if we think about fathers who are experiencing separation and divorce. We know that is a very high-risk time for poor mental health, suicide and family violence.

There are opportunities for bereavement support for children and families who have experienced the death of a father by suicide. It is important to provide support to them in the long term to also mitigate the intergenerational impacts of suicide in families. There are also some very practical strategies around workforce development and pre-service education to prepare the workforce to engage with fathers in health settings and provide them with the support they need.

THE CHAIR: You have touched on fathers being time poor in early fatherhood, particularly if they are in, perhaps, lower paying jobs. Have you seen an impact from

the increasing cost of living? Do you think that has worsened that dynamic?

Prof. Giallo: We have not conducted recent research that has looked at the cost of living and the increase in the cost of living in recent times. I have no doubt that that would be putting pressure on fathers. From past research that we conducted, a longitudinal study of Australian children—it is a bit dated now—we know about income pressures around work. We have conducted qualitative research with fathers as well. The pressure to provide for families and to manage the impacts of rising costs on families is definitely a concern. There is the interface with work and the lack of flexibility in workplaces to access leave that might be available, and there might be reluctance to access that leave. That creates problems because children, families and partners often need the fathers early in the journey, particularly if there have been complications with a birth, childhood illness or a partner is experiencing mental health difficulties. If fathers are reluctant to take parental leave, they are not available for their families, but it is also a barrier because they are less likely to access mental health supports for themselves if they need it. It definitely is a barrier.

THE CHAIR: Thank you.

MS BARRY: Thank you for sharing your experience and thank you for attending today. I really appreciate you bringing that lived experience. Are there any specific interventions in the early years that have proven effective in breaking the intergenerational-risk chain?

Prof. Giallo: Specifically in relation to programs and interventions targeting fathers and the impacts of the mental health of fathers, there is not a lot of research. We are in the middle of a systematic review at the moment of international research literature focused on evidence based interventions for targeting mental health of fathers. A few years ago, we conducted a review for the NSW Ministry of Health. They were interested in father-inclusive interventions and programs that could be embedded into early years services. There are only a handful of studies and programs that specifically target mental health of fathers, but there are some promising interventions in Australia that are currently being tested or provided in services at the moment. I can speak to a couple of those.

One of them is Family Foundations. Family Foundations is a co-parenting intervention. It is designed to support parents, mothers, fathers and other caregivers in the family to strengthen mental health and family relationships in the early years. It was developed in the US and it has been rigorously evaluated with randomised control trials in the US. In 2017 or 2016, Family Foundations was profiled at the royal commission into family violence, and, not long after that, Holstep Health—which was formerly called Merri Health—and I submitted a tender application to provide Family Foundations in a particular region in Victoria. We have been delivering that program for over eight years or so. Over 1,000 families participated in that program across that time, and over 800 fathers have been involved in that program. We have been able to establish excellent engagement with fathers in that service, a strengthening of family relationships and a reduction in conflict among mothers and fathers. Also, importantly—and it is relevant to this inquiry—there has been improvement in the mental health of fathers. We have seen a reduction in fathers' psychological distress, depression, anxiety and stress. That is one program that is evidence based.

I have a federally funded grant at the moment to trial Family Foundations with families in regional and rural areas. We have an opportunity to collect data about the impact of that program on fathers in regional and rural areas, who have even less access to health services. We are commencing that now, and that is due to finish in two to three years.

The other program of interest that I have been involved in is the Working Out Dads program. We have just finished a federally funded trial of Working Out Dads. It is a facilitated peer group discussion combined with physical exercise over a six-week period for fathers in the early parenting period. It is for fathers experiencing mental health difficulties or are at risk of mental health difficulties. We compared Working Out Dads to a brief telephone intervention for fathers provided by a maternal child health nurse. We found that there was actually no difference in the outcomes for fathers who participated in both interventions. The mental health of fathers in both groups significantly improved, and we saw a reduction in mental health difficulties from the clinical range into the normal range.

For us, a line of inquiry now is to look at trialling and potentially piloting a brief telephone or face-to-face intervention with fathers in maternal child settings and look at the impact of that, in terms of their mental health and also access to support following that intervention. There are colleagues around the country who are engaging in different forms of support. You might have heard of SMS4dads. Also, PANDA provide a peer support service for fathers. There are some promising things happening around the country. I think Australia is leading the way, but there is a long way to go.

MS BARRY: Thank you. Are there any programs currently in the ACT similar to the programs that you have identified?

Prof. Giallo: There is nothing that I know of specifically for fathers, other than PANDA, who provide a national service—it is a telephone based service—in the perinatal period. It is typically accessed by mothers, but they try to engage fathers and promote fathers accessing their service. I do not know the statistics on how many fathers access the service, but I know they try very hard to engage them and promote their service for fathers. Richard Fletcher in New South Wales has been providing SMS4dads, which is also at a national level. Again, I do not know how many fathers are accessing that and what the outcomes for fathers are when they have accessed it. That is possibly something that you could follow up on if you are interested.

MS BARRY: Thank you. There have been conversations around careers led by men or women. One of those careers is nursing, for example. Is it your experience that men are less likely to engage in accessing services when a female is providing the service? If there is, what is the data showing you that?

Prof. Giallo: We have not investigated that specifically. In some qualitative work that we have done, we asked fathers about their experiences of accessing care in the early years—from maternal child health services and maternity services—and they have not necessarily expressed a barrier or reluctance to access services because it is a predominantly a female workforce. In contrast, fathers have talked more about their experiences of being practically invisible and not being asked, by any health professional, about their health and wellbeing. The problem with that is that we are

really missing an opportunity to engage with fathers who are right there and would like to be asked about their health—not all fathers, but it creates a conversation and opens up the opportunity to at least engage with fathers about their mental health and give them the opportunity to talk about what might be happening for them. I have not specifically asked fathers about that.

We have done some qualitative interviews and some research with maternal child health nurses and midwives. They recognise the importance of fathers and they acknowledge the importance of engaging fathers, but there are some barriers for them in that work. One of them is the perceived lack of skill, training and experience to engage men about their mental health. There is a reluctance and anxiety about being able to do that and do that well. There is another structural barrier in that fathers are not perceived to be clients of the service, so the health professionals are less likely to ask fathers. If they do have a father who shares that they are experiencing mental health difficulties, there is no way to record them on their client system records. So it is a challenging space. They recognise the importance. They would like workforce training and development to do that work, and they would like the structure of the services to recognise fathers as clients and engage them. So there is some work to be done.

MS BARRY: Thank you.

MS TOUGH: I guess my question will piggyback a bit off Ms Barry's questions. Firstly, thank you for sharing your lived experience. My questions come from my background in the workplace relations space, but also as someone who experienced perinatal mental ill-health, and go to the social and cultural constructions around how families establish when they become new families, as well as the roles that men and women are perceived to have. Although laws and workplace policies have changed quite a lot over recent years, in that men now have more access to parental leave, legally, there is still a cultural barrier that stops them using it—

Prof. Giallo: Absolutely.

MS TOUGH: or does not allow them to work a career that is more flexible, whereas it is still the default that, if a woman returning from parental leave says, "I want to work part time," or this or that, workplaces are very accommodating. There are whole sectors out there of male-dominated workplaces that just do not allow that conversation to take place. So, while laws have changed, what do we do to break down that stigma? We have men who might have children with complex needs and a partner going through mental ill-health, but they cannot be there at the time. The mother, who is going through her own thing, then has to look after the child with complex needs and tries to convey that to the father when they get home. How do we break down the barrier so that men are actually able to be present, which then helps their own mental health?

Prof. Giallo: You have raised a couple of things that are really important and dear to our heart as well. For one of my colleagues at La Trobe University, Professor Amanda Cooklin, this is her area of research. She is focused on the work-family and work-policy interface and the impacts of the mental health of fathers on families. She has looked at research, and it is part of our research too, that looks at different types of work conditions that influence or are associated with fathers' mental health. We know that fathers with low autonomy who have limited access to leave and are in inflexible work

conditions have the poorest mental health. As you say, even when fathers do have access to family-friendly leave or parental leave, there is a reluctance to take that leave. I recommend reaching out to Amanda Cooklin about that specific research. She has been doing a lot more in that space more recently than I have.

Also, they have been really trying to think about how we can break down some of the barriers to fathers accessing that leave and what workplaces can do to encourage fathers to take it, rather than actively discourage them. Sometimes there is an active discouragement to take it. Sometimes it comes from fathers and the families themselves making decisions. It is a challenging time, as you know. One person in the family will be reducing workload, paid work, and that puts pressure on the family, and decisions are made to not take the leave and continue to work and receive their pay. There are lots of reasons as to why fathers do not access it. I would encourage you to chat to Mandy.

The other issue you raised is around families who are caring for children with disabilities and chronic health conditions. They are a specific group of fathers who struggle with poor mental health and suicidality. For one of my postdoctoral researchers, Dr Monique Seymour, this is her area of research. She has been looking at the mental healthcare needs of fathers of kids with chronic health conditions and the pressure that puts on family, and the strain on family relationships when fathers are unable to access leave to attend the appointments and provide support. That can put strain and pressure on a couple's relationship as they try to navigate and negotiate that.

Workplace provisions policy to enable fathers to have access to flexible leave is critical. Families need support to navigate those issues together. Programs like Family Foundations, delivered in the context of that family situation, can be useful as well, because it helps families think about what is happening, what the pressures are and what the stress is on their life, and it helps them strengthen their skills to be able to communicate and negotiate that. There is lots of room for addressing those sorts of issues. There are different layers of complexity for different groups. Migrant and refugee fathers are another group where there are lots of complex layers.

MISS NUTTALL: Thank you.

Prof. Giallo: Thanks for your question.

THE CHAIR: We are out of time.

Prof. Giallo: Sorry—I probably spoke too much. I could talk for hours, I am sure.

THE CHAIR: That is okay. It was not a problem at all. Thank you so much for your contribution.

Prof. Giallo: No worries. Thank you, I hope it was useful. All the best with the inquiry.

THE CHAIR: Thank you for your attendance today. We really appreciate it. Have a great day.

Short suspension.

ANLEZARK, MR JOSHUA, Chief Executive Officer, Meridian
FRASER, DR VIK, Executive Director, A Gender Agenda

THE CHAIR: We welcome witnesses from A Gender Agenda and Meridian. Please note that, as witnesses, you are protected by parliamentary privilege and bound by its obligations, which means that you must tell the truth. Giving false or misleading evidence will be treated as a serious matter and may be considered contempt of the Assembly.

The committee recognises that some of the issues raised in this inquiry are, of course, sensitive. If anyone is finding this hearing difficult, we are very happy to take a break, and a duty counsellor is also available onsite to provide support, if needed. A support handout is available at the entrance to the committee room, which includes tips and strategies for self-support and referral points, if needed.

Would either or both of you like to make a brief opening statement to cover off on anything that is not addressed in your submission?

Dr Fraser: I would, if that is okay. I would like to start by acknowledging that we are gathered on the lands of the Ngunnawal people. I pay my respects to elders past, present and emerging.

I hope that my presence here today will support your understanding of the need to consider the experiences of trans, gender-diverse and intersex individuals and communities when discussing suicide, and particularly suicide in men and boys.

I want firstly to acknowledge that, within our organisation, we not only provide support services to service users who have an experience of suicide; we are a lived experience organisation. Our staff and our board are people who are trans, gender diverse and intersex. Our staff and our board are parents, friends or family of people who are trans, gender diverse or intersex.

Many of us therefore carry deeply personal experiences of the impact of suicide and suicidal distress on individuals and communities, and the compounding impact of silence around this issue, and loss in the broader community.

A Gender Agenda's submission highlighted the unique drivers of suicide for men and masculine people who are trans, gender diverse or have a variation of sex characteristics. We outlined the lack of services equipped to provide support for our communities when they are in crisis, particularly in the ACT.

I want to acknowledge that this is not necessarily because existing services do not want to support our communities. I know they do; but a lack of understanding, awareness, skill or training, compounded by social norms and assumptions, all work to create barriers to seeking support. These barriers need to be acknowledged and addressed to support our communities to ensure that our men, boys and masculine people are safe and supported, and that the work to do this is shared across the whole community, to provide support in any space, with no wrong door.

Every year, on 20 November, Transgender Day of Remembrance is held to honour the

memory of lives we have lost to anti-trans-gender violence. A similar event is held on 8 November—Intersex Day of Solidarity. This violence includes members of our community who have died by suicide, recognising that discrimination, stigma, shame and isolation are all forms of violence.

Public debates about our rights to exist, our ability to participate in social activities and our right to access the health care we need continue to drive distress in our communities. We work hard to provide support to prevent people from reaching suicidal distress, providing regular opportunities for communities to connect with and lean on each other, or access peer-led individual support in different settings. But, increasingly, with the pace of attacks on our community, whether individual or systemic, it is becoming impossible to meet this need.

