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The Case for a Suicide Prevention Act in Tasmania

Briefing Paper

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Contents

About Us ... 3
Executive Summary ... 3
Introduction ... 6
The South Australian example ... 8
Rate of suicide ... 11
Balance on council ... 13
NSW's plan for a Suicide Prevention Act ... 14
Potential elements of a NSW Act ... 16
Next steps for NSW ... 18
The Commonwealth ... 19
The Tasmanian context ... 19
Tasmania's Suicide Prevention Strategy ... 22
Tasmania's current strategy ... 24
Data ... 27
References ... 29

Note: This briefing paper was delivered to the government before the release of Implementation Plan Two of the Tasmanian Suicide Prevention Strategy (2023-2027) in October.

About Us

The Mental Health Council of Tasmania (MHCT) is the peak body for community managed mental health services in Tasmania. We represent and promote the interests of our members and work closely with government and agencies to ensure sectoral input into public policies and programs. We advocate for reform and improvement within the Tasmanian mental health system. Our purpose is to strengthen and advocate for our communities and service providers to support the mental health and wellbeing of all Tasmanians, and our vision is that every Tasmanian has access to the resources and support needed for good mental health and wellbeing.

Executive Summary

This briefing paper shows how a Suicide Prevention Act could strengthen Tasmania's considerable efforts to reduce suicide, a formal policy priority of successive governments going back to 2010. It does this by assessing South Australia's Suicide Prevention Act (2021) and NSW's plan to introduce similar legislation next year.

MHCT is not seeking to critique Tasmania's Suicide Prevention Strategy (2023-2027). Indeed, we acknowledge the more than 600 community member and stakeholder engagements that informed the development of this strategy and its first implementation plan, the most extensive consultation process ever undertaken in Tasmania. Rather, MHCT wants to show how the South Australian experience and efforts underway in NSW provide a roadmap to strengthen our state's strategy.

Tasmania already has the building blocks in place: The Premier's Mental Health and Suicide Prevention Advisory Council; a suicide prevention strategy in its third iteration; a suicide register (established in 2017) and the Tasmanian Suicide Prevention Community Network (TSPCN).

A Suicide Prevention Act would embed those mechanisms and strategies into law, as well as make the reduction of suicide a legislative requirement in Tasmania.

Proponents say a Suicide Prevention Act safeguards suicide prevention bodies and plans against a change in government and promotes accountability to parliament and the public given the reporting requirements such laws usually demand. This shares responsibility across all levels of government and community.

"It means everyone is accountable," says peak independent body Suicide Prevention Australia. "An Act ensures every government department and official, whether it's housing, education, social security or health, must look at their work through a suicide prevention lens."

Selected highlights of how a Suicide Prevention Act could strengthen Tasmania's strategy.

Tasmania's Suicide Prevention Strategy	How an Act would strengthen the strategy
Aim is sustained reduction in suicides	Reducing suicide in South Australia (SA) is mandated by law
Strategy calls for targeted actions for groups who may be at increased risk of suicide	SA Act requires provisions to address prevention of suicide among priority population groups
Tasmania wants to build capability across government agencies to understand suicide prevention and apply a suicide prevention lens to new policies and programs	SA Act requires certain state agencies – called prescribed state authorities -- to have plans in place to prevent suicide among staff & public. NSW considering similar plans for govt agencies
Unclear what govt is seeking to measure itself against – reducing deaths by suicide, attempts or suicidal distress.	SA Act includes performance indicators against which progress in relation to the prevention of suicide can be tracked over time.
Premier's council meeting tempo is unclear	SA Suicide Prevention Council must meet at least six times any calendar year
Annual report provided to Premier and Minister for Mental Health and Wellbeing and communicated broadly to stakeholders. Unclear if this is released to the public	SA Council must report to Health & Wellbeing Minister annually. Minister must, within six sitting days, give copies to both Houses of Parliament, which puts report in public domain

Tasmania's current strategy builds on and extends previous work to enable a whole-of-community, whole-of-service-system and whole-of-government approach to suicide prevention. MHCT is pleased the strategy refers to the social determinants of health, a known risk factor for suicide. This is vital given our growing understanding of the impact the cost-of-living crisis is having on people's distress levels, for example.

The South Australian Act makes no reference to the social determinants of health -- which can include poor housing, unemployment and lack of welfare support -- while the state's suicide prevention plan barely mentions them. South Australia is, however, putting a lot of emphasis on the legal requirement for certain state agencies (prescribed authorities) to have strategies and measures to prevent suicide among staff and the public who engage with them. NSW says its strategy will address underlying factors contributing to suicide. This will include focusing on "broader social determinants of health such as financial insecurity, unstable housing and social isolation – key factors that exacerbate suicidal distress".

MHCT believes there is enough evidence to support the introduction of a Suicide Prevention Act in Tasmania. It's an initiative likely to be endorsed by all sides of politics and across the health and mental health sector, as well as welcomed by the community. The timing is also good, with the second implementation plan of the current strategy under development. One of the biggest challenges would be striking a balance between legislating for a suicide prevention lens to be applied to policy while ensuring the law is not tokenistic or shuts down the bureaucracy.

Japan is the country with the oldest Suicide Prevention Act in the world. Its legislation has helped reduce the rate of suicide by 40 percent since it was introduced in 2006.

This briefing paper has been informed by a literature review, media articles and interviews.

Introduction

Tasmania's premier and government have made clear that suicide prevention is a priority.

"The impact of suicide is personal and deeply felt, affecting almost every Tasmanian and their community at some point in time," wrote Premier Jeremy Rockliff at the beginning of the Tasmanian Suicide Prevention Strategy (2023-2027). [1]

"The pain and isolation that people experience when they are living with suicidal distress, or affected as a family member or friend, can only be countered by working together to build a more compassionate and more connected community where people get the support they need, when they need it. To do this, we must bring together all levels of government, all agencies, and all people across the Tasmanian community."

Suicide is one of the greatest preventable public health and social challenges of our time.[2] U.S. research shows up to 135 people are exposed to a single suicide.[3] They may experience intense grief such as immediate family and close friends, be work colleagues or otherwise have known the person.

