Submission on the Draft Tasmanian Suicide Prevention Strategy

Suicide Prevention Australia

October 2022

Introduction

Suicide Prevention Australia

Suicide Prevention Australia is the national peak body for the suicide prevention sector. With over 350 members representing more than 140,000 workers, staff and volunteers across Australia, we provide a collective voice for service providers, practitioners, researchers, local collaboratives and people with lived experience.

Over 3,000 people tragically die by suicide and an estimated 65,000 people attempt suicide each year. Over 7.5 million Australians have been close to someone who has lost their life to, or attempted, suicide. Our shared vision is a world without suicide and with our members, we work to inform through data and evidence; influence systemic changes that drive down suicide rates and build capability and capacity for suicide prevention.

Context

Over the past decade, 817 people in Tasmania have died by suicide.[1] In 2021, 87 Tasmanians lost their lives to suicide. This represents an age-standardised rate per 100,000 people of 15.9, the age-standardised rate in Tasmania is consistently higher than the national average (12.1 in 2020).

Suicide is complex, multi-factorial human behavior, it is more than simply an expression of mental ill-health. Factors that contribute to suicide may include stressful life events, trauma, mental or physical illness, drug or alcohol abuse and poor living circumstance. Sadly, the link between unemployment, financial distress, and suicide is well established.

While Tasmania has not reported increases in suicide rates during the COVID-19 pandemic, other measures of distress, self-harm and suicide attempts demonstrate ongoing suicide risks in the community. As we emerge from the pandemic and compounding natural disasters, research shows suicide rates can peak 2-3 years after crises.[2] Accordingly, this Strategy is developed at a critical juncture.

Key Recommendations

1. Expand the vision to include a commitment to zero suicides in Tasmania
2. Include early intervention and quality in the principles, priorities areas and/or enablers of the Strategy
3. The Strategy adopts additional actions including:
    - Commitment to a Tasmanian *Suicide Prevention Act* to drive whole-of-government reform and accountability
    - Appointment of a Minister for Suicide Prevention

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[1] Mental Health, Alcohol and Drug Directorate. Compassion and Connection: Tasmanian Suicide Prevention Strategy 2023-2027 (Draft for public consultation). Tasmania, September 2022.

[2] World Health Organisation. (2016). Psychological First Aid For All: Supporting People in the Aftermath of Crisis Events, available online: https://www.who.int/mental_health/world-mental-health-day/ppt.pdf; Jafari, H., Heidari, M., Heidari, S. & Sayfouri, N. (2020). Risk factors for suicidal behaviours after natural disasters: A systematic review, The Malaysian Journal of Medicine, 27(3); Cartier, K. M. S. (2021), Suicide rates may rise after natural disasters, Eos, 102, https://doi.org/10.1029/2021EO153699; Horney, J.A., Karaye, I.M., Abuabara, A., Gearhart, S., Grabich, S. & Perez-Patron, M. (2020). The Impact of Natural Disasters on Suicide in the United States, 2003–2015, Journal of Crisis Intervention and Suicide Prevention, 42(5).

- Establishment of a Suicide Prevention Office, or at a minimum, including explicit suicide prevention responsibility in the Mental Health, Alcohol and Drug Directorate
- Commitments to designated lived experience positions within all levels of Government
- Inclusion of key performance indicators around lived experience in any services or research commissioned under the Strategy
- Renegotiate the bilateral agreement to contribute towards postvention funding in partnership with the Commonwealth
- Embed accreditation standards into the commissioning processes for suicide prevention services
- Make monthly suicide data from the Tasmanian Suicide Register publicly available in a timely way
- The development of new supports after a suicide attempt or suicidal distress for family and loved ones impacted
- Expansion of safe spaces and alternatives to emergency departments including youth-focused alternatives
- Addressing data gaps around suicide attempts and self-harm data
- Building the capacity of communities through research and evaluation activities
- Inclusion of community awareness and gatekeeper training

4. The expansion of aftercare services should include a range of service models, including both clinical and non-clinical supports, supporting those most at-risk across multiple pathways and including key workforce and data enablers

Acknowledgements

This submission has been developed with the support of Suicide Prevention Australia's Victoria-Tasmania Joint State and Territory Committee. We acknowledge and thank members of this Committee for their advice on the submission and contribution to its development.