Young people increasingly report a lack of safety in environments that they encounter daily. Distress caused by compounding factors continues to increase. Data fails to adequately capture the lives or deaths of our communities, and our services struggle to respond to the needs of our communities as they emerge.

For us to make a difference, we need to acknowledge the disproportionate impact of suicide on trans, gender-diverse and intersex men, boys and masculine people. We need to be included in the discussion of suicide, and the work of suicide prevention for our communities needs to be everyone's work. We need to acknowledge the unique drivers for our communities and develop strategies to address these drivers wherever they may occur before they lead to suicide or distress.

I want to thank everyone here for the opportunity to be part of this hearing. It is such an important start. Your willingness to include our voices in communities makes a massive difference to us, and I look forward to any questions that you might have.

Mr Anlezark: I do not wish to make an opening statement; thank you.

THE CHAIR: I will go directly to you, Miss Nuttall.

MISS NUTTALL: Thank you. AGA's submission mentions that, due to the prevalence of mis-gendering and being asked inappropriate questions and other inappropriate responses from crisis services and other mental health services, a lot of trans, gender-diverse and intersex men will come to your organisation in the first instance when seeking help. I am interested in understanding what sort of support you have found yourself providing in practice.

Dr Fraser: Thank you for the question. I think there are two elements to that. We find that, even prior to coming to us as a service, people will go to each other in the community. The trans community supports itself, even prior to accessing a service. This puts a disproportionate load on people who are often experiencing their own suicidal thoughts or grief around suicide.

In terms of the support that we have offered, we have recently seen a sharp increase in the number of young people accessing our services through our outreach service in schools. All of my staff have recently become proficient in providing ASIST suicide first aid, as well as mental health first aid, de-escalation crisis support. We are not a

crisis service, though, and we are increasingly finding that we are meeting people who are in crisis, and we do not have a place to send them. As individuals from the community, we find ourselves in a really difficult situation where we are saying, "Here is this person in crisis, here is my friend, my partner, my lover; what do I do with this person when there is nowhere to refer them?"

MISS NUTTALL: How much of that work are you actually funded to do? Any of it?

Dr Fraser: We are not funded to do any crisis support. I think that is the most simple and straightforward answer to that question. We do have funding to provide outreach support, and we do have funding to provide mental health activities in that sort of social support and social connection. I see that as pre-prevention work. In the same way that we have postvention work being fulfilled by other community organisations, we are doing prevention work. Crisis support is simply not something that we are funded for.

MISS NUTTALL: With that, I am interested in understanding whether you have seen in other jurisdictions, for instance, a model where there is a very good LGBTIQA+ specific crisis support service in place. Do those models exist?

Dr Fraser: There are models. QLife is a national service that provides crisis support for the LGBTIQA+ communities. A recent impact report showed the huge impact that it does have. It is funded to run, I think, from 3 pm to midnight each day, so it is not a wraparound support service. There are not any providers of that service in the ACT, either. Of course, we have a unique environment.

That would be the stand-out service. Individual organisations are doing the suicide prevention work very well. Switchboard in Victoria have dedicated prevention and postvention programs that are quite successful for the broader community, and another program that I believe has been quite effective as well. Beyond that, there is not a concerted model about which we could say, "We should replicate this," because our community is also a different environment here.

MISS NUTTALL: Would part of that go essentially to establishing a crisis service like that in the ACT? I am assuming co-design would be a really important part of that.

Dr Fraser: Yes, absolutely. One of the driving points from the Changing the Landscape work that was done by Switchboard and a few other organisations highlighted the need that any suicide prevention service targeting our communities needs to be designed by our communities.

MISS NUTTALL: In terms of the crisis services that we have in the ACT, is there a view about what it would take to make those services genuinely culturally safe, especially for trans, gender-diverse and intersex people accessing it, or is it really just not the right fit?

Dr Fraser: There are avenues that would help to make them safer. When I listen to the community and things that are raised, when you are in crisis, when you are in distress and you ring, and you are mis-gendered as soon as someone answers the phone, that is a big factor. There are cultural norms that we have in our society where we will refer to someone as "ma'am", "sir" or whatnot based on a voice.

If we can work on that, that would be a big part of actually getting someone to have the conversation in the first instance. I think, though, there are also broader systemic issues and broader levels of understanding that need to be addressed in order for our communities to be safe in those environments.

A lot of crisis services are run by religious organisations. I am a person of faith myself, so I do not want this to come across as being a statement about religion. However, we have to acknowledge that many religious institutions have participated in acts of discrimination and violence towards our communities in the past—sometimes in the present as well. Having a service that is a religiously oriented service is a barrier to participation.

Awareness of the different drivers for our communities is lacking in a lot of services and support systems. It is about education, training and a genuine commitment to actually understand the needs of our communities, and that needs to go hand in hand with a cultural change to say that we are not going to debate our community's right to exist anymore.

THE CHAIR: One of Meridian's asks is for increased investment in suicide after-care services that are responsive to the needs of LGBTIQA+ people. Can you walk me through what after-care services are currently available and why they are not sufficient?

Mr Anlezark: There are a number of after-care services available in the ACT. Currently, some work is being undertaken and led by the Youth Coalition to design an after-care service for youth. That includes LGBTIQA+ youth, which hopefully will deliver some promising results.

In terms of that co-design approach, it is quite deep and quite considered, so whether that results in a new service or a better integration of existing services, I think that will have some benefit. What is equally important to after care is the prevention aspect, and organisations like Meridian and AGA are strongly invested in that work.

Going to Dr Fraser's point before about not being a crisis service, Meridian is not a crisis service, either, but we often have existing clients presenting in crisis. It is very challenging and creates significant risk for staff when a client presents in crisis and you are not comfortable with where you are referring to, and they are actually seeking the support from you at that time and in that moment.

THE CHAIR: A primary focus for the 2019-24 ACT Mental Health and Suicide Prevention Plan was to provide inclusive and responsive programs and services to LGBTIQA+ communities. What progress have you seen since 2019 on that objective?

Mr Anlezark: Promising progress, particularly in terms of mainstream organisations, investment in their capabilities around supporting LGBTIQA+ people and seeing increased reaching out to organisations like Meridian and AGA to help build that capacity. I think there is still work to do in understanding what some of the unique drivers are, and where sexuality or gender identity may actually be the issue or where it is just a component of a person's identity.

Some services are incredible and can see the whole person. With some services, if someone identifies as having diverse sexuality or diverse gender, all of a sudden, it is a matter of saying, "Can't deal, need to refer." I think there is broadly a strong commitment and progress being made, but there is still a need for specialist services as well.

THE CHAIR: I understand that that plan is being revised. Have you been engaged in the development of a revised or a new replacement plan, given that one expired last year?

Dr Fraser: There was a roundtable that we were invited to earlier this year to discuss the next iteration. That is AGA's involvement at this point. I believe that there will be further consultations; I am not sure.

Mr Anlezark: Meridian's involvement is similar.

THE CHAIR: A roundtable?

Mr Anlezark: Yes.

MS BARRY: Thank you for attending today. I want to understand LGBTIQA+ issues from a culturally and linguistically diverse background. Are you collecting data that reflects that dynamic? What trends are you seeing? What are young people or older people telling you about that?

Mr Anlezark: In terms of data collected, it is demographic service user data. We do see it. With those intersectional experiences when you have a stigma and marginalisation overload there, it compounds suicide risk. Meridian takes a person-centred approach to that, and responds to the individual and their needs, while recognising that there are multiple contexts which—

MS BARRY: Intersectionalities—

Mr Anlezark: Yes, which feed into that. We really focus, particularly in our mental health services, on the presenting issues, but we make sure that linkages to specialist multicultural services are there as well. We also build the cultural competence of our team to respond to the needs of culturally and linguistically diverse people who are also LGBTIQA+.

MS BARRY: One thing I have heard from young people is that they often do not know what culturally competent organisations exist where they can seek help. LGBTIQA+ kids have indicated there are multiple intersectionalities when you are from a CALD background. Are there any services that you currently work with? If so, who are they?

Dr Fraser: Certainly, A Gender Agenda has been looking to build our connections with Forcibly Displaced People Network, as well as the Multicultural Hub. We have a long history of working with Multicultural Hub to support our young people.

Within the ACT, there are no specific LGBTIQ services that work with multicultural groups. However, the connections that we have with existing multicultural communities

are really important in that regard. One of the things that we have found, particularly when we are supporting young people, is providing access to and awareness of organisations in other jurisdictions that are able to support them. Muslim and Proud is an example in Sydney. A lot of the young people that we have worked with have found the ability to find safety in their experience of their faith, their culture and their gender.

It is an area in which we need to do more work. One of the things that we are deeply aware of, in conversations that we have had both with young people and with other organisations, is that there are sometimes views that do not necessarily match the experience. An assumption that is often made is that if you are from a culturally or linguistically diverse background, you will automatically experience transphobia in your home. We know that that is not necessarily the case; in fact, many people from culturally and linguistically diverse backgrounds have amazingly supportive families and home environments.

Combating those perceptions also becomes a barrier for those young people. One of the things that I heard recently from a community member was the belief that they needed to be trans in one space and have their cultural background in another space, and that it was hard to find a space where you could be both. That is something that AGA is incredibly passionate about addressing.

MS BARRY: I want to draw out the conversation around some of the misconceptions about parents from multicultural backgrounds not supporting their children. There are parents, especially first generation, where that lack of support still exists in the home. Are you working with parents to educate, understand and provide that support to their children to have a safe environment?

Dr Fraser: Where we can, we absolutely do. Sometimes parents are reluctant, for various reasons, to engage with us. One of the conversations that we regularly have with mHub is around how we reach into their communities and their service users in order to provide that support.

We have a few projects that are waiting for funding, if I am honest, so that we can provide that support in a much more effective way. Certainly, similarly to Meridian, we are person centred; on a case by case basis, we will provide the support that is needed. We do find young people coming to us and saying, "Can you explain this to my parents?" We say, "Sure; bring your parents along." They bring their parents and we are able to have that conversation in a really supportive way.

Mr Anlezark: The ACT has quite a high international student population. One of the things that we see, particularly through our HIV and sexual health work, is international students arriving in Australia, in Canberra, and that is the start of the exploration, certainly in our experience, of their sexuality. We know that it happens around gender identity as well, and that it is a really affirming experience for them. That duality of identities is not necessarily related to family of origin at home, but perhaps to the political context in the country of origin.

MS TOUGH: The Meridian submission talks about a lack of nationally consistent or reliable data on the experiences of gay, bi, trans and queer men and people living with HIV in regard to suicidal ideation and suicide attempts. It is leaving a really significant

group of the population overlooked in general data. Do you know if there is a reason why capturing this group of the population in this data is not happening? How do we make sure that this group is included, so that they can get the right support and the right research is done to help them?

Mr Anlezark: With respect to people living with HIV, I want to recognise that HIV impacts everyone, not just gay, bisexual, people who have sex with men or other identified priority groups. In our submission we reference HIV Futures, which is a longitudinal survey that does capture that. There are surveys such as Writing Themselves In and Private Lives 3; I think the fourth iteration captures community data.

One of the big challenges that will be addressed in the next census, with some more work to come, is around the 2020 ABS standards around sexuality and gender. I do not have it to hand, but AIHW have done some analysis of that, using household surveys, where that standard has been applied, and we are starting to get a bit more.

It is important to note, though, in terms of rates of suicide, that there is an untold story that we will never know. If you look at the suicide ideation in the data that we have available for all LGBTIQA+ communities and then look at suicide rates, although we do not have the data, it would suggest that there are disproportionate rates that may have issues of sexual gender identity underlying that.

Dr Fraser: To follow on from that, some of the things we also know from the data that we collect around intersex lives, as an example, is that more than half of the intersex community have an experience of suicidal distress directly related to their intersex body.

It is important to note that birth data and death data both utilise a binary system of recording. They do not ask for further information, so the AIHW suicide data is reported along binary lines. We know that that will capture trans men who have affirmed legally their identity. In the data for men's suicide, we know that a proportion, one to three per cent, of those lives will have been trans men.

We also know that in the data related to women's deaths by suicide, there will be trans men where violence at a systemic level occurs to deadname that person after their death. We know the impact of trans men being buried as women on the community as a whole and on that person's family. That is a hot issue for us.

We are lucky in the ACT that last year the ability to change your identity legally was made quite a lot easier. That was a lifesaving change for many people. However, the data collection techniques that we have are insufficient to tell the full story of our communities. There is no way, in terms of how data is collected, that we can ever tell the story of intersex lives lost to suicide.

There have been amazing studies. Bonnie Hart has led a number of studies looking at suicidal distress in intersex individuals. But that data is data that has been collected through conversation with community. Until we can capture intersex lives properly in data—and, unfortunately, the census has decided that they will not do it this time—we will never be able to tell this story.

MS TOUGH: Thank you for sharing that.

MISS NUTTALL: Understanding that, again, particularly trans, gender-diverse and intersex lives are statistically so over-represented in suicides, and given the grief that touches so many people in the community, as public policymakers, how best do we approach those conversations, and not shy away from the statistics and the lives behind that, without re-traumatising people in the community unnecessarily?