Preliminary data from the Australian Institute of Health and Welfare (AIHW) shows there were 87 suicides in Tasmania in 2022.[4] That means an estimated 11,745 Tasmanians affected in one year alone, underscoring the ripple effect of suicide and the need for grief supports, known as postvention. This of course does not account for those grieving loved ones from prior years or beyond 2022.

Postvention efforts are especially important as people bereaved through suicide are up to eight times more likely to take their own life than the general population.[5]

South Australia is the only jurisdiction with a Suicide Prevention Act in Australia (2021). NSW plans to introduce such legislation into parliament in 2025.[6] Internationally, Japan's Suicide Prevention Act is credited with helping reduce suicide rates by 40 percent since it was passed in 2006. The only other countries with similar laws are South Korea (2011), Canada (2012) and Argentina (2015).[7]

Suicide Prevention Australia (SPA) says there is real, ongoing distress across the country based on crisis line, emergency department and ambulance data.[8] Its Community Tracker recently revealed a record half of all Australians are reporting elevated cost-of-living and personal debt distress. Cost-of-living and personal debt was the main cause of elevated distress among Australians reporting suicidal behaviours (58 percent), as well as those seeking help from frontline suicide prevention services (54 percent), particularly clinical services (64 percent).[9] Half of those who suicide each year were not accessing mental health services at the time, says SPA. Past crises show it might take two to three years for suicide rates to peak, after protective supports cease and immediate social cohesion subsides. Research also shows almost half of suicides and self-inflicted injuries are linked to child abuse and neglect, alcohol and other drug use and partner violence.[8] This is important context for Tasmania as the state embarks on its

10-year Change for Children Strategy and Action Plan, following the harrowing Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings.

A SPA survey shows most Australians (79 percent) support a Suicide Prevention Act. This rises to 86 percent in Tasmania/ACT/NT.[10] Some 96 percent of sector respondents agree a whole-of-government approach is needed.

The cost to the Australian economy from mental illness and suicide is estimated (conservatively, given data limitations) at up to $70 billion per year.[11]

SPA's Director of Policy and Government Relations, Chris Stone, told MHCT there was interest across Australian states and territories in passing a Suicide Prevention Act. However, the Commonwealth had rejected national legislation.[12]

"There seems to be resistance to the whole idea. We're hoping that getting it in NSW will change minds," Stone said.

The South Australian example

The South Australian Suicide Prevention Act was passed in 2021 with bipartisan support. It says the Act is “to reduce the incidence of deaths by suicide in this State, to establish the Suicide Prevention Council, to provide for the preparation and implementation of suicide prevention plans, to encourage the training of persons and organisations in suicide prevention and postvention, and for other purposes.” It also legislated a suicide register.

South Australia had a council and a suicide prevention plan before the act was passed, Nadia Clancy MP, chair of South Australia’s Suicide Prevention Council, told MHCT.[13]

“The council being legislated means you have to get stuff done. You can’t float on by. You are accountable to parliament,” said Clancy, who is also the Premier’s Advocate for Suicide Prevention.

Added Stone: “Your plans are vulnerable unless you have an Act. An Act can mandate that a plan has specificity in terms of measuring outcomes and timing, so we can evaluate if it is working. Most things can be done, but then the government changes and it doesn’t get done. The South Australia Act embeds the Suicide Prevention Council. It can’t be dissolved by the next minister because it’s in the legislation.”[12]

The SA Act can be found here. Its objectives are:[14]

a) to reduce the incidence of suicide in the State;

b) to promote best practice suicide prevention policies across the State;

c) to articulate the role of the State in implementing suicide prevention strategies;

d) to provide for training and education in relation to suicide prevention;

e) to provide for the identification of priority population groups and implementing suitable initiatives to prevent suicide within such groups;

f) to provide a framework to ensure that suicide prevention response is a priority across all levels of government and community

The functions and powers of the SA Suicide Prevention Council include:

- Prepare and maintain the State Suicide Prevention Plan;
- Make recommendations on policies and programs intended to reduce deaths by suicide and attempted suicides, and enhance postvention responses;
- Advise and report to the Minister for Health and Wellbeing on the operation and effectiveness of the State Suicide Prevention Plan;
- Receive reports from prescribed State authorities in relation to their suicide prevention action plans, and to summarise and submit such reports to the Minister;
- Ensure training in preventing suicide is available to the community and professionals;
- Provide opportunity and a platform for people with lived experience of suicide, and other members of the community working in suicide prevention, to voice their opinions and concerns;
- Increase the profile and accessibility of suicide prevention initiatives;
- Support collaboration between suicide prevention networks and local government;

The Suicide Prevention Council must meet at least six times in any calendar year (actual tempo is six to eight times a year, says Clancy). It must, on or before 31 October each year, report to the Minister. That report must include data on deaths by suicide from the last financial year. The Minister must, within six sitting days after receiving a report, give copies to both Houses of Parliament.

The council commenced work on Sept 5, 2022.

Members include those with lived experience; working to prevent and respond to suicide in the community; from population groups most affected by suicide and people in leadership roles across government. They include Taimi Allan, South Australian Mental Health Commissioner; Dr John Brayley, Chief Psychiatrist; Helen Connolly, Commissioner for Children and Young People; April Lawrie, Commissioner for Aboriginal Children and Young People; Professor Nicola Spurrier, Chief Public Health Officer. There are no government ministers on the council.

Clancy advised that flexible language be used in listing the titles of people appointed to the council. She noted there was no flexibility in the Act to account for a change in someone's title, a challenge the council already faced.

SA's Suicide Prevention Plan (2023-2026) went into effect in June 2023. The Act requires it to include performance indicators that can be tracked over time; provisions addressing the

prevention of suicide among priority population groups; and provisions relating to the education and training of people in relation to suicide prevention. [15]

It includes sections on populations disproportionally impacted by suicide, such as Aboriginal and Torres Strait Islander people, LGBTIQA+ communities, men, those in regional, rural and remote areas, first responders, veterans, and people who have experienced early life adversity.

Clancy said the first report covering the first full year of the suicide prevention plan's operation would be done by Dec. 31, 2024. The plan – but not the Act – says these annual reports are to be made public. The plan must be reviewed every four years.

Certain state authorities, called prescribed authorities, are required to have suicide prevention plans that set out strategies and measures they intend to put in place to prevent suicide among staff and the public who engage with them.