This submission acknowledges the unique and important understanding provided by people with lived and living experience of suicide. This knowledge and insight is critical in all aspects of suicide prevention policy, practice and research. The recommendations of this submission reflect ongoing advice on policy priorities from Suicide Prevention Australia's Lived Experience Panel.

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Vision and Priority Areas

1. Do you agree with the general vision, priority areas, and actions of the strategy?

Recommendations:

1. Expand the vision to include a commitment to zero suicides in Tasmania
2. Include early intervention and quality in the principles, priorities areas and/or enablers of the strategy

Vision

The vision of a compassionate and connected community working together to prevent suicide in Tasmania is appropriate. This vision could be strengthened and made more ambitious with the inclusion of a reference to working towards zero suicides in Tasmania. Suicide Prevention Australia is committed to a world without suicide and believes zero is the only acceptable number of suicides in our community.

Priority areas

The priority areas are generally supported and reflect the current evidence base around suicide prevention, including as laid out by the Prime Minister's National Suicide Prevention Advisor in her Final Advice. There is merit in adding 'that intervenes early' to priority two (delivering compassionate and connected services that meet people's needs), this would highlight the need for early intervention as a key focus of suicide prevention in Tasmania.

Reference to quality should be added to either the principles or enablers for the Strategy. There is growing recognition of the need to ensure suicide prevention programs and services are delivered to minimum quality standards and have sustainability factored into their design. Communities need to have the assurance that Australia's suicide prevention programs provide a consistent, high quality and safe standard of care.

Action areas

Advice on the proposed action areas is detailed in response to questions 2 and 3.

Actions

2. Are the proposed actions sufficient to achieve the vision?

The proposed actions are all suitable and important priorities for suicide prevention in Tasmania. However, they alone may not be sufficient to achieve the proposed vision or to set Tasmania on a path towards zero suicides at this critical time.

3. Are there any other actions you can suggest to achieve the vision of the strategy?

Recommendations:

3. The Strategy adopts additional actions including:
    - Commitment to a Tasmanian *Suicide Prevention Act* to drive whole-of-government reform and accountability

- Appointment of a Minister for Suicide Prevention
- Establishment of a Suicide Prevention Office, or at a minimum, including explicit suicide prevention responsibility in the Mental Health, Alcohol and Drug Directorate
- Commitments to designated lived experience positions within all levels of Government
- Inclusion of key performance indicators around lived experience in any services or research commissioned under the Strategy
- Renegotiate the bilateral agreement to contribute towards postvention funding in partnership with the Commonwealth
- Embed accreditation standards into the commissioning processes for suicide prevention services
- Make monthly suicide data from the Tasmanian Suicide Register publicly available in a timely way
- The development of new supports after a suicide attempt or suicidal distress for family and loved ones impacted
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- Addressing data gaps around suicide attempts and self-harm data
- Building the capacity of communities through research and evaluation activities
- Inclusion of community awareness and gatekeeper training

The below outlines the case for a series of additional actions that can achieve the vision of the strategy.

Suicide Prevention Act

To deliver on the whole-of-government objectives of the strategy, the Strategy should include commitments to a *Suicide Prevention Act*. An Act is the missing link to the whole-of-government approach to suicide prevention. With half of those who die from suicide not accessing mental health services, an Act legislates the need for suicide prevention activities in key portfolio agencies, including human services, education and justice.

At a high level, it signals the commitment of the Government to suicide prevention and at a practical level, it will require agencies and officials to consider the impact of – and opportunities for – suicide prevention in the work they do. An Act is necessary to ensure decision-makers across Government are united in working to prevent suicides. Legislation can ensure clear shared and individual accountability and focus agencies on practical and measurable steps to reduce and prevent suicide.