Dr Fraser: That is a really meaningful question; thank you. One of the things that I hold quite closely here ties into some of the parental support stuff as well. We constantly tell a story of death for our community. We tell a story of mental illness for our community. That tells the broader community that our community is a community that is going to die; that our community is a community that is going to experience poor mental health outcomes and poor life outcomes.

There is a completely different story that can be told. There is a story about our lives, our joy, our strength and our courage. No-one is willing to tell that story. Instead we have politicians debating whether or not we should have access to health care, rather than saying, "Hey, when we let a young person live their life the way that they see their friends living their lives, how amazing can that young person be?"

There is a story about saying to a parent, "Do you know what? You're afraid for your child. You have all these what-ifs for your child. Every parent has those fears and those what-if questions. But what if you let your child thrive? What if you say, 'Hey, no matter what, I'm going to love you and I'm going to be there with you every step of the way?'" What happens with that child? They have great life outcomes. We know that. The data supports that.

Let us tell that story instead. Let us tell that story when we are debating whether or not we should amend birth certificates, rather than talking about the damage that this could do. Let us tell a story of strength; then maybe all the policy will flow from that so that we are preventing suicidal distress before it even becomes a topic of conversation.

THE CHAIR: We will have to leave it there. On behalf of the committee, I thank you for your attendance today. If you have taken any questions on notice, please provide your answers to the committee secretary within five business days of receiving the uncorrected proof *Hansard*. Thank you for your submissions.

FITZGERALD, Mr Benjamin, Team Leader, Street to Home, St Vincent de Paul Society Canberra-Goulburn

THE CHAIR: We welcome a representative from the St Vincent de Paul Society Canberra-Goulburn to the hearing. Please note that, as a witness, you are protected by parliamentary privilege and also bound by its obligations. You must tell the truth. Giving false or misleading evidence will be treated as a serious matter and may be considered contempt of the Assembly.

The committee recognises that some of the issues raised in this inquiry are sensitive. If anyone is finding this hearing difficult, we are very happy to take a break. A duty councillor is available on site to provide support if needed. A support handout is also available at the entrance of the committee room which includes tips and strategies for self-support and referral points if needed.

Mr Fitzgerald, would you like to make a brief opening statement that covers anything that is not addressed in the submission?

Mr Fitzgerald: Yes; thank you. Good afternoon, everyone. I would like to begin by acknowledging the traditional custodians of the land on which we meet and pay my respects to elders past and present. Through working in the community sector for six years in the ACT and four years in the UK as an emergency care worker, I understand the importance of preventative rather than reactive measures when addressing this important issue. This year marks 100 years of the society's work in the Canberra region. For a century, we have stood alongside people experiencing the toughest of times. Providing material, financial and emotional support, our teams of professionals and volunteers work together on the front line to support older people, younger people, migrants and refugees, and also those facing hardship and homelessness.

While we do not deliver a program specifically focused on suicide prevention, our frontline teams, particularly within our seven specialist homelessness services, support individuals at various stages of suicide ideation every day. We see how mental ill-health compounded by poverty, homelessness and social isolation can lead to complex and deeply personal crisis. All of our Vinnies programs, including Compeer, which connects older adults with diagnosed mental health conditions to volunteers for friendship, show us the power of trust and human connection. In our Street to Home program, which supports rough sleepers across the ACT, trust is everything. It is what keeps people engaged, especially when solutions are slow or systems feel overwhelming. Without trust, hopelessness can take hold, and that is where risk escalates.

We are calling on the ACT government to increase funding for specialist homelessness services to include dedicated mental health and suicide prevention roles. We also advocate for tailored training, debriefing protocols and safety planning resources for frontline workers so that they can respond with the confidence and care when suicide related incidents arise.

THE CHAIR: Thank you. Obviously, suicide is a complex and multifactorial issue. To what degree do you see the lack of provision of absolute necessities, such as housing and related services—wraparound services—contributing to men's suicide rates in the

ACT?

Mr Fitzgerald: Accessibility of services is a big issue. To start with, wait times for public housing and access to safe and secure crisis accommodation is particularly difficult for the Street to Home program. The fact that ACT Housing expects companions to often address a lot of complex issues and demonstrate that they are housing-ready before they are eligible for priority is incredibly difficult. Expecting people to address complex issues when they have normally already experienced significant trauma and are still in crisis is incredibly difficult.

THE CHAIR: What I have heard is that, in many cases, the lack of support for public housing residents has worsened their mental health. Organisations like Vinnies do a lot of the heavy lifting in this space. What would you like to see the government do to generally support vulnerable tenants when they are in public housing?

Mr Fitzgerald: Accessibility to mental health services is particularly an issue for people when they are housed as well. We had an assertive mental health outreach worker through CatholicCare. That was about two years ago, but, from my understanding, that role is no longer there. We saw some really positive results when there was an assertive mental health outreach worker who could work with companions and take some of that load off Street to Home. Street to Home provides assertive outreach. We are out in the community, working with rough sleepers in the parks and various other areas. By having the support of the assertive mental health outreach worker to work alongside us in that approach, we saw some really positive results.

Wait times for psychology and even counselling services can sometimes be up to six months, and going to the GP and getting a mental health care plan often only allows you access to online mental health services, which, for someone who is rough-sleeping and does not have access to the phone or internet, is incredibly difficult. The big thing is that an assertive approach to mental health services would make a significant difference for the Street to Home program and wider Vinnies.

THE CHAIR: By "assertive", you mean proactive outreach, engaging with people where they are and saying, "We're here to help. What can we do?" Is that—

Mr Fitzgerald: Yes; definitely. It is about increasing the accessibility of services. Street to Home provide both assertive outreach and community inreach. We are at the Early Morning Centre, we are at the Roadhouse, we are at the CAHMA barbecue and we are now at ACT Housing as well, which allows people to come and see OneLink, ACT Housing and the Street to Home program at the same time, rather than having to retell their story to three different organisations. So, if we could potentially partner with an assertive outreach worker as well, it would mean that the companion would be able to receive wraparound services straightaway, rather than repeating their story to four different organisations.

THE CHAIR: Failing that, is the current situation such that, essentially, Street to Home is having to kind of do that. I can imagine that Housing ACT or OneLink would then say, "Hey; what else is going on in your life? What can we help with? We see there is a mental health issue here that needs some support, but we are essentially supposed to provide housing—having you move into the space that is vacated."

Mr Fitzgerald: Yes; definitely. The tricky thing for Street to Home is that we are funded to support 30 companions with our case management; we are not funded to provide the assertive outreach that we do. We have put a budget submission forward for an assertive outreach worker, which is just as important as an assertive mental outreach worker, in my opinion. It is difficult. Right now, we are providing that support where possible, but we are severely stretched at the moment. We have a waiting list of up to 30 to 40 companions at any one time, so, when we get requests from the public and other members around the rough sleepers that are in the city, or various other locations, we still go out and provide the support we can to them—information on services—and we try to get the ball rolling for them, because, if it is going to be a month or two before they actually receive a specialist case management service, we do not want them starting in one to two months; we want to get the ball rolling at the early stage. Trying to balance supporting the immediate needs of companions who are rough-sleeping over the top of the 30 companions who have gone through the correct pathway of completing an assessment with OneLink and then being referred to our service is incredibly difficult. The resources are stretched and we are struggling to know where to put them at the moment.

THE CHAIR: I asked this of an earlier witness: what kind of engagement do you have with ACT Policing? Many residents do not think of calling Street to Home when there is something going on in Petrie Plaza; they think of calling the police.

Mr Fitzgerald: Yes.

THE CHAIR: Do they then contact you? Are you aware of them contacting mental health providers or AOD service providers? What does that relationship look like? What are the improvements that the government might be able to drive?

Mr Fitzgerald: It is always something that can improve. But we are really fortunate that we have a relationship with the City Police Station. We complete a monthly walk with the city police. That is when we go out and share information where possible, identify rough sleepers, and then make sure that, where possible, we link them to supports. The tricky thing is that, is if we do not see support with the funding of assertive outreach, it may be one of the things that we will struggle to have capacity for.

Managing to manage confidentiality while making sure that someone is getting wraparound services is incredibly difficult. We need to be conscious of confidentiality and privacy, but, when a companion is rough-sleeping in the streets and they are not able to access services, and we do not know what services they have access to or what referrals have been made, it becomes quite difficult. We have had rough sleepers in the city before who have been in quite difficult circumstances for up to three years. Getting them appropriate mental health services has been quite difficult, as well as knowing whether those referrals or outcomes have been followed up. We understand that it is not something we need to immediate action, but how do we manage that duty of care moving forward, to make sure that they are receiving the appropriate services? That line is quite difficult.

THE CHAIR: So you have an issue with confidentiality but also by not having an outreach worker who can go to them? They are expected to—

Mr Fitzgerald: Definitely. That is where we see an assertive outreach worker would further build those relationships. We are fortunate to have a relationship with the Early Morning Centre, Roadhouse, ACT Housing, and even the police with our monthly walks, but, if we had a funded and dedicated assertive outreach worker, we could further build those relationships with the assertive mental health outreach team and potentially look at a model where we integrate some of the services. Rather than the companion interacting with the services six different times, with potentially six different stories being heard, a team could potentially go and provide all the needs immediately.

Often, a big thing is the transient style that our companions live when they are rough-sleeping. They are often moved on or do not feel safe in a location. If we get the ball rolling and start to get support services for a companion, they are often not in the same location the next day or later the same day when we go back to link them to another service. Having that assertive outreach worker would hopefully build relationships with other providers and break down barriers to accessibility.

THE CHAIR: Thank you.

MS BARRY: Thank you for appearing today. I have some questions around masculinity. Many submitters indicated that men would often not seek help due to fear or stigma. How does that present in your service? And how do you see it play out?

Mr Fitzgerald: A lot of the time, for people who access our services, there still is stigma. A lot of companions we are not aware of are sleeping rough in bushland and other areas. There is a lot of stigma around men receiving support for mental health, but also for homelessness. When we see people, they have often got to the real crisis point of their journey. If we could look at preventative rather than reactive measures, and being able to give support to people before they get to crisis, we could see some real benefits moving forward. It comes back to the assertive nature of the work that we do, particularly with the Street to Home program. If we are out in the community where people are accessing services like the Roadhouse, free meals, laundries, and that kind of stuff, we are increasing accessibility and hopefully breaking down the stigma. When we are at the Roadhouse, there is no big sign saying, "Street to Home is here. Talk to them"; we just have conversations with people and make sure that, if someone is new to a service, they are linked to appropriate support systems.

MS BARRY: What are some of the measures that you put in place to alleviate concerns around stigma and stress? What does that look like, in terms of a practical approach?

Mr Fitzgerald: Primarily, bringing services to the companions who are rough sleeping is the most important thing, and it is to do with our amazing case managers and the team that we have at the Street to Home program and at Vinnies as a whole. We have the time and capacity to hold space with them and create an environment where people feel safe—an environment that is free of stigma and judgement—and then we start to have the conversations around support needs.

MS BARRY: You touched on this a bit when you mentioned that sometimes there is a gap between referral pathways. From your perspective, where does the coordination break down? Where is the point where coordination breaks down and you essentially

lose the person who needs assistance and the system kind of forgets them?

Mr Fitzgerald: The biggest thing is the lack of a housing-first model here in the ACT, and in Australia. It is about the transient lifestyle that our companions often live. We receive a referral and we identify with the rough sleeper. Quite often, their belongings, their phone and their means for communication are stolen and we just lose contact. They move on. More access to suitable and safe emergency and crisis accommodation means that we know where the companion is and we are then able to bring the services to them.

There was an experience that I had with a companion once. I really struggled to engage with them over a number of months, but a hospitalisation created an opportunity for me to get the ball rolling, because I knew where he was going to be. We achieved some really positive outcomes in a matter of days that we had not achieved in months. Unfortunately, he was discharged back to homelessness and that cycle started again. I still see him on the streets and he is no further forward than when I was working with him two or three years ago. I am still having the conversations with him three years later. If there were safe and suitable crisis accommodation and a more assertive outreach model, we could have broken down some of the barriers and hopefully got him the support that he needed.

MS BARRY: Thank you for that. There is evidence in submissions that emphasises that faith based and community organisations are often the last door open for men in crisis. I want to understand how the faith dimension of Vinnies work influences your approach to dignity and recovery for men. What lessons from community based compassions could government services adopt to reach men earlier and more humanely?

Mr Fitzgerald: The biggest thing is to treat people with the same respect we would treat anyone else here today. That is the big thing we do in the Street to Home program. We understand that the system is not ideal, so the first thing we do with our companions is make sure that we manage expectations. A lot of the time throughout the journey, we are not the first service provider that they have interacted with, so we make sure that we manage the expectations and act within the parameters of what we can manage. We acknowledge that the system is not ideal, and then we communicate to them that we are advocating for change in that system, so that we are not saying that we think that the system is sufficient.