Those government authorities are:

- Attorney General's Department
- Department for Education
- Department of Primary Industries and Regions
- Department for Child Protection
- Department for Health and Wellbeing
- South Australia Police
- Department for Correctional Services
- Department of Human Services
- Department for Infrastructure and Transport
- South Australian Fire and Emergency Services Commission.

Clancy said actions taken could be as simple as information to the public, supports they can access. Little things to reduce stress. The Department of Transport could install signs in train stations or on fencing about helplines, she said. Officials could show compassion and provide information about supports in letters to someone who will have their home acquired because of a new road; or who faces eviction from their house.[13]

"It's putting a bit of humanity and compassion into the way governments talk to staff, each other and constituents … Trying to shake up bureaucracy a little so it's not so worried about covering itself in terms of liability," Clancy said.

Clancy said the prescribed authorities would present drafts of their action plans to the council in October. Those plans would be finalised by year-end. The council had also invited another 10 agencies to join. Among those to accept was the Department of Premier and Cabinet. Responsibility had been given to prescribed authorities to develop their plans because they know what makes sense for them, Clancy said. Someone from each agency attends every council meeting.

"We talk about how suicide prevention is whole-of-government, whole-of-community, that's the approach we take. By making these authorities take some responsibility and look at their work, the way they interact with employees and clients through a suicide prevention lens is really good," Clancy said.

Media have noted that while the South Australian Health and Education Departments are required to introduce plans, these don't apply to public hospitals and schools. Chris Stone has been quoted as saying that without deadlines, progress hadn't "been quite as fast as we would have liked". Stone said the South Australian laws provided a "good template", but he wanted NSW to go further by extending suicide prevention plans to government-run organisations such as schools, hospitals and Service NSW offices.[16]

Stone told MHCT the key thing about the SA Act was the prescribed authority plans because accountability could be embedded.[12]

"That is where the rubber hits the road. That is where accountability can factor in but unfortunately for the SA Act there wasn't a timeframe for implementation of those plans, so they don't exist yet. I think the impact will be dramatic once they are up and running," Stone said.

Stone predicted a subtle cultural impact on public servants who could get creative and innovative in portfolios such as finance. If an act of parliament says suicide prevention is your job, that unlocks your ability to do all sorts of things to reduce distress in the financial space for example, he said.

Rate of suicide

Despite the South Australian Act's first objective being to reduce the incidence of suicide, the state's plan does not refer to measuring the annual rate.

Clancy said the council was working on lead and lag indicators but did not intend to assess itself against the rate of suicide in the state. She noted sensitivity around this data, and how it could fluctuate from year to year for a variety of reasons. The council wanted to focus on reducing suicidal distress and measure this.[13]

The SA Department of Health runs a survey that includes mental health, which the council would probably measure itself against, Clancy said.

"We are looking at how many people we have trained in community and government departments. Trained to have a conversation with someone who is struggling, how many people are aware of the networks, how many people are connecting with services," she said.

Stone said he was not against measuring rates of suicide. But he contended it was more important to measure suicide attempts because they were a better gauge of community distress. There was more statistical confidence in this number, it didn't jump around so much.

Hospital data was available, though there is evidence men were less likely to end up in emergency departments than women, he added.[12]

Stone pointed to [recent ABS survey data](#) on suicide attempts, but said it was problematic because it was done rarely (the previous one was 2007). Suicide Prevention Australia has called for a survey every four years.

Suicidal thoughts and behaviours refer to whether a person had ever seriously thought about taking their own life, made a plan to take their own life, or attempted to do so, and whether they had done so in the last 12 months. A person must have said they had seriously thought about taking their own life to be asked if they had made a plan and/or attempt.[17]

In 2020–2022, one in six Australians (16.7 percent or 3.3 million people) aged 16–85 years had experienced suicidal thoughts or behaviours in their life, while 3.3 percent (644,600 people) had experienced suicidal thoughts or behaviours in the previous 12 months. This includes:

- 3.3 percent of people who had seriously thought about taking their own life
- 1.2 percent who had made a plan to take their own life
- 0.3 percent who had attempted to take their own life.