A *Suicide Prevention Act* provides a legislative framework to work towards zero suicides in Tasmania. It would legislate:

- The tabling of the new and any future strategies to Parliament as well as transparent annual, outcomes-focused reporting

- A requirement for relevant Agencies to deliver suicide prevention plans for both their employees and those they support
- Effective governance arrangements to ensure the potential suicide impact of policies is considered, multi-agency collaboration and that the perspectives of lived experience inform design and delivery

Suicide Prevention Acts have been delivered overseas and in Australia. The Japanese Basic Act for Suicide Prevention set priorities for cross-government, whole-of-community suicide prevention. Between 2008-2011, hospital admissions almost halved and from 2009 suicide deaths declined dramatically and hit a 15-year low in 2012.[3] Canada, South Korea and Argentina have also progressed Act. South Australia passed the first Australian Act in 2021 and the NSW Opposition has committed to an Act if elected in early 2023.

Enhanced governance arrangements

The proposed governance arrangements under the new draft Strategy are an improvement but could be strengthened with further machinery of government changes, including:

- Appointment of a Minister for Suicide Prevention- suicide prevention should be included at the portfolio level in ministerial arrangements, for example, the Premier could expand his portfolio to Minister for Mental Health and Suicide Prevention. This is consistent with arrangements at the Commonwealth level and in the Northern Territory
- Establishment of Suicide Prevention Office- all jurisdictions should have a dedicated suicide prevention office, for example, the recently established Victorian Suicide Prevention and Response Office headed up by a Suicide Prevention Adviser. At a minimum, the Mental Health, Alcohol and Drug Directorate should have suicide prevention added to its title reflecting the well-documented distinction between mental health and suicide.

Lived experience

Additional actions are required to ensure lived experience is central to all aspects of the Strategy, and people with lived experience are sufficiently supported and renumerated in these roles. Commitments to designated lived experience positions within the Department of Health should be made. This will ensure lived experience leadership and insight in the delivery and implementation of the Strategy. For example, Victoria has appointed an Executive Director of Lived Experience and the National Mental Health Commission has a Director of Lived Experience.

An action to include key performance indicators (KPIs) around lived experience in all services commissioned under the Strategy will ensure accountability and support systemic changes to embed lived experience in all aspects of suicide prevention. The inclusion of lived experience KPIs can leverage any investments made under the Strategy towards better outcomes guided by lived experience.

[3] Takeshima, Tadashi et al (2014). Suicide prevention strategies in Japan: A 15-year review (1998–2013). Journal of public health policy. 36. 10.1057/jphp.2014.42; 2Nakanishi, M. et al. (2017). The Basic Act for Suicide Prevention: Effects on Longitudinal Trend in Deliberate Self-Harm with Reference to National Suicide Data for 1996–2014. Int. J. Environ. Res. Public Health 2017, 14, 104. https://doi.org/10.3390/ijerph14010104.

Postvention

Bereavement by suicide raises suicide risk by two to five times the rate of the general population.[4] Postvention support is an important method for addressing this risk, encouraging healing and reducing suicide contagion among those who have lost a loved one. Making postvention services available is an essential component of suicide prevention.[5] Access to formal postvention support is a critical aspect of trauma-informed support for those bereaved by suicide.

These findings are supported at a Tasmanian level through the Suicide Bereavement Support Needs of Community Members in Northern Tasmania study undertaken in 2020 by the Centre for Rural Health, University of Tasmania, funded by Lifeline Tasmania.[6] This study highlighted a lack of general service availability in regional areas and low awareness of existing services were the main barriers to service access; a need to upskill local service professionals and utilising peer connection and support, and to build on local community-driven postvention responses. In addition, postvention needs to be included within suicide prevention training and awareness programs

The Tasmanian Government's bilateral agreement with the Commonwealth Government did not include funding for postvention. This contrasts with bilateral agreements with New South Wales, Queensland, Victoria and the Northern Territory. To address the risk of inequitable access to postvention for those most at-risk, an action should be included in the Strategy to renegotiate the bilateral agreement and contribute towards postvention funding in partnership with the Commonwealth.