Through building trust and that relationship with them, but also by explaining to them that we cannot fix everything immediately, we have seen some much more positive results in the companion layer two or three months down the track. They still engage with the service, because they know it is a longer journey with housing and support services. At times, we see a lot of breakdown in trust when community organisations potentially promise something or do not communicate something clearly around expectations and the reality of the systems. That is where you can sometimes see the breakdown, because they were told one thing and it has not happened.

As well, we are accountable to what we say to our companions. If we say we are going to be there or if we say that we will complete something, we make sure that we are there or we communicate with them, so that we can build trust and a therapeutic relationship

with the companions.

MS BARRY: Thank you.

MS TOUGH: I want to pick up on that idea of trust as well—trust in mental health services for rough sleepers. In your submission, you had a case study that had a positive outcome for someone who was a rough sleeper and had a real mistrust of mental health providers. You were able to work with them and they have had a quite positive outcome, which is wonderful. How often do you come across mistrust in mental health providers by rough sleepers? And how often are you able to create trust? And what are some of the ways in which you go about doing that?

Mr Fitzgerald: For almost every companion we work with, there will be mistrust in the mental health system. We are quite fortunate that we are separate to mental health services to a degree and we are separate to government organisations or bodies. The brand of Vinnies allows us to build rapport and trust quite quickly. But, again, as I touched on, it is about managing the expectations and having really clear communication with the companions, but also making sure that we are accountable. We walk alongside our companions. We communicate all the information that is out there for them but let them make their own informed decision on treatment and what their options are moving forward. That allows them a certain degree of empowerment and allows them to feel that they are still making decisions. Having that kind of onus on it has seen them engage quite positively with the program. Again, it comes back to the nature of assertive outreach. If Street to Home or our night patrol programs or the Roadhouse did not provide that hub and community for people to come to, trust would break down quite quickly.

MS TOUGH: That is really interesting. I will follow on with outreach. If you could run whatever program you could possibly run—you were funded for specific outreach and you could design an outreach program that your experience would say was probably going to work—what would that look like?

Mr Fitzgerald: I would have an assertive outreach team, similar to a PACER model. We would have pathways directly to OneLink and bypass numbers. In the UK, when I was in the ambulance service, we could call someone's GP and speak to them straightaway, bypassing the traditional pathways. It meant that we could provide care straightaway. I would have something similar with OneLink and ACT Housing. We could meet with the companion who is rough sleeping and, instead of saying, "I am going to complete a release of information for ACT Housing, and then, in a week or two weeks, I will hear back from them and find out where your application is at," and then getting the ball rolling, I could speak to someone who could give that information to me straightaway.

If they have issues with ID, I could speak to Street Law or Canberra Community Law straightaway and get their ID sorted. I could speak to Access Canberra straightaway and get proof of identity sorted so they can lodge applications. Quite often, understandably because of the transient lifestyle, they do not have access to ID, which means they cannot lodge an application. They go to Access Canberra to get a proof-of-age card but they do not have the ID to do it. There are no pathways for homelessness services to bypass that. Due to the lack of ID, they quite often continue

to rough sleep. Getting a proof-of-age card is such a small thing, but it ultimately leads people to continue the cycle of homelessness.

Regarding the story about the companion, over the last three years the majority of what we have been trying to do is about getting 100 points of ID so that we could explore more pathways. It is still not happening, because of that transient nature. It is about having staff with the capacity. Quite often, we do not have the capacity to spend the time that we would want to spend with the companions who are rough sleeping, because we are managing our other 30 companions, our reporting and all our other competing priorities. If you had a dedicated worker and a dedicated team with bypass numbers and you could break down the barriers to accessibility, you would see amazing returns on your investment. By actually getting people off the streets, whether that it is into crisis or transitional accommodation, hard-to-lets or long-term public housing, they would have the wraparound support to see them succeed as well—not just popping someone in a hard-to-let property in a high-density complex and seeing how they go. We know that most of our companions suffer from complex mental health and AOD, and that is a symptom of the trauma they have experienced. It is about providing that community with the wraparound services—providing them with the skills that they can see. That is what we see with the housing-first model. The fact that people are expected to demonstrate that they are now ready to be housed, which is a human right, is not appropriate.

MS TOUGH: Thank you. That is really helpful. That is helpful for the whole committee.

Mr Fitzgerald: Thank you.

MISS NUTTALL: Forgive me. Please feel free to say, "Laura, check the *Hansard*", as I missed a bit. I am interested in understanding the New South Wales mandatory reporting guide and the impact it has had since its release, and whether you think there have been any conversations with the ACT government to provide something similar.

Mr Fitzgerald: I can take that question on notice. That is something that our team has worked on. Regarding the benefit, through the Street to Home lens, it is making sure that there is consistency across the sector—that all homelessness organisations or community organisations provide consistent care. It is something that we are starting to see work really positively with mandatory reporting and safeguarding. Something like that in the homelessness sector around mental health and suicide ideation would see a consistent level of care across programs.

We are quite lucky in the Street to Home program in that we have a lot of experience in the sector. I am quite lucky to have a background in emergency services. It is something I have dealt with quite a lot and I am able to provide that training to my team. Making sure that there is a consistent approach to mental health could be really beneficial, as well as making sure that there are consistent tools. At the moment, each program is using their own tools and safety plan to make sure that people are safe. There are different tools. If a body or a worker could work with us to implement a consistent tool that is used across all programs, it would take a lot of inconsistency in support and approaches out of the picture.

MISS NUTTALL: Thank you very much.

MS BARRY: You talked about service integration. You mentioned being able to access services directly rather than going through an intermediary. What are the barriers to implementing that today?

Mr Fitzgerald: The first one is the funding of an assertive outreach worker and having those conversations with the relevant people. We have started some of those conversations and, quite often, they kind of get lost or are not followed through. It is also tricky because lots of people are managing a number of competing priorities and we are already quite overstretched in the Street to Home program. If we had that assertive outreach worker, we could give them the project to not only provide assertive outreach support but also build accessibility, build pathways and build relationships in that area. The biggest thing is capacity at the moment.

MS BARRY: To your knowledge, there are no legislative or policy constraints around being able to tap into this or access the services directly?

Mr Fitzgerald: There is nothing that I am aware of. Again, confidentiality and privacy would be the big ones. With appropriate consent signed, we would be able to break down that barrier, I imagine. The difficult thing is that, if someone has accessed Access Canberra or OneLink through one pathway, providing a bypass is potentially an issue. However, if we can justify that we are providing a bypass for this reason, so that we can demonstrate outcomes being achieved, and that this is normally a companion who would go through the cycle for three years, we could quite quickly justify that bypass—if it means that, instead of having them go through that pathway over and over for three years, they get support straight away. It is a really vulnerable cohort for whom we need to improve accessibility.

MS BARRY: There is a lot of cost-effectiveness as well.

Mr Fitzgerald: Yes; definitely.

THE CHAIR: Are there any frustrations with the OneLink onboarding process in relation to the barriers you have been discussing?

Mr Fitzgerald: Particularly in our working relationship over the last couple of years with Woden Community Services, we have broken down a lot of barriers and it has improved dramatically. The nature of OneLink and potentially the fact that there is not adequate funding—and there is the change of contract going on at the moment—are things that have made it incredibly difficult for them to implement all they wanted to implement to improve accessibility. It is really difficult because, quite often, a companion will call OneLink. It is also very difficult because you are getting the story from the companion. They are potentially told that there is not much they can do, and then you have to follow up and do referrals and those kinds of bits of pieces, which makes it quite difficult. If there were more funding and more consistency in the approach, we would hopefully see a more consistent response from them.

Instead of asking a companion to call OneLink and complete the assessment, we would have received the information and could complete the majority of their assessment on

their behalf. In that way, instead of people having to speak on the phone to OneLink for 45 minutes or an hour at the Early Morning Centre, the Roadhouse or in public while they are homeless, it would help to increase accessibility. But, again, it is really difficult to manage that while we are already managing 30 people waiting for support services. With more dedicated funding and a more assertive model from OneLink, or, if there was not an assertive model, OneLink utilised the assertive outreach worker to start that process with OneLink, we could see some really positive results and people would achieve more outcomes.

THE CHAIR: They are simple things, right? I spoke with someone at the Dickson shops who was calling them on the payphone, and he said, "They said they will call me back."

Mr Fitzgerald: It was something that they used to do. They were at the Early Morning Centre, but, due to capacity, it is something that has fallen off. They attended our "Who is new on the street" meeting, which helped us build partnerships and relationships, but, again, because of capacity, they have not been able to be there as much. With adequate funding, we are really keen to work with them and help improve the accessibility of that service. We do not want to bypass OneLink. We think it is really important to have that centralised point, so that the referrals come through the correct pathways and we can triage needs, particularly when we do not have the capacity to meet the demand, but we do not want it to be a barrier to someone achieving support and achieving their outcomes.

THE CHAIR: Thank you. We will wrap it up there. On behalf of the committee, thank you for your attendance today. You took one question on notice. Please provide your answer to the committee secretary within five business days of receiving the uncorrected proof *Hansard*.

Hearing suspended from 1.03 pm to 3.02 pm.

COLLINS, MR GLEN MICHAEL, Co-Founder and Board Member, Running for Resilience

VAUGHAN, MR JOSHUA, Chief Executive Officer, The Right Direction Australia and Kinnections

THE CHAIR: Welcome back to the public hearing of the inquiry into men's suicide rates. This hearing is a legal proceeding of the Assembly and has the same standing as proceedings of the Assembly itself. Therefore, today's evidence attracts parliamentary privilege. The giving of false or misleading evidence is a serious matter and may be regarded as contempt of the Assembly.

The hearing is being recorded and transcribed by Hansard and will be published. The proceedings are also being broadcast and webstreamed live. When taking a question on notice, it would be helpful if witnesses used the words, "I will take that question on notice." This will help the committee and witnesses to confirm questions taken on notice from the transcript.

As this hearing will touch on sensitive matters, some witnesses or people watching these proceedings might be impacted or even triggered by what is said or heard. Please take care of yourselves throughout this process. Take it slowly. Breathe deeply and take breaks when needed. Witnesses do not need to share any traumatic details. We have a duty counsellor onsite and available if needed. For those in the room today, please indicate to the committee secretary if you would like an introduction, or pop in to the small committee room in the corridor. The counsellor is there to support you if needed, or for company while you have a cup of tea, if you want one.

A support handout is also available at the entrance to the committee room. We encourage witnesses to take a copy home, as unpredictable emotional reactions may occur in an extended window after leaving the hearing. The handout has tips and strategies for self-support and referral points, in case of a crisis or if you need more in-depth counselling supports. For those attending remotely, an electronic copy is available via the secretariat.

We welcome witnesses from Running for Resilience and the Right Direction Australia and Kinnections. Do you have any comment to make on the capacity in which you appear?

Mr Collins: As well as being a co-founder and current board member of Running for Resilience, I am a participant and volunteer.

Mr Vaughan: As well as being CEO of The Right Direction Australia and CEO of Kinnections Australia, I am a director with Marymead CatholicCare Canberra and Goulburn. I am also here today as Manbassador for the Man Walk Tuggeranong, Canberra.

THE CHAIR: Please note that, as witnesses, you are protected by parliamentary privilege and bound by its obligations. You must tell the truth. Giving false or misleading evidence will be treated as a serious matter and may be considered contempt of the Assembly.

Would either of you like to make a brief opening statement? Do you have something to cover that was not included in your submission?

Mr Vaughan: I have a statement, if that is okay?

THE CHAIR: Yes, go ahead.

Mr Vaughan: I thank the Assembly. My submission focuses on the importance of men's suicide rates nationally, as well as with a focus locally. It is a matter that is very dear to me, and to my extended friends and family.

As mentioned, I have a few different roles. I want to focus mostly on the work that is current and ongoing that I do on a volunteer basis with the Man Walk. My statement really centres around the role that the Man Walk does, for those that are unaware, and the importance that it carries, in this particular space, in supporting men who are struggling with mental health and/or wellbeing issues.

The Man Walk is a free, weekly walk and talk for men aged 18 and over. It is led around Australia and internationally by men who are known as Manbassadors. That is my role that I take here in Canberra, at Tuggeranong. We provide a safe, welcoming space, generally where blokes can connect and chat, and we support one another.

It is a simple, grassroots movement, and it is helping to connect men, strengthen communities, combat isolation as much as we can, and shift the culture around men's health by stealth. By walking together regularly, men build connection, resilience and a sense of belonging. We are hoping that this is before things reach a crisis point. There is no pressure or judgement. It is just a chance to show up, move and talk.

As Australia's fastest growing men's health charity, the Man Walk has a proven track record in delivering impactful, community-led health and wellbeing initiatives across the country. What started with one guy walking in Kiama in 2018 has grown into an international movement. Now there are over 20,000 regular man walkers, and we are approaching 100 million steps together.