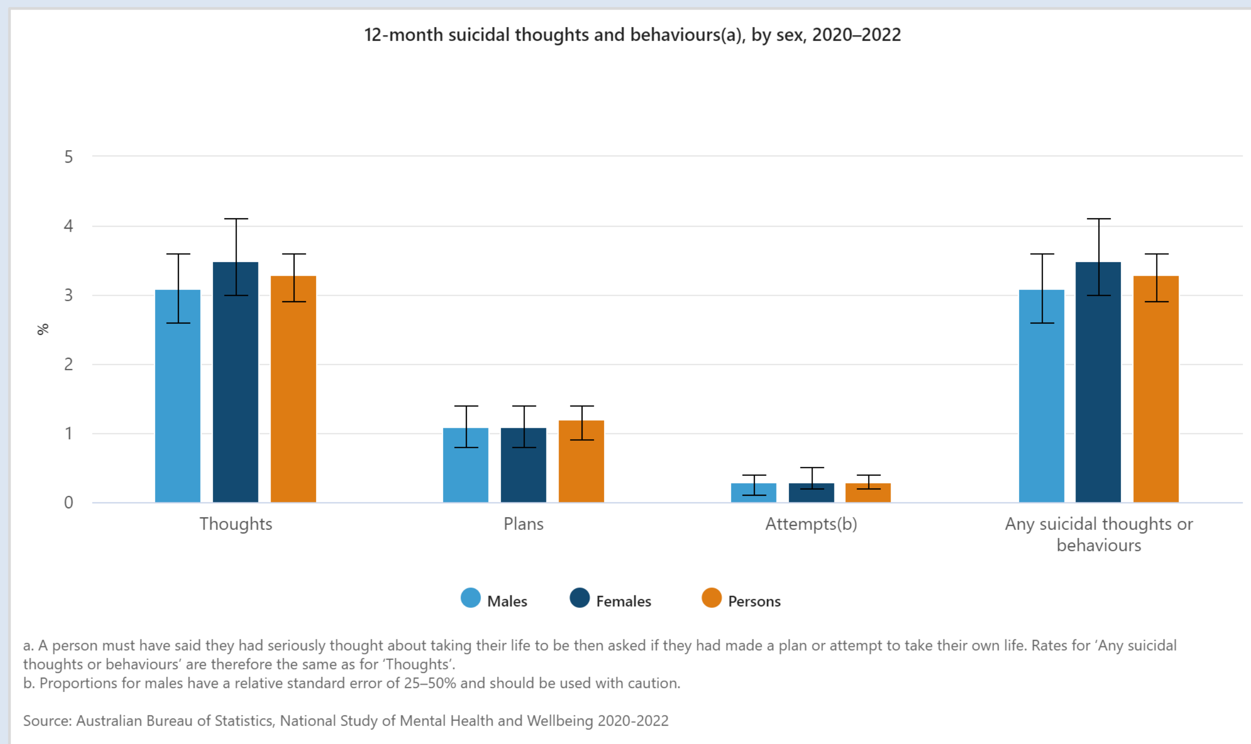

Figure 1 Australian Bureau of Statistics ((https://www.abs.gov.au/statistics/health/mental-health/national-study-mental-health-and-wellbeing/latest-release#lived-experience-of-suicide)

NSW on the other hand is focused on reducing suicide rates.

"Our objective is clear: to drive down suicide rates in NSW … We want NSW to be at the forefront of ambitious and determined reform efforts to reduce lives lost to suicide in this state," Minister for Mental Health Rose Jackson, also minister for housing and homelessness, wrote in the foreword of a discussion paper prepared for the NSW Suicide Prevention Legislation.[7]

Despite concerted efforts, there has been no significant reduction in the NSW rate of suicide, says the paper. It was 10.8 in 2022 from 9.8 per 100,000 in 2012.

Stone indicated that measuring rates of suicide would be easier for states with larger populations and publicly available suicide registers such as NSW and Victoria.

Tasmania was the third state to establish a suicide register (2017) after Queensland (1990) and Victoria (2012). NSW established a register in 2020. South Australia set up one in 2022, the year after its Suicide Prevention Act passed. Most other states and territories now have registers. When asked what had been achieved in South Australia since June 2023, Clancy said:[13]

- The council had met with people in charge of development of a new women's and children's hospital in Adelaide to share their views on how it could be planned better to improve the safety and mental health of young people.
- The number of suicide prevention networks was growing, with the council holding a meeting each year in a different metro and regional area.
- Prescribed authorities would have their action plans done by the end of 2024.

Balance on council

Clancy said she believed the South Australian council had the right balance of personnel despite the absence of any cabinet representative. She said the previous council, before the Act was passed, had a premier's advocate rather than a minister.

"I think given the frequency of meetings, the work on prescribed authorities, it works well. I speak to the premier and the minister for mental health a lot. The minister has been to a couple of meetings. It's a good balance," Clancy said.

Stone said there were many different models. He noted that Emma McBride, the Assistant Minister for Mental Health and Suicide Prevention, did not sit in federal cabinet. He said a model where a council chair sat outside cabinet could allow that individual to be more forceful than most ministers, adding he believed South Australia's council was "quite effective" and integrated with government. Nevertheless, Stone's preference was for a minister with the suicide prevention portfolio to be at cabinet level or have a suicide prevention council headed by someone sitting in government.

NSW's plan for a Suicide Prevention Act

In the NSW discussion paper, Minister Jackson says their strategy will be a whole-of-government approach addressing the underlying factors contributing to suicide. This will include focusing on "broader social determinants of health such as financial insecurity, unstable housing and social isolation – key factors that exacerbate suicidal distress".[7]

The South Australian Act makes no reference to the social determinants while the state's suicide prevention plan barely does. Tasmania's Suicide Prevention Strategy (2023-2027) makes a few references to the social determinants.

NSW says while it is embracing a whole-of-government approach to suicide prevention, it acknowledges there is a gap in the structure for stronger cross-portfolio delivery of initiatives.

"Historically, suicide prevention has fallen predominately under the responsibility of the health portfolio. This legislation aims to instigate a cultural shift within the government where suicide prevention becomes a collective responsibility, with established mechanisms for ensuring accountability," says the discussion paper.

Suicide prevention legislation would articulate roles and responsibilities of government agencies and hold them accountable for initiatives. This framework would foster a cultural transformation, necessitating all government agencies to assess, consider, and implement suicide prevention initiatives, both internally and externally for service users. Early stakeholder advice has highlighted the need for mechanisms to enable whole-of-government efforts in the legislation for it to be an effective policy lever, says the discussion paper. If legislation passed with only minor functions, it would unlikely result in systemic reform. While the legislation would be state based, it would need to complement Australian government policies and initiatives in suicide prevention, the paper adds.

A cross-portfolio Working Group is bringing NSW Government agencies together to inform development of the legislation. This group is also engaging people with lived and living experience of suicide, groups at greater risk of suicide, stakeholders, and peak bodies.

Mental ill-health isn't always the primary driver of distress leading to suicide. Addressing the social determinants of health is crucial, says the discussion paper. These drivers can be social, economic, or environmental. Risk factors can compound and intersect, as such people in distress may require a range of supports and engage with several government services on their journey to reduce distress. Multiple sources of distress can converge, amplifying an individual's level of distress, impairing their ability to manage life stressors. This compounded distress can be exacerbated by intersecting identities, leading to experiences of discrimination or disadvantage based on factors such as race, ethnicity, gender, disability, nationality, sexual orientation, and geographic location. Consequently, certain populations may face a higher risk of suicide due to impacts of these factors, the paper adds.

Embracing a whole-of-government approach will enable NSW to address inequities, recognising them as underlying drivers of suicidality, says the discussion paper. It maps an example of touchpoints where people in distress may interact with government services. The infographic below is intended to be an example.