Accreditation

Embedding accreditation and standards into the commissioning of programs and services in suicide prevention supports safe, high-quality and effective programs and services. Investments in suicide prevention will not be effective unless directed to programs that deliver outcomes. For this reason, Suicide Prevention Australia partnered with people with lived experience of suicide, consumers, clinicians, service providers and accreditation experts to develop the Suicide Prevention Australia Standards for Quality Improvement, which were released in June 2020.

As outcome-oriented standards, the Standards are designed to support the suicide prevention sector and provide assurance to consumers that the suicide prevention programs developed by an organisation are safe, high-quality and effective. The Standards offer an opportunity for organisations to participate in an accreditation program that will provide consistency in delivery and quality improvement. These are bespoke, fit-for-purpose standards reflecting the unique aspects of suicide prevention. Over 130 programs have now registered for accreditation including many providers in Tasmania.

A new Tasmania Suicide Strategy should embed accreditation standards into the commissioning processes for suicide prevention services. This is consistent with standards forming part of other commissioning services e.g., drug and alcohol, homelessness services. Any services commissioned

[4] World Health Organisation. (2014). Preventing suicide: A global imperative, Geneva.
[5] Andriessen, K., Krysinska, K., Kolves, K., & Reavley, N. (2019). Suicide postvention service models and guidelines 2014-2019: a systematic review, *Frontiers in Psychology,* 10:2677.
[6] Bridgman, H., Auckland, S., Alderson, R. (2021). Suicide Bereavement Support Needs of Community Members in Northern Tasmania. Final Report. Centre for Rural Health, University of Tasmania. Not publicly released.

under the new Strategy should be accredited or working towards accreditation. This will ensure safe, quality and effective practice across the State.

Support after a suicide attempt or suicidal distress for family and loved ones

Suicide attempts and suicidal distress have significant impacts not only on the individual experiencing suicidality but also on the carers, family and friends surrounding them. While aftercare services support survivors of suicide attempts and postvention supports those bereaved by suicide, there is a major gap in the support available to those loved ones impacted by a suicide attempt or suicidal distress. These friends, families and communities are missing out and need support.

With an estimated 65,000 people who attempt suicide each year and many more who experience suicidal thinking and distress, there is a need to address this major service gap. A peer-led model, co-designed with individuals with lived experience including across other priority cohorts, should be developed. Similar to effective postvention models, a non-clinical model that offers counselling, emotional and practical support, and can connect individuals in need with relevant services is required. These services should be delivered in tandem with, and connected to, existing aftercare and postvention services.

Investment in support services of this kind would be expected to reduce psychological distress, promote help-seeking and improve well-being for individuals whose loved ones face suicidal distress or attempt suicide. It would also support understanding and relationships between those experiencing suicidal distress and their loved ones and could in turn support the recovery journey of suicide attempt survivors.

Alternatives to emergency departments

Safe Spaces are emerging as an important suicide prevention alternative to Emergency Departments. Many individuals experiencing suicidal thinking currently present to Emergency Departments yet these complex clinical environments are not the most appropriate point of care for people who experience mental distress and people with lived experience report distress can be exacerbated by this setting.[7]

Safes Spaces aims to provide an alternative and is an umbrella term referring to non-clinical, peer-led support for people in suicidal crisis. They are also known in some areas as safe havens or safe haven 'cafes'. They do not replace clinical mental health interventions but support people to navigate the mental health system, connecting to local services and developing self-management skills.[8]

The original concept was trialled as the Safe Haven Café in 2014 in Aldershot, United Kingdom. Individuals experiencing mental health problems were able to visit the centre and converse with mental health professionals and peer workers. An evaluation found a 33% reduction in the number of admissions to acute in-patient psychiatric beds within the Safe Haven's catchment areas.[9] Safe Spaces and Safe Havens have been rolled out in most States and Territories in Australia.