There are over 100 walks weekly across 70 locations in Australia, New Zealand, the UK and Japan. There is a growing online community, with over 12,000 social media followers. There is a powerful peer-to-peer model supporting physical, mental and social health and wellbeing, and accessible entry points. There is zero cost, there is zero pressure and there is maximum impact.

Locally, here in Canberra, our Tuggeranong group commenced in June 2019. We just celebrated our 378th walk this Wednesday. We have a Facebook community of 160 members, and around 20 regular walkers. That can be weather dependent, because a lot of them are old and they like to sleep in!

By supporting men to connect before crisis, we are helping them build resilience, normalise help-seeking, and become strong role models in their communities. In doing so, the Man Walk is quietly changing the conversation around masculinity, around loneliness, and mental health in Australia, one step at a time.

THE CHAIR: Do you want to make a statement as well?

Mr Collins: Yes, I will make a quick statement as well. I am representing Running for Resilience today. Suicide prevention is something that we are extremely passionate about. We started about six years ago, from one pub run, with 12 or 15 people—a one-off event. We have now evolved into up to 11 weekly runs, in six or more locations around Canberra. We are only within Canberra at the moment, but it is growing. There are around 1,000 participants every week. It is a free event—no details, no money exchanged to participate. We just ask for one thing from our runners or walkers, and that is to support each other as their donation.

We are not a running club; we are a community, and we welcome those from all walks of life and all abilities—men and women. We believe exercise, and talking with friends, is the best habit you can have to support your mental health.

With respect to how the government could potentially help, firstly, with some support, keeping it very practical, we think that promotions via ACT Health and sport and rec channels could be of benefit. I refer also to continually helping us to build partnerships with other preventive programs. There is research—helping to measure the impact of exercise and community against suicide rates. Lastly, there is making events like ours—running, walking or any exercise events around the Canberra region—easy to run. I refer to things like appropriate lighting around lakes and other running tracks, or where people like to exercise, easy access to first aid—defibs around the areas—insurances, and keeping the footpaths safe for all participants.

I am very open to answering questions on anything else that you would like to know about Running for Resilience.

THE CHAIR: My first question relates to evidence we heard earlier today, in a submission from one of the other witnesses, the Australian Institute of Family Studies. They have done research which shows that 25 per cent of men said there was nobody they would speak to if they were experiencing a depressive episode. This is something we hear about all the time, in relation to help-seeking behaviour.

How important do you think it is for initiatives like yours? Is that something that you are specifically trying to target? This is a two-pronged question for both of you. How does that connect in with a peer-to-peer setting, and then into more clinical support, if that is what is needed?

Mr Vaughan: With respect to the practical experience from the Man Walk, because we are a smaller group—we have, on average, anything from 12 to 15 regular walkers a week—we are able to create a connection fairly quickly. That is the catalyst to build a little bit more trust. Generally, when guys first join the group, without having the evidence to back it, I know that most of our referrals come from wives and partners, or even children, who suggest to dad, "Here's a group. Here's something you might be interested in. Why don't you go and check it out?"

A lot of the guys will mention that they heard about us, or their significant partner has heard about us; hence there is that little bit of a push. That points to some evidence around needing a gentle prod or a gentle poke to be more forthcoming around something

that is a good opportunity to support your mental health.

As far as reaching out for support goes, we do find that there is a lot of support through our conversations. Following the walk, we always end up with having a coffee. We are lucky enough to have a very small cohort at Bunnings—Bunnings have been greatly supportive, locally—and we have a little area that we go to. It is consistent; the barista there knows our orders now, so it is a really calm and supportive environment.

Luckily, with my experience and connection with the local community services, in my role at Marymead CatholicCare, I have been involved in five direct referrals to our allied services in support of requests that have come from walkers, who have, over a matter of a few days or a few weeks, built up the courage to put their hand up and ask for help, and ask for some advice about a first step, or a good step to take.

I am lucky that I have that experience, from working in the sector. I think that the education piece around that is essential. Focusing on males, and focusing on male suicide, for the benefit of the Assembly members here, is a gendered issue, and you need gendered responses. Tapping into men, and tapping into the way that men think, feel and act around mental health, is a unique thing, and it is very different to how women would potentially approach it, in a more open and honest way, with friends, peers or family.

Whether it is the Man Walk or whether it is exercising with Running for Resilience, there is a real strength in men being side by side and shoulder to shoulder. A lot of the other gender-focused organisations appreciate that, if you are trying to talk with another guy, another fellow, you do not look them in the eye. You talk next to them, you talk side-by-side with them, and it builds a little bit more trust. It is a real thing, and it is a real experience that is shared amongst guys. If you are doing something, or sitting across from someone, if you are exercising or walking, it does not really matter, but you are close and you have the presence there.

As alarming as it is to hear that 25 per cent of men will not reach out for help, I do not see that that is a reason not to try. We need to try to build a whole communication with and a re-education of community around, "There are ways around this. We can support you in how you need to be supported," but we need to be more clever about how we approach that.

Mr Collins: Going on from what Josh just said, we definitely understand that a lot of men do not resonate with suffering from mental health, and a lot of suicides can be prevented through situational events. With how we have evolved, and just to differentiate Running for Resilience from any other regular running club or sporting activity, we have really embraced sharing stories—men and women openly sharing their stories and struggles that they have had, and how they have overcome mental health problems, whether it be depression, anxiety or whatever factors could potentially lead to suicide. It is about trying to normalise it.

We have found a huge response and had a lot more people open up and tell their stories. Everyone involved knows that it is very normal, at some stage of their life, that they could hit absolute, rock bottom; it is about thinking about how many people are potentially there to support you. It is about making sure that the support is there.

We have differentiated ourselves from any other exercise program because we are super open about it; we see the change, and we have had so many personal accounts where people have said that R for R has been a huge contributor to saving themselves. We really do hit home the importance of sharing your story, and we try and normalise that as much as possible so that everyone feels open to being vulnerable.

THE CHAIR: Mr Vaughan, you mentioned you have those connections into the community sector because of your professional experience, and I know Running for Resilience has been trying to build some more connections for referral pathways. How have you gone with that, and what do you see are the opportunities, and maybe the gaps, in terms of when you realise that someone probably needs some professional help, some clinical help? Also, are you starting to get referrals back, where maybe someone has been seeking help for, say, three months or something like that, and they are told, "Actually, we just think you need a bit more connection with your community"? Are you getting people referred to Running for Resilience or to your initiatives, Mr Vaughan?

Mr Collins: Yes, we have partnered up with organisations like Menslink, Bravery Trust and Lifeline. We definitely work alongside them with different events and promote their cause, because we are very much the first step to take. If people need to seek extra help, we are not professional counsellors, but we would like to think that we have a fair bit of training, in the volunteers, in a bit of mental first aid. We would like to see that being more easily accessible.

Mental first aid is so important, in how to recognise a friend, a work colleague or even, potentially, a stranger that has attended a run, and who could be suffering severe depression and anxiety. It is definitely on our radar that we want to make mental first aid very available for all our participants, along with the Medicare Mental Health Centre, which has been great; it has been a good stepping stone from us. If people want to seek further help at no extra cost, they can access them.

Mr Vaughan: You may well have heard already from other witnesses around access to services, the waitlists and the over-subscriptions, and the issue we have with capacity within the sector. Everywhere is over-subscribed with clients or people on waitlists, and that is a sad state of affairs. If we had infinite money and resourcing, that would be a different story, no doubt, but we do not.

Recognising that there are gaps between not only being referred to, but accessing, clinical-based services, we foster a lot of conversations around protective behaviours, around what you can do in the meantime that will help you to stay strong and to keep on top of what can, a lot of the time, feel really overwhelming—feelings, emotions and what your experiences are.

The protective factors include the social connection, which I think would be huge, in Running for Resilience. For the Man Walk, that is a huge component, around actually being connected with people who could be in a similar situation to yours, but you know there are people who are willing to listen and to support you. Also, it brings back a little bit of purpose and that positive future focus.

Regular calendar events are really important. Running for Resilience has 11 runs happening a week, roughly. We have three, and everyone knows where they are, what time they start, and what you will get from those. There is also the community aspect. We are having lots and lots of information come out now around the importance of and necessity for human connection in the community, and about that being one of the key indicators of positive wellbeing and mental health.

Referring to and accessing services, yes, that is always there. It is not as timely, probably, for most people who need to access that. Again, there is a really important education piece around the other protective practices, and things that organisations like ours are actually providing.

MS BARRY: Thank you both for attending today. It is really encouraging to hear about the work that you do. I want to explore the concept of masculinity. I want you to tease out for me how that plays in conversations that you have during that work. Is that a factor that is considered? Are there things there that perhaps society can look at identifying positively? Are we speaking the right language? Are we using masculinity as a tool, as a weapon? What are the conversations that men have around masculinity?

Mr Vaughan: I think a lot of damage has happened with the term "masculinity" when it is aligned to an act or an action. Unfortunately, we hear a lot about toxic masculinity. Therefore, that is attributing behaviours or actions, in this space, predominantly from men against women; it is considered very damaging, and it can feel very judgemental of people, too.

With respect to how we target masculinity, we actually test it out, and it is happening within the group already. Maybe I did not mention it earlier, but, at 50, I am one of the youngest guys in my walk, believe it or not, so we cater for an older age group. It is the theme that is coming through, with the Man Walk in particular. We have conversations all the time around "what my dad used to do", and "what I thought was a strong man", and "what strength looked like for me in my house, my home and my upbringing".

We test those experiences now, regarding what kids need, and what we understand now that people need—partners. We draw down on what masculinity can and should look like, and how you can role-model that. We talk. We have guys who start sharing over coffee, and they will share really personal stories or accounts of what is happening. There is normally a reflection or a response that says, "Mate, that's very brave of you to talk like that; thank you for letting us in."

Masculinity, I think, means lots of different things to lots of different people. I think we have to keep reframing the conversation so that there is a strength in being kind, caring and open, and that is as important as the one around this physical strength, and this bravado of being a bloke, and thinking, "It's weak to speak," or "Real men don't cry." I think we are moving past that now, which is great, but we still need to be cognisant that it is a really important conversation that we have to keep having.

Mr Collins: Going on from what Josh said, we are definitely making a lot of ground on the term "masculinity", and I think it is starting to change. At least, for my generation, instead of being closed off, and afraid to be emotional or vulnerable in front of friends or family, it is definitely coming around. We like to show that, in Running

for Resilience, with different personal accounts, and show big, burly, rugby-playing men that they should not be afraid to shed a tear and talk about their struggles, because, in the end, they know that it is a much better outcome to be vulnerable and show your weaknesses, as opposed to, ultimately, what can happen further down the track when you do not, which is suicide.

We discourage men from taking their shirts off while they run, at Running for Resilience, because they come back to the pub, and it is a bit inappropriate. There is a time and place. If you are in the river or at the beach, that is all good.

THE CHAIR: I know what you are talking about.

Mr Collins: We call it "peacocking". We like to keep everyone welcome, and that includes females as well. We are against peacocking, and we make people aware of that, but everyone else is extremely welcome. We have seen a big shift in people respecting each other, along with supporting each other, whether it be other pedestrians on the footpaths or making way for cyclists; it is about definitely losing that macho definition of what it is to be masculine, and being grounded and open to vulnerability.

MS BARRY: How has that shift come about? Is it through peer-to-peer support conversations? What do you think is driving that shift?

Mr Collins: We try and drive it through our messaging, at the very start of the runs. We make it very evident that it is not a dating club. If you are not here for the cause of mental health and suicide prevention, maybe it is not the right club for you. We very much push that from the get-go, and want everyone to be engaged, listening to people talking, and being welcoming to solo runners or first-timers, because we want it to be a safe place—very inclusive and inviting.

Mr Vaughan: As Glen mentioned, it is a matter of talking about it, sharing stories, and being openly proactive around supporting what masculinity is and what it can be.

I would like to expose publicly my huge man-crush on Steve Biddulph. I think his definition of masculinity is perfect. He keeps getting asked about, "What is masculinity?" He says, "It's simple. To be masculine, you have a strong backbone, but a soft heart." By that, he means that you are strong when you need to be strong, and you are consistent. You keep boundaries, but you also have this caring side of you, where you take people in and listen to them, and you show them the softer side of you as well. I think that is a great analogy for how masculinity should be thought of.

MS BARRY: There is evidence—and you have also mentioned it, Mr Vaughan—that older men are more likely to face loneliness. You mentioned that positive community connections can help to alleviate some of those concerns. Can you identify, in your view, what positive community connections look like, especially for people who have lost families, or for older men who have lost their partners and their children have moved away; what does that look like?

Mr Vaughan: I think loneliness is the real, serious epidemic facing most people, including men. We are at crisis point, and I know there is evidence that attributes physical health to loneliness. What does it look like? I think it looks like consistency.

It looks like safe places where you are not worried or anxious about being judged, or made to feel less of, because you are maybe opening up or you are fragile.