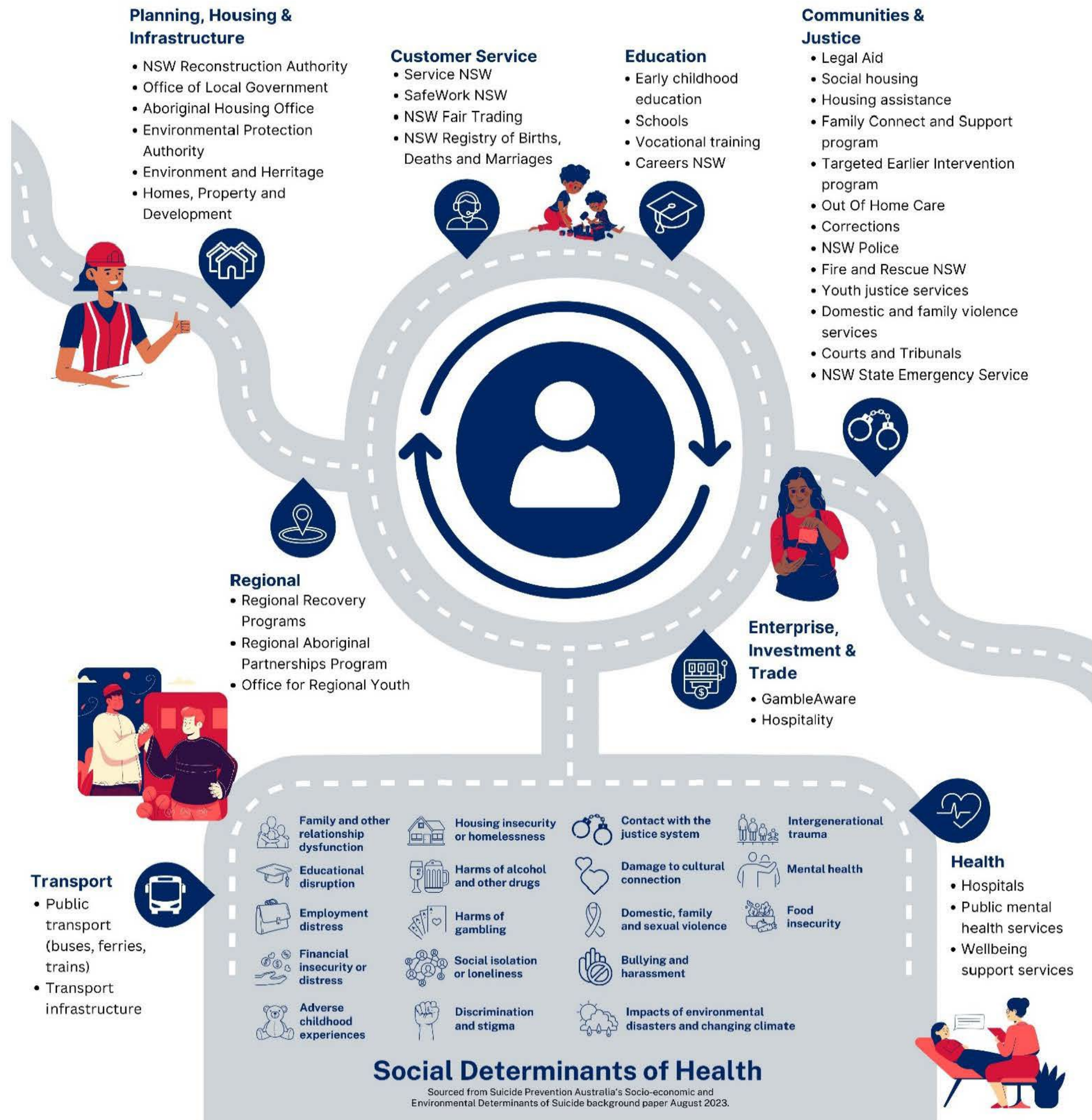

Figure 2 Example of key touchpoints in the community. Source: NSW Suicide Prevention Legislation (https://www.nsw.gov.au/sites/default/files/2024-07/nsw-suicide-prevention-legislation-discussion-paper.pdf, p.9)

Potential elements of a NSW Act

1) A state-based suicide prevention plan

Legislation could include a requirement for a whole-of-government plan with actions that include specific initiatives for priority groups at greater risk of suicide, clear accountability, and timeframes for renewal. Responsibility for developing the plan would be assigned, for example to the Mental Health Commission of NSW, and include timeframes for delivery.

Benefits: A state-based suicide prevention plan would ensure commitment and action that is responsive to community needs. While NSW has a Strategic Framework, it does not have specific actions for implementation. A state-based plan could operationalise the Framework.

Risks: Increased administrative burden of upgrading the Strategic Framework to a state-based plan out of session, given the Framework runs until 2027.

2) Agency-based action plans

Legislation could include a requirement for agency-based suicide prevention action plans akin to South Australia and Japan that align with the state-based plan and include clear reporting and accountability measures. Agency-based action plans could be reported on annually. The NSW Mental Health Commission may be well placed to support agencies to develop their plans.

Benefits: All government agencies are committed to suicide prevention and have actions to implement to reduce distress in the communities they service and support. Agencies know their community best and are well suited to develop localised suicide prevention activities.

Risks: Agencies do not feel supported with resources or technical advice to develop suicide prevention action plans. Challenges in achieving culture change at an agency level.

3) Suicide Prevention Council

Legislation could establish a new suicide prevention council which includes mechanisms to embed people with lived and living experience of suicide in governing the Act.

4) Suicide prevention capacity building

Legislation could include mechanisms to ensure public facing staff have the capability and capacity to interact with people in distress who are accessing their service or under their care. Capacity building (through training) as a key function of legislation has been implemented in Japan, Canada, and South Australia. The discussion paper says training would not be mandated, noting many workforces (teachers for example) undertake mental health and suicide prevention training that would likely meet the objective. If included in NSW's legislation, the paper proposes an existing body provide technical advice.

Benefits: Public facing employees would be supported with skills and knowledge to respond compassionately to people in distress and refer to existing support services.

Risks: Potential administrative and financial concerns with providing widespread training to public sector employees.

5) Data collection and sharing

Legislation could include opportunities for better sharing of data and strengthening data collection methods related to suicide prevention for policymaking and strategy evaluation.

Benefits: Increased data sharing across agencies to inform suicide prevention efforts.

Risks: Privacy and confidentiality must be protected. Possible increased administrative duties for agencies.

6) Consideration of suicide impact in policy decisions

The legislation could include more opportunities for government to consider suicide impact in policy and legislation decision-making to reduce the risk of potential failures of public administration causing community distress.

"The way this could be practicably implemented in NSW legislation is uncertain," notes the discussion paper. "The potential for this to become a tick-box activity is front of mind, as is the potential large administrative burden that could be imposed on government agencies if the right balance of scope and mechanism is not achieved."