[7] Roses in the Ocean. (2021). Discussion Paper: A National Safe Spaces Network, available online: https://rosesintheocean.com.au/wp-content/uploads/2021/12/Discussion-Paper-A-National-Safe-Spaces-Network.pdf.
[8] Life in Mind. (2021). Safe Spaces, available online: https://lifeinmind.org.au/safe-spaces.
[9] National Health Service UK. (2016) Case study: Safe Haven Café in Aldershot. Available from: https://www.england.nhs.uk/mental-health/case-studies/aldershot/

Recent commitments to Safe Havens planned in Southern Tasmanian are welcome. The new Strategy should consider the development of additional Safe Spaces and Safe Havens as alternatives to emergency departments for those experiencing suicidal distress. Additional facilities should be coordinated with Primary Health Networks and the Commonwealth in line with any future national standards and to support a national network of Safe Spaces. As outlined in the recent report, *In Their Words* there is a particular case for investment in youth-focused alternatives to emergency departments.

Data priorities

The inclusion of data as an enabler of the draft strategy is welcome. Data and evidence are critical to driving better suicide prevention policy, planning and practice. More reliable, timely and robust data can improve policy development and planning to aim for improved timely prevention and postvention responses at different levels of government, including State and Local Governments in Tasmania. The establishment of the Tasmanian Suicide Register is an important step. However, this register must be real-time to support better service and policy responses. For example, other jurisdictions make monthly suicide deaths data available to the public on a monthly basis.

Additional data gaps beyond suicide deaths need to be urgently addressed in Tasmania and other jurisdictions. Importantly, this includes gathering additional data on suicide attempts and self-harm including through medical professionals, ambulance and police call-outs and other community services.

Other

4. How well does the TSPS reflect the experiences and needs of your community?

Suicide Prevention Australia is the national peak body for the suicide prevention sector, we represent members from all over Tasmania. The draft TSPS is broadly aligned with the National Policy Platform set by our members including priorities for whole-of-government approaches; lived experience; data and evidence; and workforce, sector and community capability.

5. Do you think that the action areas will have a sufficient impact on service provision?

The proposed action areas, including the additional actions outlined in this submission, can have a significant and lasting impact. If adequately funded and progressed in conjunction with Commonwealth Government priorities and a comprehensive approach to workforce development, they have the potential to have a major impact on service provision.

6. What could be included in the TSPS that has not already been included?

A number of proposed additions are outlined in response to earlier questions.

Further:

- Aligning to action 1.2, enhancing capacity of communities - Connecting with People training is valuable for the health workforce, yet additional gatekeeper training and capability building is needed for the broader community. This is needed to increase awareness and capital in communities, and the capacity of communities to recognise and respond to suicide. For example, see final report from the evaluation of the CORES suicide prevention

networks and training in two regional Tasmanian communities, as an example of a community-level model.[10]

- There is opportunity for evaluation activities to not only provide the process evaluation to determine how suicide prevention should be implemented, but also in the co-design process, and to build the capacities of local communities, for example the use of Participatory Action Research. Please see the referenced manuscript local evaluation of the National Suicide Prevention Trial in Tasmania, describing how this continuous feedback can assist with the quality assurance and implementation of community-based programs.[11]
- Under Action 3 – Expanding our approach to enable collective action across multiple agencies and sectors – There is mention of supporting efforts across systems, and collaboration, but little mention of systems approaches in the draft. There is an opportunity to build on key learnings from the National Suicide Prevention Trial, in Tasmania but also across Australia. Further long-term, community-led systems-based approach are warranted, to explore their relevance and efficacy in Tasmania. In Tasmania, this can build on increased collaboration established through the Trial (the Tasmanian Suicide Prevention Advisory Group, the Launceston Suicide Prevention Trial working group, the Break O'Day Mental Health Action Group, for example), coordinated across Government, i.e. through the PHN and local government area level, with key input from the Tasmanian Suicide Prevention Community Network. Such approaches should align with, and be adaptable to, the prevailing social constructs, cultures, strengths and social norms within communities.