It is about availability, too. That is why I think these no-cost, free events are so important, having regard to community-building capacity as well. Price is a barrier for a lot of people, and we see that with the cost of living. If there is more support and promotion to create these spaces that have next to no barriers to attend or participate in, that will go a long way to supporting men.

Mr Collins: I believe possibly the biggest cure for loneliness for older men is just to have a purpose of supporting someone else. With the Man Walk and R for R, we can give them purpose. They can just be a participant at the start, but that can soon change and they can be a volunteer. It gives them a purpose, in rocking up every week and feeling like they are making a difference. It goes a long way to helping them get through some dark moments in their life.

MS TOUGH: Mr Collins, you touched on this earlier, and it is also in your submission: men do not always resonate with the term "mental health", and suicide is more likely to be because of situational distress, such as something that is happening or has happened in their life, rather than a mental health condition. Can you elaborate a bit on what you mean by this? Is there an underlying mental health condition that a man might not want to acknowledge, or have diagnosed or addressed, sitting there underneath the social distress that has happened? I am curious as to what you mean by that.

Mr Collins: Going on with the masculinity term, it is about not giving in to the fact that you may have a mental health problem, whether it is depression or anxiety. They do not quite identify as having a mental health problem, and that might skew the numbers, because I think they definitely have one. Deep down, they know, but they are not willing to say it—

MS TOUGH: They are not willing to name it?

Mr Collins: to claim it or to own it. With situational distress, it does take an event or a certain time of year, when it gets too much, and that is the main contributing factor to suicide. I think it is definitely there, but they are afraid of owning it. They are afraid of being vulnerable and, unfortunately, it takes a situation to tip them over the edge.

MS TOUGH: We have heard from other witnesses today about how it is often a relationship breakdown or loss of a job—that kind of situation. Is that what you have seen in Running for Resilience—a trigger for people to maybe come along?

Mr Collins: Yes, definitely, such as a traumatic event. It could be the death of a loved one or a relationship breakdown. We get a lot of people from Defence, especially around our area, around Kingston. I have never been in Defence myself, but it would be a huge stress on friends and loved ones, with all the postings and not having a stable base. Just last night, I was speaking to someone in the Navy, and they said they have had four people so far this year die from suicide. He mentioned that he has been to four funerals this year. If you think about the number of people that go to a funeral—it could be 200 or 300 people—and this person who has, unfortunately, committed suicide did not think once to contact one of these people. It definitely hits home that the support is

there, but you have to be brave enough, man up, speak, and ask for help.

MS TOUGH: Did you say you have six Running for Resilience locations across Canberra?

Mr Collins: There are about six locations, and growing by the week.

MS TOUGH: One opened in Tuggeranong only a few weeks ago, from memory.

Mr Collins: Yes. Two Before Ten has got on board at Denman Prospect, and now Tuggeranong. Also, Frankies at Forde in Gungahlin, the Dock, the Jetty, and UC. A couple of schools have jumped on board with Recess 4 Resilience. There is scope for growth there, because we think it is super important to get into schools, to create that habit early on.

MS TOUGH: Mr Vaughan, you said there are a few locations in Canberra?

Mr Vaughan: At the moment there is Tuggeranong. There have been a few other locations of Man Walk around Belconnen. There was an early walk at ANU, but the Tuggeranong one has been consistent for the last six years. It is important to say, too, that I do not think mental health is the problem; it is about seeking supports.

MS TOUGH: For mental health, yes.

Mr Vaughan: Yes. We all have mental health, and we all have good days and bad days, and ups and downs. The issue is about accessing services and reaching out for support, when you are having one of those experiences or times when you need to.

MISS NUTTALL: You mentioned that, with the Man Walk, it tends to be older men that are showing up. I am interested in the demographics that you see consistently attending. Where do you think there might be demographics that you are currently not seeing as much, and why might that be the case?

Mr Vaughan: On behalf of the Man Walk, we absolutely do seem to cater for an older population, and that is ringing true across the majority of the sites nationally and internationally. The cohort that we do not see, which I really wish we would see, would be the early 20s, post school, post further study, maybe moving into relationships. I would guess there would be a lot more pressures—family and relationship pressures, work pressures and that kind of thing.

We would love to attract younger guys in that cohort. I can think of the opportunities that that would bring in itself, in revitalising and making those communities a bit stronger. Our oldest guy is 84, and he is a bit of a juggernaut, which is amazing. We know that, with a lot of the guys, the older blokes, 75 and upwards, they are at real risk of loneliness and isolation, with separation from families and friends and that kind of thing. They are not going to go running. They would like to go running, but this is where walking is attractive, because it is an easier physical activity. If we were to target a group that is missing, it would be the early 20s, mid 20s, for us.

MISS NUTTALL: We have had evidence from a number of priority groups, including

young fathers, culturally and linguistically diverse men and trans men. Are they also areas where you would like to see more people coming in, or are you fairly well represented there?

Mr Vaughan: Absolutely, yes. Again, because we miss that lower-age population, we do not see a lot of young fathers, unfortunately. We do not have any trans men in our group, and I am not sure what the statistics look like, across the other sites. I would hazard a guess that they would be fairly low. With culturally and linguistically diverse, we have a real mix in our little group; again, we are small. There are some large groups across the country, and in some of the larger groups in Queensland—Redcliffe, I think, is a good example—they have up to 150 regular walkers a week. You can see, from the posts and the photos, that there is a diverse snapshot of people that attend those ones.

MS BARRY: It seems to me that there is a real opportunity here, between Menslink and you guys, to connect, because you have younger people coming through from referrals, and there is an opportunity for mentorship support, because you have a repository of older men with experience.

Mr Vaughan: Yes, absolutely. That is why I think things like this are really important, as a promotion vehicle, to say that we are out there doing this. Any additional supports we can have in promoting the importance of it, and the accessibility, would be great.

THE CHAIR: Sometimes we hear that, in the more formal service provision area, it can be hard for services to collaborate. They are often competing for the same pool of money, and there is also not the time. One of the issues we have heard today is about men not having time to connect, especially in early fatherhood and so on. I am wondering what you would like to see, if anything, to encourage more collaboration across the entire service sector; and, with community initiatives like yours, whether you think there is a role there for government.

Mr Collins: Definitely, there is the help with the promotion of it—to put it in people's eyes, to see that it is available and welcoming for people, through different government channels. That is one of our best points on how the government can help. We just evolved; it started with a group of runners, but we have tried to evolve as well. There is Yoga for Resilience, and pickleball. We know that not everyone wants to run.

It is about making it accessible. The support networks are there, but if the government could assist in any way with helping to promote our side of things, that would give us a lot of scope for growth, to have future locations and extra runs, and at least to get the majority of Canberra covered.

Mr Vaughan: With the promotion of health benefits around physical, emotional and mental health, there could be more support and promotion from government agencies across that, too, and connection with families—family relationships. With all these things that go to promoting this pro-social approach to being connected, healthy and building community, there is so much there, really.

THE CHAIR: In your submission, you mentioned the social determinants of health, and the importance of looking beyond the clinical interventions when it comes to addressing suicide. That is something we see; health is just put in the clinical category,

but there is all this other stuff that is preventive, or where it could catch someone in a moment of crisis, but it does not get counted.

Mr Vaughan: Yes.

MS BARRY: There is a question that I have asked of most people today. There is evidence in some of the submissions that men will generally not access services because they are gendered. I am wondering whether that is your experience. Is that what you see coming through, in those groups that you support?

Mr Vaughan: I wrote in my submission that I think we need a gendered approach. By that I mean that we have to think the way that men think. Is the question about whether there is a pattern coming out that men will not access services that are run by women?

MS BARRY: No data is currently being collected, but there are submissions that indicate that men will generally not access services where they are provided by women, especially mental health services. I was wondering whether that is your experience, and whether there is work that we can do to increase—

Mr Vaughan: From the direct referrals that I have been involved in, none of the men have asked me if they will be seeing a female counsellor, so I do not see that as an issue in our space. I cannot speak for other areas. There are cultural aspects involved, too, of course. I have not experienced that, no.

THE CHAIR: On behalf of the committee, I thank you for your attendance today. If you have taken any questions on notice, please provide your answers to the committee secretary within five business days of receiving the uncorrected proof *Hansard*. I do not think you have. Thanks very much for taking the time to be part of the inquiry.

ALDRIDGE, MR GREGORY OAM, Chief Executive Officer, EveryMan Australia
HEWITT, MR JOSH, Manager, EveryMan Australia
GATHERCOLE, MR BEN, Chief Executive Officer, Menslink

THE CHAIR: We welcome witnesses from EveryMan Australia and Menslink. Please note that, as witnesses, you are protected by parliamentary privilege and bound by its obligations, which means that you must tell the truth. Giving false or misleading evidence will be treated as a serious matter and may be considered contempt of the Assembly.

The committee recognises that some of the issues raised in this inquiry are, of course, sensitive. If anyone is finding this hearing difficult, we are very happy to take a break, and a duty counsellor is available onsite to provide support, if needed. A support handout is available at the entrance to the committee room which includes tip and strategies for self-support and referral points, if needed. Would any of you like to make a brief opening statement covering matters that are not addressed in your submissions?

Mr Gathercole: Yes.

THE CHAIR: Go ahead.

Mr Gathercole: Firstly, thank you for this opportunity. I would like to two statements. First up, I would like to say any death by suicide, whether it is male or female, young or old, is a tragedy and it affects many, many people. We are all aware of that. I would like to just read an extract from a speech I made two weeks back, at our Menslink Business Breakfast, which was a great success for us. It really highlighted death by suicide and the need to be able to speak. So, if I am able to do that—is that all right?

THE CHAIR: Yes, please.

Mr Gathercole: We all know that mental health challenges for young men are significant. Navigating hurdles, pressures and new experiences often leaves them in need of support, more than ever before. While tough times for young men are nothing new, what matters is that we are choosing to act. In Silence is Deadly, we are aiming to educate young men on self-identification when things are not going well. This health literacy is crucially important for young people, as men with increased health literacy are more likely to value preventative mental health approaches—in short, to seek help before it becomes too much.

Obviously, we must act, because the consequences of silence is deadly. Suicide is the leading cause of death for men aged 15 to 44. On average, men who die by suicide lose 35 years of life. Despite these realities, seeking help remains difficult. For many young men, the simple act of raising a hand can feel impossible. They fear being judged, appearing weak or being excluded.

This is where our program Silence is Deadly makes a difference. Delivered to more than 10,000 boys each year, it challenges stigma, normalises help-seeking and reinforces the importance of looking out for your mates. With consistent messages, role models—we had Barry speaking the other day—and the support of everyone in rooms like this, we can make putting up a hand that little bit easier.

Mr Aldridge: This is my first inquiry in 48 years. So, not being aware of the protocols, I did not prepare any opening statement. So, thanks, Ben, you have inspired me.

Mr Gathercole: Thank you.

Mr Aldridge: One of the things about EveryMan is, while we work a lot with guys who come from pretty ordinary backgrounds, our specific focus is really on working with men with very high and complex support needs. One of the defining characteristics of that cohort is that guys have chronic histories of support failure that go back to childhood. The first time there was a family intervention because of domestic violence, or somebody died and the children go into foster care—whatever the needs and issues were that were generated by those traumatic events—for a lot of our clients, they were never responded to effectively.

That is no shade on the organisations themselves. They were full of people who are really well-meaning and they had models of support that they applied. But a lot of our guys, for one reason or another, never benefited from that. It could have been an acquired brain injury, it could have been a response to trauma, it could have been an intellectual disability or parents could have had alcohol or other drug problems. But their failure to respond to support interventions, for most of our guys, was followed by more support and interventions that did not work, and then some after that. That translated into their experience in their teenage years, their early adulthood and often to when they were older.

I reflect on our guys quite a lot, because I have been working our organisation since 2004. I remember one of our early case managers going out to visit a guy in a violence prevention service and found him trying to hang himself in his garage. I think a lot of the guys who we were work with who are suicidal or who have committed suicide are the ones who are not engaged with any system where they could respond to an invitation or a suggestion to ask for help.

In fact, we have a lot of people that we work with who have been so adept at failing the system, because they have had so much practice at the system failing them, that for many of them the systems that should be supporting them are disengaged from them and are reluctant to engage with them. A lot of them have been banned from service delivery—because of behaviour; because of drug use; because of competition between the support agencies over which a particular personal issue should be fixed up first; their mental health issue; or their drug and alcohol issue—and they are often left alone and vulnerable, and they tend to live in communities where they are surrounded by violence and often live in fear. They are mostly disengaged from their family. So they are chronically socially isolated, which ticks just about all of the boxes for making them highly at risk of suicide. Sometimes I am surprised that more of our guys have not committed suicide than actually have.

I really appreciate the fact that this inquiry has been convened, because Josh and I are here to talk about the guys that very often do not have people to talk about them. So thank you.