A potential mechanism could be to require all significant policy decisions be made with regard to or be consistent with the state-based suicide prevention plan. The plan would detail considerations for policymakers to take into account. Another potential mechanism could be to leverage NSW's Statement of Public Interest, which must accompany any government bill before proceeding in the Legislative Council. The Statement of Public Interest considers why the policy is needed based on evidence and stakeholder input, policy objectives, alternative options to consider, analysis of benefits and risks, pathway for implementation, and consultation undertaken to inform the policy. There is potential this could be amended to consider the potential impact on suicide. Other options could include addressing this aim via executive government processes, such as a Premier's Memorandum.

Benefits: Suicide prevention in an all-policies approach will mitigate risk of government agencies inadvertently increasing psychological distress in the community.

Risks: This could become a tick box exercise or result in a large administrative burden for agencies.

Next steps for NSW

The discussion paper posed these questions for individuals with lived and living experience.

1. Which inclusions in the "Potential elements of a NSW Act" do you think are required to enable a whole-of-government approach?

2. Are there any anticipated implementation barriers or unintended impacts you foresee for any of the potential elements?

3. What other elements do you suggest for inclusion in a Suicide Prevention Act for NSW?

Suicide Prevention Australia has commended NSW for taking a whole-of-government approach and focusing on the social determinants of health.[18] It says the social determinants need to be addressed, especially for those most at-risk. This includes early life, education and child protection through to employment, welfare, domestic violence, alcohol and other drugs, housing, social isolation, gambling and the environment.[8]

Chris Stone said one of the "slightly disappointing things" about the NSW discussion paper was what he called "vague" mechanisms to embed suicide prevention into policymaking.[12] Stone pointed to social housing, noting tenancy mangers were not trained to deal with people who had mental health issues or disability – conditions suffered by many in social housing. They were under-qualified for their role. A suicide prevention plan for a department that handled social housing would ensure workers could deal compassionately with clients, he said.

Another suggestion would be to require a suicide impact statement on policy, said Stone. He didn't believe this would be onerous. But it would force consideration of the issue and be an opportunity for advocacy if the statement wasn't good enough.

Associate Professor Fiona Shand from the Black Dog Institute has said a Suicide Prevention Act needs to compel a government to review policy changes for their potential effect on suicide rather than focus on just a health system response.[16]

"As one example, changes to alcohol availability have been demonstrated to impact on suicide rates," she said. Shand wants the NSW laws to hold government ministers accountable for suicide prevention.

Stone told MHCT he agreed.[12]

"There needs to be some level of accountability. Exactly what that looks like will be tricky to negotiate. It's surprising how making something publicly reportable can be powerful," he said.

The Commonwealth

As noted above, the federal government has rejected the idea of introducing a Suicide Prevention Act for Australia. Chris Stone said officials cite the lack of evidence for its effectiveness, which he says is setting a "very high bar" for what counts as evidence. Stone noted the success in Japan.[12]

"Yes, there were lot of other things going on there, but it led to a bunch of initiatives in (Japanese) governments that would not normally have occurred, and we saw suicide rates drop substantially. That's about as good as it gets in the policy space … We continue to press," he said.

One drawback of not getting the federal government on board was the exclusion of Centrelink from any suicide prevention policy given it is often a point of distress for people, added Stone.

The Tasmanian context

Before looking at Tasmania's Suicide Prevention Strategy (2023-27), MHCT would like to share a lived experience journey by Maree McCulley from Hobart. Maree is a strong advocate for a Suicide Prevention act in Tasmania. She is a lived experience member on the Premier's Mental Health and Suicide Prevention Advisory Council. Maree is also a member of Mental Health Lived Experience Tasmania and MHCT. Maree believes a Suicide Prevention Act in Tasmania would allow the government of the day to maintain funding for education and training, focusing on suicide prevention and reducing our suicide rate. This would be an important legacy to future generations of Tasmanians, she says.

That Iron Will Travel

By Maree McCulley
Hobart, Tasmania

While I was living in Melbourne in 2002, I was diagnosed with obsessive-compulsive disorder (OCD) after a traumatic event.

My OCD compulsion was to check around our house, see if everything was turned off. Initially, it took two hours to leave for work. During times of high stress, it could take four. I was frightened something would happen to the house or family and friends if I didn't do these compulsions.

This is how OCD starts.

I would put things in the car boot such as the iron, which I'd wrap in a beach towel and place in a shopping bag. I did this regularly. No one knew. Most OCD people are good at hiding their little secrets. I kept mine from my husband for about two years.

He began to wonder why everything was turned off, including the DVD player he'd programmed to record shows he wanted to watch later. I would say we'd had a power blackout. Then one afternoon my husband wanted to iron his work shirt and couldn't find the iron. I had to explain my actions, my ritual, of the past two years, and tell him things were escalating.

My husband and a close friend encouraged me to seek medical advice. After seeing a GP, I saw a psychiatrist who specialised in OCD. I underwent cognitive behaviour therapy, exposure therapy and response prevention therapy, and started taking medication. It was difficult and took time, but I managed to control my OCD.

After we moved to Tasmania, one of the most effective ways I managed my OCD was by running. However, any stressful situation could trigger my condition. In 2019, I injured my right ankle in a serious work accident. My doctor and an orthopaedic surgeon said I would never run again. I was devastated. Running relaxed me. It was central to my mental health.

The injury made me feel isolated as I couldn't drive or get around easily. I was unable to connect with my running community and friends. A little voice inside my head kept repeating that I was a failure. Worthless. A burden to my family and friends. I would be better off gone. Those little voices got stronger until I was in a dark tunnel.

That was when I started making plans to end my life.

By then, my husband and daughter encouraged me to seek help. I called Lifeline (13 11 14) and was advised to go to the Royal Hobart Hospital Emergency Department. The hospital admitted me for two weeks, where I had the support of psychiatrists and counsellors, and started new medication. I then had In Home Care. It was hard leaving the hospital because I had no information on where to go or where to seek help.