7. What do you think success looks like for the TSPS?

Immediate success would be an effective and timely implementation of the Strategy, priorities and actions. Importantly though, long-term success would be to arrest any future increases in suicides across Tasmania and turn the trend towards zero suicides. This could be evidenced in the interim through both reduced rates of suicides and suicidal behavior. It could also be demonstrated by reductions in the age-standardised rate of suicide in Tasmania that place it at or belove the national average rather than consistently above.

8. Are there any other comments you would like to add?

Recommendations:

4. The expansion of aftercare services includes a range of service models, including both clinical and non-clinical supports, supporting those most at-risk across multiple pathways and including key workforce and data enablers

Aftercare

The inclusion of aftercare as a priority action is important. Suicide Prevention Australia has welcomed the Tasmanian Government's commitment to universal aftercare as part of the new National Agreement on Mental Health and Suicide Prevention noting:

[10] Smith, L., Purton, T., Mond, J., & Auckland, S. (2020). The Evaluation of the CORES Devonport and Launceston Networks: Final Report. Tasmania: University of Tasmania, Centre for Rural Health. Available at: https://cores.org.au/wp-content/uploads/2020/08/CORES-Evaluation-Final-Report_V.4.pdf

[11] Grattidge, L., Purton, T., Mond, J., Lees, D., & Auckland, S. (2021). Participatory Action Research in Suicide Prevention Program Evaluation: Opportunities and Challenges from the National Suicide Prevention Trial, Tasmania. Australian & New Zealand Journal of Public Health, 45(4), doi: 10.1111/1753-6405.13116. Available at: https://onlinelibrary.wiley.com/doi/full/10.1111/1753-6405.13116

- A suicide attempt is the strongest risk factor for subsequent suicide, and the risk for suicide after an attempt is significantly elevated compared to the general population:[12]
- Between 15 and 25% of people who make a non-fatal suicide attempt will make an additional suicide attempt, with the risk highest in the three-month period following a suicide attempt.[13]
- The relative risk for suicide after an attempted suicide is between 20 to 40 times higher than in the general population.[14]
- The most common psychosocial risk factor for deaths referred to a coroner, including deaths by suicide between 2017-2020 was a 'personal history of self-harm'.[15]

The delivery of any action to expand aftercare needs to address the following key issues:

1. No one model will work for all suicide attempt survivors, different approaches are needed
2. Clinical and non-clinical supports are key to the recovery journey including long-term supports
3. More proactive outreach is needed to reach those most at-risk including a 'no wrong door approach' and overcoming existing barriers to reaching people in distress (e.g. privacy restraints)
4. Multiple pathways are required (not just emergency departments); people should be referred through community organisations, Head to Health, police, counsellors, psychologists, GPs and paramedics etc, there could also be referrals from the new Mental Health and Wellbeing Local Services and Area Services developed in response to the Royal Commission.
5. Workforce development (including the peer workforce) and better data on attempts are key enablers

We note also, local models can be learned from and built on for exploring non-clinical supports to providing aftercare, for example the Mental Health Action Group and Community Champions peer-led outreach for people returning home after a suicide attempt, and those bereaved by suicide in the Break O'Day area.

[12] Shand, F., Woodward, A., McGill, K., Larsen, M. & Torok, M. (2019). Suicide aftercare services: an Evidence Check rapid review. brokered by the Sax Institute for the NSW Ministry of Health

[13] Commonwealth of Australia, Department of Health. (2021). National Mental Health and Suicide Prevention Plan, available online: https://www.health.gov.au/sites/default/files/documents/2021/05/the-australian-government-s-national-mental-health-and-suicide-prevention-plan-national-mental-health-and-suicide-prevention-plan.pdf.

[14] Sax Institute. (2019). Suicide aftercare services, Evidence Check, available online: https://www.saxinstitute.org.au/wp-content/uploads/2019_Suicide-Aftercare-Services-Report.pdf.

[15] AIHW. (2021). Psychosocial risk factors and deaths by suicide, available online: https://www.aihw.gov.au/suicide-self-harm-monitoring/data/behaviours-risk-factors/psychosocial-risk-factors-suicide.