THE CHAIR: I just wanted to follow up on that. You have spoken about the repeated

institutional failure experienced by the men you are working with and how that can create a dynamic of mistrust in relation to governments and services. Given that dynamic, what would you like to see change? What would an ideal world look like if those services were responsive to that?

Mr Aldridge: We just came from a conversation about men and boys in relation to domestic violence, convened by Minister Patterson. It was quite obvious that the question of men and boys is on everyone's mind but it is mostly in relation to the problems that some men and boys bring with them—maybe violence to others. In this case, we are looking at self-harm, but that also impacts families.

I think it is easier for our community to be caring of or at least interested in the lives of the young men that come to Menslink, because they are still young. But a lot of guys reach an age where people give themselves permission not to care about them anymore. It is a pretty common thing to understand—that young men who have been in the out-of-home care system, when they get close to 18, are already noticing the system losing interest in them. People are not overtly saying this, but there is a sort of systemic attitude, which is, "Okay, well, once they're adults, they're not our problem anymore."

The issue that we have is that, once young men turn 18, there is no systemic interest in men. There is no policy interest in men. Governments do not have policy interest in men. I know that the Men's Rights Association—of which we are not members, let me point that out now—will argue that men need a minister for men or whatever. That is not really our view. Our view is that agencies that are providing services to the community need to be responsible for generating a framework for meeting the needs of the men who fall within their particular silo and being proactive about that.

Our experience is that a lot of people will want to work with the men who want to be worked with. As long as there are services around to work with those guys, then good on them, because those guys have an entitlement to be supported. The challenge is for the ones where agencies find it much easier to refer somewhere else. I think that is something that government needs to understand about those men in terms of their whole life, not just the silo that happens to be dealing with them.

I use the word "silo" all the time. I do not mean that pejoratively. I understand why government organises itself in particular ways. The problem is that the community sector mirrors that. When people talk about whole-of-person supports, very often it is the issue for the silo—whether it is homelessness, mental health or whatever—and the whole person is generally supported to the extent that that helps them participate better in the service delivery and, once that happens, they lose interest in the man as a human being, who has a whole life outside of the problems that they have.

So I would encourage government policymakers to start having some conversations about what the underlying attitudes are that people who work in government actually have towards men as a community, not just the men that they happen to know personally.

THE CHAIR: In resolving those silos, do you imagine a service system where there are more service providers able to themselves offer more holistic support or more instances of individuals being supported by multiple different service providers, who

are actually working collaboratively rather than perhaps competitively?

Mr Aldridge: It is an interesting question. I think there is a segment of the community that will always respond to new funding opportunities and suddenly get interested in a group of people that they have not been interested in before. I know my own experience was that, until our organisation came into being, the entire child protection and some of the other community service sectors never really thought about our client population, because there was nowhere to send them. Once we opened up, suddenly people started to see us as being the solution for guys that they had never really thought about before, because they did not have anywhere to send them.

So I think the proliferation of men-focused services and an expectation that the people who provide those services are interested in the lives of men outside of the area of service delivery, would mean that a lot more men would be willing to go and seek help, because they would see the agencies as being interested in them. That help-seeking that Ben was talking about before is much more likely to happen if people are saying to each other, "I went down to the local community service area the other day, and they had a men's room. It wasn't even a dance room and it did not have two football magazines on it, but there were people sitting around talking about stuff that men were interested in, like what happens when you lose your job, what happens when you retire and all of that stuff."

I think any agency could realistically start to develop itself. But the community sector, traditionally, has mostly employed women, and, as well-meaning as a lot of the women's services that I have worked for have been, they are not terribly good at working out how to make their agency look not just men-friendly but also men-focused. That is really the direction I would like to see people starting to explore. There are no answers to that yet. It is like a whole area. Once you start to look at it, then you start to see the opportunities to address things that have not been visible before.

THE CHAIR: Do you have anything to add to that, Mr Gathercole? It is okay if not, we can go to the next question.

Mr Gathercole: No. I am happy with that.

MS BARRY: He has answered most, if not all, of my questions. That was really insightful, and you are absolutely correct that we do not think about men outside of men who would engage, for example, in services like mental health and domestic and family violence. It is not a focus for us; so that was really, really insightful that most of our policies are not towards proactive but are more reactive to those behaviours.

I know you are not a fan of a minister for men—so I will not go there—but where do we start as a government? What are some of the things we can do today to make sure that we shift that focus? You have mentioned that people working in departments should look at how they are responsible for the staff and what they are doing to take care of the men that work around them. But what additional things do you think that we could be doing, outside of government as well, to refocus?

Mr Aldridge: That is an interesting question. When we participated in the commissioning process for homelessness services and they had the first consultation

with the men's sector, almost all of the organisations that turned up for that were generalist services, and some people actually acknowledged that they were not men's services, and what they would do is iterate problems that were not just problems for men but also problems for women and problems for people from non-English speaking backgrounds or whatever. They were generally things that are wrong with the system.

I think one of the things that would be interesting to do would be to start engaging, at least with the sector, as a means of providing feedback to government on the question of, "What is it that we don't know about men? What are the things about men, men's experience and men's lives that we're not currently paying attention to?" If you do not get what you are not looking at, you cannot start to look for it. I think that would be a really good place to start.

Mr Hewitt: We know that men will get to crisis or beyond crisis before that is the point that they will reach out. For the men that come to us, it is not a singular crisis; it is multiple. For example, the housing system says that there is a Housing First policy, but we understand that, if I put a man in a house and there is a crisis everywhere—he has turned up with a complex mental health condition, with a long history of drug and alcohol and with a long history of the support system failing him—we are going to have to address all of things in order for that house to be sustainable.

The moment that the system segregates itself up and says, "We just do this bit, and then this bit and this bit," we know that we end up spending a long time with that man. We say that our program is 12 months, but we are looking at a number of years in order to make that sustainable. Otherwise, he gets kicked out of the house and then he is back and we will see that referral over and over again, and then you get parts of the service system that say, "I don't want to work with him anymore because he's too difficult."

Mr Aldridge: Or "We've already banned him and we're not reengaging with him."

Mr Hewitt: Yes, "We're not going to work with him again."

Mr Aldridge: It is like there is a permission to just shrug your shoulders and say, "Too bad." I think that, with a lot of the guys we work with, people do not feel like they have the same sort of moral and ethical obligation to be concerned about that they do with other people. It has been said that the only men that the system seems to be interested in are single dads who are a bit incompetent and maybe have a heart disease—that, if they are a bit sick and a bit helpless, you can rescue them. But the ones that require more commitment are very often the ones that have been disengaged from the system, because the system has given themselves permission to shut the door behind them and not care about who picks them up afterwards.

MS BARRY: Again, that is very insightful. While we consider those broader systemic changes, what are some of the things that you currently do to encourage men to seek assistance, to get help and to have conversations about their mental health?

Mr Hewitt: We run a service that has multiple arms to it. That means that we can take a man into our accommodation service but I also know I have counsellors, plus I also have a men's behaviour change program. But then we end up where we are at the point where we are holding all the risk of that one person, and then the system goes, "Well,

they're with EveryMan, so that's okay." That becomes difficult in and of itself. For example, if he does have a complex mental health issue and he is not connected to mental health, we are then asked to be the mental health provider as well. He then views us in a particular and we lose the relationship that we have. If I have to say to him, "Well, you're supposed to take medication and now's the time to take it," it is–

MS BARRY: It is a different relationship.

Mr Hewitt: Yes, I am shifting the dynamic completely, and that becomes, I think, incredibly problematic, particularly when you are trying to sustain a relationship, given that that is the thing that has not happened in the past.

Mr Aldridge: I think that that multiple arms aspect of our organisation is really interesting, because a lot of the thinking that we have now comes from decades ago. I am just reflecting on what the needs are of the men who come through the door. Our services are complementary and, being a homeless program, have a facilitated referral into our counselling service. But we use the same clinical framework across all of our programs. Someone does not have to wait for a counselling service in another agency to have a vacancy, because that client is the client of the whole agency. So we move our resources around to try and respond to their needs as they arise. That is sort of a safety net.

It is an unusual model for most community services, anyway, but the reason we have ended up doing it is that, for a long time, we have been the only agency in the ACT that has been interested in working with this particular cohort of men. So, when the funding came up, we got it, and we now have this program. But it also does leave us incredibly vulnerable, if there were a change in government policy, where one of the silos was taken out, because there was a change in that government department's philosophy about funding priorities and needs and all the rest of it. That is why I think it is really difficult for individual government departments and the sectors that sit underneath them to really see the clients from a whole-of-life perspective. One of my experiences of working alongside of Menslink for many years is that the diversity of programs means that the young men who come through Menslink are much more likely to be a seen in a broader context.

Funding organisations for individual services but hoping that other agencies will pick up the other bits does not work. You see that with our partner contact program. Until we got funding through the ACT government recently, we had to cross-subsidise our partner contact service by taking money out of our men's counselling service, which diminished the number of counselling appointments that were available for men—and nobody complained. Our contract managers were not coming back saying, "I see you've reduced the number of appointments for men because you're using some of that money to pay for partner contact."

We could not provide domestic violence services without providing a partner contact. In other jurisdictions they would say, "Why don't you refer those women to a women's service?" and I would say, "What—the ones that are already overloaded with the clients that they've got? We put them in a queue and then they have to wait for that agency that does not have any current invested interest in them as people to wait for them to get their turn?" We cannot do that for the people in our agency. So we have really

cross-subsidised all of our programs with funding from all of our other programs to make sure that we have got the capacity to do that as much as we can: a whole-of-life wraparound.

MS BARRY: What does system integration look like? What does it look like in terms of integrating with existing mental health services, for example? I know there are other services as well.

Mr Hewitt: That is a really good question—because, suddenly, you are talking about a statutory authority who is trying to work with the community services sector, and that becomes problematic in and of itself. For example, for a lot of the men we work with in accommodation, we are going to place them in an environment that is difficult. It is an environment where there is a huge amount of risk, and a statutory authority, like mental health, will go, "I am not going to go in there." Then we are left with this man—and the risk. We have had the assertive outreach team say to us, "You go in and get him and bring him out, and then we will." But it is like, "Why is the risk on me different to the risk that I am going to place on you?"

I think your question is really interesting, because it becomes difficult when you have got two competing priorities here—the statutory authority who says, "We have to do this", whereas, we are actually trying to look at this man as more than just the mental health condition that he has. Here is this man who ended up with us because there are a whole lot of things that have gone on in his life, but no-one has ever looked at him as more than just that set of problems—not the man that is actually here working with us.

MS BARRY: Thank you so much. I have lots of questions, but I know that Ms Tough—

MS TOUGH: That is all right. You touched a bit on what I was going to ask. Hopefully, I will touch on some of the questions you were going to ask.

MS BARRY: Thank you.

MS TOUGH: Firstly, I want to say thank you for the work you are doing in our community. I knew of Menslink before getting elected. I did not know of EveryMan, and I have now referred on to EveryMan a few constituents who have come to me. They have had nowhere else to turn. They have engaged with so many services and just keep hitting brick wall after brick wall. I have referred a few to EveryMan, and I have had feedback like, "EveryMan actually saw me, and someone is talking to me and taking me seriously as a person." So I wanted to say thank you.

Mr Gathercole: Props for you guys—well done.

Mr Hewitt: That is good feedback. Thank you.

MS TOUGH: There were a few situations; so that is wonderful. Earlier on today, we heard from St Vincent de Paul, and they talked about building trust when you have a man who, in their case, is sleeping rough and how you build that trust between an organisation and a person who is distrusting of government and distrusting of health providers. I am just wondering how you go about doing it—and the same for Menslink. How do you build that trust with younger men who maybe do not want to be trusting

of government and authority? How do you build that trust so you can have those relationships and help them?

Mr Hewitt: Time.

MS TOUGH: Time?

Mr Hewitt: Yes. I think part of the problem is that, when services are asked to provide a service within, say, a 12-month timeframe and we are working with a man who has high, complex needs, 12 months is not even remotely going to be enough. This is a man who the system has told over and over again, "Quick; hurry up, hurry up, hurry up," but we know that that does not work. So we have to spend far more time with him—and even before we can start to intervene in certain things. He does have to trust us because, at the end of the day, we are going to be the people who are going to say, "I think we need to start here, because this seems to be the most problematic thing," but knowing that there a whole lot of things that we are going to have to keep in our mind. So time.

Mr Aldridge: I think time is absolutely the fundamental thing, but I think the other side of that is that your organisation has time to develop an identity that is communicated in the community. I would say that the same thing is true for Menslink as it is for us. Our organisations have been around for pretty much the same amount of time, with various degrees of relationship. I think Menslink has a very positive reputation in the community, and most young men will at least know somebody who has heard of Menslink or gone to a program and, if some people from Menslink turn up at a school, they will think, "They're from Menslink".

We do not get that from the general community. My explanation of that is that, usually, nobody ever finds out about us until a man in their life falls over really badly. People can often be quite denigrating of a lot of the people that we support until they discover that somebody in their family is one of them, and then they learn about it. So we do not have the same sorts of opportunities for social media communication to the community, because people do not like a lot of the people that we work with.