As part of my workplace accident, I was assigned a rehabilitation provider. They notified my employer I had OCD and suicidal thoughts. I'd never told anyone at work I suffered OCD, as it hadn't affected my ability to do my job. The rehabilitation provider even accused me of faking my mental health issues during In Home Care, saying I wouldn't be covered by worker's compensation if I continued to say I was suffering such conditions.

All this happened when I under a lot of medication, feeling drowsy. It was around the time of COVID lockdowns. People were working from home. This gave my employer the opportunity to make me redundant. During a Zoom meeting on a Friday, I was told my role was no longer needed and I was being laid off. Have you ever thought what happens to people made redundant on a Friday afternoon? The stress they feel, especially if they've had suicidal thoughts and a mental health issue?

This was all done very impersonally. I suspect my mental health issues had something to do with it, even though I had worked for the organisation for seven years. To make matters worse, I had to meet one of my managers to drop off work documents and equipment. They didn't thank me or wish me luck. My work colleagues didn't contact me afterwards, which was soul destroying. I thought some were my friends. The only support I got during that time was from my family and close friends.

Now unemployed, my mental health dived. I felt worthless, a failure. Depression clasped its menace around me. I could not get out of bed. I didn't want to be here anymore. Those little suicide thoughts, part of my OCD, went round and round in my head again. My husband contacted my clinicians to make sure I went and saw them.

One day my husband wanted me to go to the RHH Emergency Department. I was reluctant because the people and the noise in the waiting room scared me. My husband got me to take my medication and lay in bed with me until I fell asleep. The next day an urgent phone call was made to see if I could get into a private clinic but there was a long waiting list. It would be a three-day wait to get a bed in the RHH psychiatric ward, so my husband supported me at home with family members until I felt stronger, until the suicidal thoughts were not so strong. This took seven days. At no time did any professional call to check on me.

Nevertheless, it was at this point that I started to realise I was not alone on this journey. I had family and friends around me. I learned ways to cope.

Some of my strategies include listening to meditative music, journal writing, and bushwalking when my ankles allow. Recently, I have added adult colouring books.

Everyone has some kind of journey they go through. We need to be more open about suicide because it can happen to anyone at any time in life.

Tasmania's Suicide Prevention Strategy

This interactive graph from the Australian Institute of Health and Welfare (AIHW) shows trends in Tasmania's suicide rate for the past 40 years.[19]

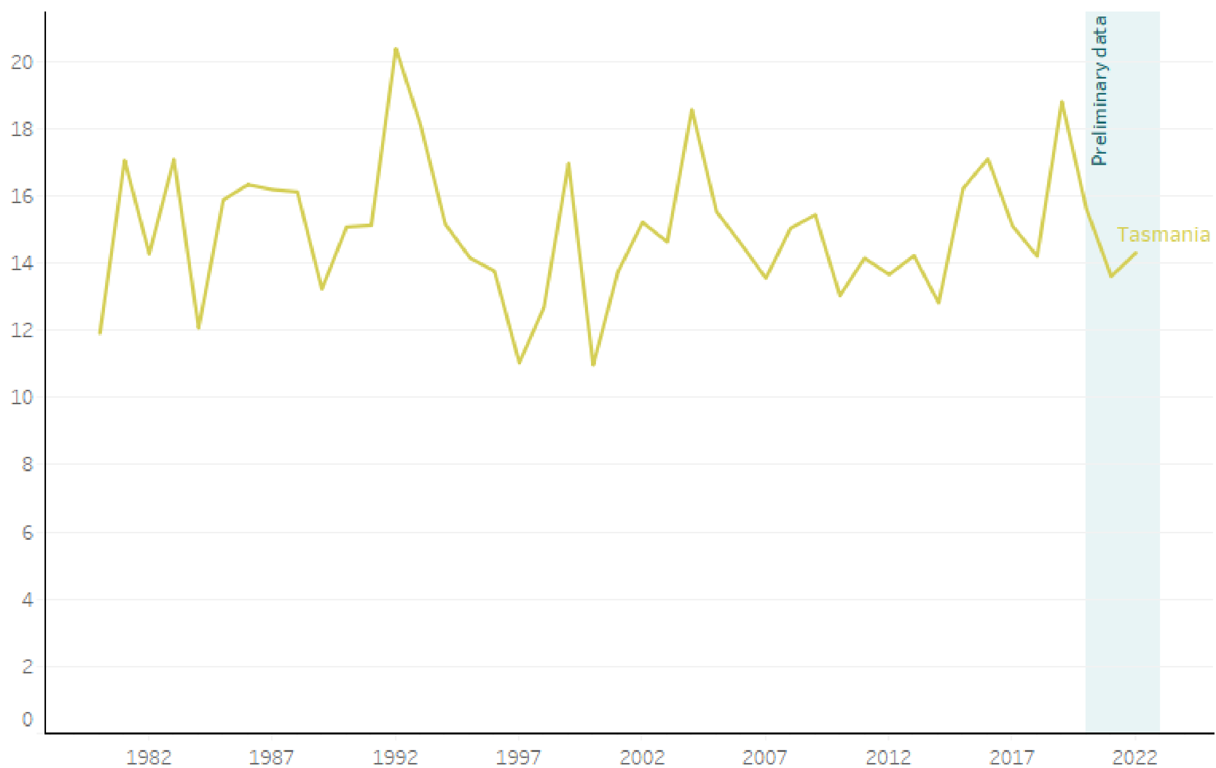

Figure 3 Source: Australian Institute of Health and Welfare (https://www.aihw.gov.au/suicide-self-harm-monitoring/data/deaths-by-suicide-in-australia/suicide-deaths-by-state-territories)

Tasmania has often had the second highest suicide rate in the country after the Northern Territory.