We work with sex offenders, people who have committed homicide and people who have done a lot of harm to people in the community. We have had staff members whose friends have said, "You're not still working with those people, are you?" They have had to defend themselves against people that know them quite well. But the good thing is that our staff have been around for a long time. Our turnover rate is around three and a half per cent. It has been like that for about the last few years. We have worked really hard at developing a very strong organisational culture and investing in leadership training and development, so that people who come up through the ranks get supported for doing really difficult work.

What that means is that, over time, they go out into the community, they meet that guy who has just come out of jail, or that person who has just turned up on the streets or whatever, and somebody will say to them, "You're being supported by EveryMan. I heard they're okay." They do not all say that; some of them will complain about us no matter what we do for them. But the word of mouth in the community of people that we support, particularly through the prison system, has made a significant difference for us, I think.

Mr Gathercole: Just briefly, for us, it is about walking the journey. We are a very different service than what these guys are. One of our services is our mentor program. Our mentor program deals with young fellows that do not have a male role model in their life. They are commonly 12, 13, 14 or 15. They have seen whatever male person in their life check out, for whatever reason. So the distrust is evident straight up.

We talk to our mentors about walking the journey with those young guys over their mentor program. That does not have to be hard. You do not have to do anything special. You just have to be present. You just have to be there, be trusted and be reliable. That is something that young fellows just have not had. Can you imagine that—when you are 10, 12, 13 or 14 and you already have that mistrust? Our mentor program is a really easy program and we do not try too hard—"Just be there with me, mate"; "I just need to get to footy practice on Saturday"; "No worries, I'll get that done." It is a really simple concept but it is bloody complexed.

My simplistic goal would be to ensure that our guys do not end up having to avail themselves of a service such as this one. How we do that is through education, mentoring and counselling when they are nice and early—pretty simple. I know it is a very simple take on this situation. I do not want to make light of that, but that is what we try and do.

MS BARRY: It is a proactive approach.

Mr Gathercole: We are in nice and early. In our previous generation, we were really looking at the high school ages. Unfortunately, we now recognise that we looking at younger age groups, and we were asked, and we have now designed programs, to go to years 5 and 6 in primary school. My first thought was, "That is terrible." But when I actually thought about it, I was like, "This is actually really good." We are actually getting in earlier and we are teaching young fellows that is it okay to reach out, it is okay to seek help and it is okay to want to be part of your school environment, rather than disconnecting and not being part of it.

MS TOUGH: It is about getting to boys when they are at that 10-year-old mark, before they hit puberty and they start to become a teenager?

Mr Gathercole: Absolutely. Unfortunately, we see that social media and other things that are going on in society certainly affect young fellows. They are very engaged with that. For obvious reasons, it is very difficult not to be engaged with that. We work really diligently on explaining why all this is happening, so, for us, it is about education.

Mr Hewitt: We need to support young men to have emotional literacy, so that, by the time they get to us, that emotional literacy is still there and they can actually start to talk about what they need, rather than just saying, "Here I am. I don't know what to do." Then it is up to us to try to work how we even begin to address that.

Mr Gathercole: We need to do that. It is a tiered approach, I guess.

MISS NUTTALL: Regarding the men you are seeing at EveryMan, do you find that part of the initial intake process and the support you provide them is teaching emotional

literacy skills at the same time? Is that something that has to be factored in when you are working with men with complex and high needs?

Mr Hewitt: It goes hand in hand. For us, it is about understanding who the man is and where he has actually come from. We understand men with high and complex needs. Having me just speak to them like this does not work, so we use A3 pads and textas and draw our notes in front of them. That builds a level of trust too. It brings an equality into the room between me and him. By the time I am finished, he gets my notes and I do not go away and say anything else about him. Also, I am drawing his system in front of him. I am drawing who mum and dad is, I am drawing who his other family members are, and I am exploring the relationships that he has, but it is done in a visual context. Again, I am not sticking to one modality to build a level of trust. The message that goes back to him is: "This is a way that I can start to operate." We see men who will take the texta out of our hand and start to write their own notes.

Mr Gathercole: It is about engagement. You have to figure out a way to engage. We have to figure out a way to engage our young fellows. My staff—I call them my boys—have various skills and drills. It could be about sitting in a roundtable type circle and having them hold a footy, and then the footy is passed. It opens up things. There are different skills around the things that they do. It is incredibly important to tap into the way the young person wants to communicate. Certainly, not everyone is the same.

Mr Aldridge: It is interesting when you think about the purpose of the inquiry. If we are talking about doing something to reduce the rate of suicide, one of the things that has been a consistent factor in suicide prevention research is social connection. The Men Mentoring Men program offers the creation of a relationship that is partly about engaging. Kids have stories about everybody around them and they have their own reasons for not engaging with them, but, when somebody new comes from outside, there is a really good opportunity for them to form a relationship that they can attribute some meaning to—one that is different to the relationships they have in their life. When we get to our guys by that stage, a lot of people have found it too difficult to continually engage them. We have a team, and that team will regularly swap around or two people go to visit someone. Their relationship ends up being with the team and there is an association with the organisation. They feel that people will turn up to their door.

One guy came back to work one day and said, "I had a huge breakthrough today. I've been visiting this guy for 12 months, and today he let me in through the front door." You have to understand that, if you have expectations that clients will behave like clients are supposed to, you do not give yourself the opportunity to find ways of engaging with people who are not like that. The procedures and strategies that Josh was talking about before are part of giving them a service experience which does not feel like the service experience they have had everywhere else, because they have stories about that. They will be resistant initially, but then they start to experience that with the people who are with them and they can create some new stories about people who are worth connecting with.

Mr Gathercole: It is building trust.

MISS NUTTALL: You mentioned that you are helping younger boys, such as those in years 5 and 6. Regarding the Unplugged program in particular, what role do you see for

boys' mental health?

Mr Gathercole: Specifically, the Unplugged program is our program around the conscious use of social media. We all know that just saying no to young people, in particular young boys, regarding the use of social media is probably not going to be very successful. So we came up with a strategy that we need to teach young fellows about the use of social media. We realised pretty quickly that years 5 and 6 and years 7, 8, 9, 10 and above are different cohorts and that we needed to modify the program to suit those different cohorts and their different questions, and to also understand the cohorts.

My true dream in helping about social media would be to educate the adults that might happen to be in the room, because I am not entirely sure that the adults are great role models for these young fellows, unfortunately. We hear a bit of anecdotal information coming back: "I told mum about the use of Facebook" or TikTok or whatever. The young person understands, but unfortunately mum or dad or the other person does not understand. That is a really difficult situation.

Social media is a major contributing factor. I am not going to say it is a factor contributing to everything. I have spoken to you guys before about this. To go through puberty with a phone in your pocket is a hard gig. There is no doubt about that. There are the depths that you can get yourself into when you are disconnected and you are sitting in your bedroom at night with one in your pocket. There is online porn. The online porn industry is very good at manipulating you to online gambling. You can swap it around the other way: online gambling is very good at manipulating you to online porn. You are talking about a 14- or 15-year-old bloke on a Friday night who has gone down the rabbit hole of online porn and then online gambling, and he is disconnected from his mates. Guess what is going to happen the next morning when mum says, "You know what, mate? I think you need to get up and go to school." The answer is usually not very positive. That might happen once, but we see that happen as a regular occurrence. Then the young fellow becomes disconnected from school, and any support structure he might have had—mates, teachers, education or sport—is being drawn away. We have to get them to understand what is actually happening. "It is okay to do it, but try an hour a day rather than 10 hours in your bedroom. Ten hours in your bedroom, mate, is not going to turn out any good."

Mr Hewitt: For some of our guys, that also begins to reinforce a belief system that they already have. They have a system around them that has reinforced the belief system, but then they will go down the rabbit hole of TikTok and it is suddenly reinforcing exactly the same message again.

MS BARRY: Algorithms.

Mr Hewitt: Yes.

Mr Gathercole: Yes. It is unbelievable.

MS BARRY: It is unbelievable.

Mr Gathercole: We have all experienced it. I am happy to say that I am quite addicted

to having a bit of a scroll, but you have to have a bit of limitation. Luckily, I am a 60-year-old male who understands and can say, "You know what? That's enough for me." It is a tool. But, if I were a 15-year-old bloke, there is no chance. I would be easily sucked into it. Sorry—I do not know whether that answered the question.

MISS NUTTALL: That is extremely helpful. Thank you. Do you think there is a particular role for schools in this space when it comes to—

Mr Gathercole: That is a big question. Schools are overburdened. Schools are doing it tough as it is. Schools struggle to be schools. There is just too much going on in a school to add another layer and another layer. It is very difficult. Teachers are usually teaching numerous subjects, doing some relief and doing their admin. They are doing all sorts of stuff. I personally do not believe it is a school's job. I personally believe that you draw in an expert service, if you want to call it that.

Mr Aldridge: It is tough for teachers. They are like mental health workers. Young people are inspired to study in a discipline because they want to do something. People who study teaching want to teach people. If a young person starts getting caught up in using their mobile phone and is online too long, very often the conversation teachers will want to have is about how the young person is not taking advantage of their education experience. That may be true, but there are a whole lot of other things that the young person is not getting as well, and expecting the teacher to not only talk about their participation in school education programs but also talk about everything else in life is way too much.

Mr Gathercole: It is bloody complex. I have seen the programs my boys have developed and we have iteration after iteration. I think: "Where did that come from? We did that program three months ago and, all of a sudden, we now have this one." It happens really quickly. There is no way that, from a teaching perspective, you could do it in a school environment.

Mr Hewitt: The expert thing is important. You can think about respectful relationships being taught in schools. You have a PE teacher who is teaching respectful relationships and they are already overworked and overburdened, and here we are, asking them to teach something really complex to a bunch of young boys. Taking that up is really something for services like ours.

Mr Gathercole: What we see is a lack of respect or credibility. If your PE teacher is starting to talk to you about the use of a mobile phone or respectful relationships, the lights go out straight away—"Mate, we played footy yesterday. That's all you're good for." That is just the truth of the matter.

Mr Aldridge: That is the thing about schools being overburdened. They say, "We've got to run this course. Are there any volunteers? PE teacher, you're not doing too much stuff after school apart from your job, so how about you put your hand up?"

Mr Gathercole: "You've done 45 hours already this week".

THE CHAIR: Mr Gathercole, in your submission you reference how Menslink could make a big difference if you were able to have three points of contact with boys in years

7 to 10 across all ACT schools, and would also provide counselling and mentoring wherever it is needed. Where are you at now? Where is the gap between that vision, where we are and resourcing?

Mr Gathercole: We are very fortunate that we are not only aspiring to have three points of contact but also closely achieve that in one of our programs. We would love to have that availability through our entire program cohort. That would be great. The other area that we are moving into is young apprentices. I want to mention young apprentices because the statistic that is starting to come through regarding young apprentices is that they are 2½ times more likely to die by suicide than other young fellows their age. It is not rocket science when you think about it. I am not a smart bloke. You can figure it out.

A young guy leaves school in year 10. It could be a young lady, but mostly young guys leave school in year 10 or maybe year 11. They lose all their social connections. They lose all their structure. They probably disconnect from their mates. They do not go to sports anymore. They go to a trade site. The poor contractor is probably under the pump, so he gives them a harder job that is out of reach for the young tradie, so the young fellow feels stressed. Then there is alcohol. Then they probably have their first relationship—positive or negative. Their sexual education is now being taught by Pornhub. If they think that their first sexual experience is going to be anything like what they see on Pornhub, we all know that is a disaster waiting to happen. Then there are drugs. This is all in the first year of being a young apprentice. No wonder they struggle.

We are really proud and really excited. We are partnering with Master Builders ACT and Master Plumbers ACT to get into the trade schools. All we will do when they go into their first, second and third year of trade is upskill our programs to meet their needs, talk to them about help-seeking behaviours, the use of social media and those sorts of things, and then we will also provide our counselling service for young guys who need to speak to somebody outside of those programs. I am really excited about that. It is cool.

Mr Aldridge: We just started doing violence prevention services with one of the major construction unions. What you are saying about the trade site environment is absolutely true. There are some people in business who really care about their staff's experience of employment—they want them to grow as human beings—but other businesses are run by people who do not have any time or do not care. There is a whole range of humanity. Hoping that young people will get the right sort of early work experience is—well, hope is not much of a method.

THE CHAIR: Thank you. We will wrap it up there. Thank you so much for being here. We thank you for your attendance, your submissions and for taking the time to contribute. I look forward to discussing further in the future. On behalf of the committee, I thank witnesses who have assisted the committee through their experience and knowledge. We also thank broadcasting and Hansard staff for their support, and, of course, the secretariat. If a member wishes to ask questions on notice, please upload them to the parliamentary portal as soon as possible and no later than five business days from today.

The committee adjourned at 4.33 pm.