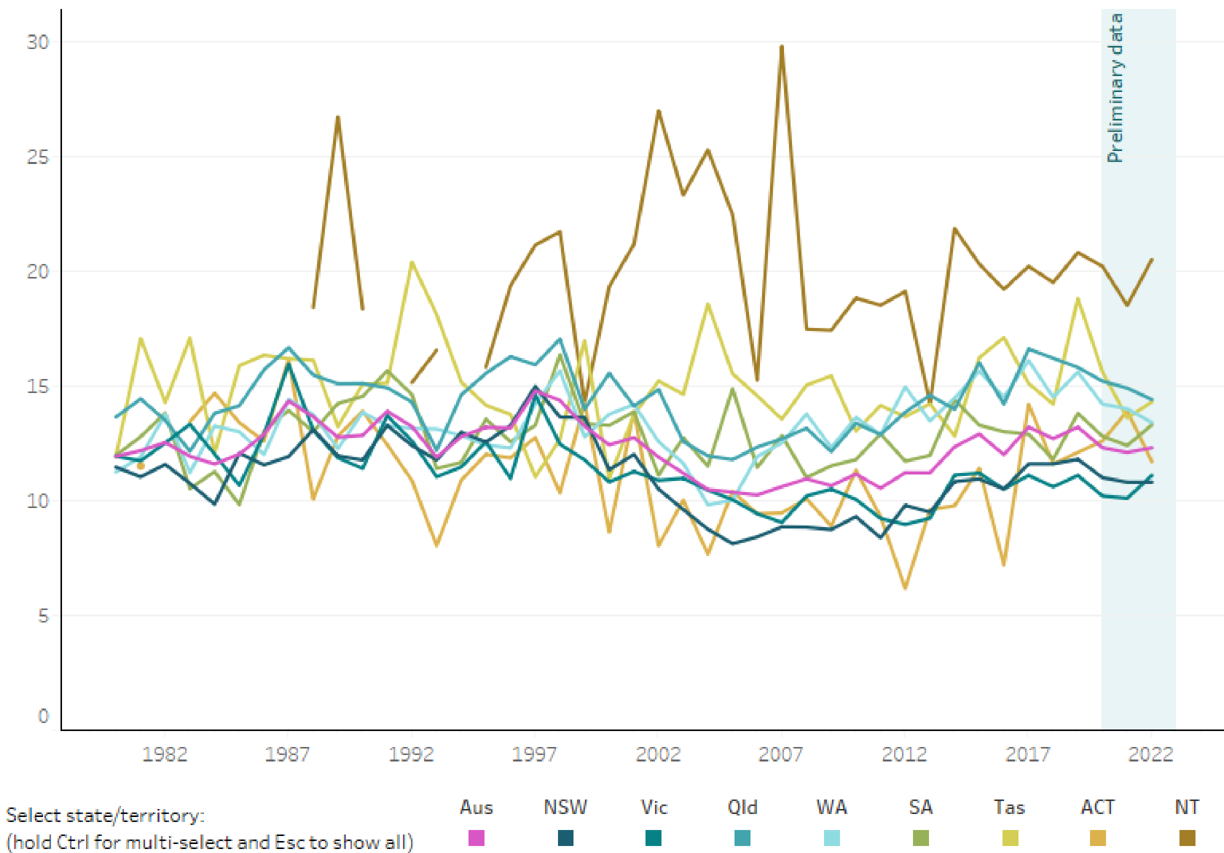

Figure 4 Source: Australian Institute of Health and Welfare (https://www.aihw.gov.au/suicide-self-harm-monitoring/data/deaths-by-suicide-in-australia/suicide-deaths-by-state-territories)

The current Tasmanian Suicide Prevention Strategy (2023-2027) is the state's third. The first ran from 2010-2014. The second from 2016-2020 (extended to 2022).

In 2010, at the start of the first Tasmanian suicide prevention plan, the rate of suicide was 13 per 100,000 people. It was 14.3 per 100,000 people in 2022 according to preliminary data published by AIHW. The lowest was 12.8 in 2014 and the highest 18.8 in 2019. The national rate was 12.3 in 2022, according to Suicide Prevention Australia.

MHCT is not seeking to interpret this data, except to say that since 2010 and implementation of two multi-year plans, there has been no downtrend in the state's suicide rate.

It's important to note that rates of suicide tend to be higher in regional and remote areas of Australia. People in such places face unique challenges due to geographic isolation, and often have poorer health and welfare outcomes than those in major cities.[20]

In Tasmania, 30,186 people identified as Aboriginal and/or Torres Strait Islander in the 2021 census, representing 5.4 percent of the state's population[21]. Nationally, Indigenous people comprised 3.2 percent of Australians in the same census. Preliminary 2022 ABS data indicates the rate of suicide is approximately two and a half times among First Nations people compared with non-Indigenous Australians.

People under 65 who use disability services also die by suicide three times greater than the general population[22]. In 2018, Tasmania had the most people with disability in the country at 26.8 percent compared to 18 percent nationally. Tasmania also had the highest rate of people with psychosocial disability in Australia at 8.3 percent.[21]

In 2022, new data showed 21.4 percent of Australians had a disability. While there doesn't appear to be a breakdown of data by state yet, we can assume Tasmania's rate has increased from 2018.[23]

Ex-military personnel are also more likely to die by suicide than the general Australian population.[24] Tasmania has the highest number of veterans per capita of any state or territory in Australia with 17,515 according to the 2021 census, accounting for 3.14 percent of the state's population, just ahead of the ACT with 3.11 percent.[25]

Tasmania's current strategy

There are three phases to Tasmania's current suicide prevention strategy. The first ended in June 2024. The second implementation plan is under development.

An annual report will be provided to the Premier and the Minister for Mental Health and Wellbeing and communicated broadly to all stakeholders, although it's not clear if this will be released to the public.

As noted above, the South Australian Act says annual reports from its Suicide Prevention Council must be delivered to its Health and Wellbeing Minister and then both Houses of Parliament. The state's suicide prevention plan – thought not the Act -- says these annual reports will be made public. A South Australian government official told MHCT that the tabling of these reports to parliament would effectively put them in the public domain.

The first Tasmanian implementation plan suggests public reporting as per the headline below but uses the same wording as the strategy -- *an annual report will be provided to the Premier and the Minister for Mental Health and Wellbeing and communicated broadly to all stakeholders*. Again, it's not clear if all stakeholders represent the Tasmanian public.

Reporting publicly on our progress

Delivering and reporting on the implementation plans will be a shared responsibility, overseen by the Executive Leadership Group for suicide prevention, and driven through the Premier's Mental Health and Suicide Prevention Advisory Council.

An annual report will be provided to the Premier and Minister for Mental Health and Wellbeing and communicated broadly to all stakeholders. The report will include:

- updated data against key indicators, where available
- reflections from our communities, people with lived experience and our workforce
- case studies to demonstrate progress, successes and challenges against activities.

Given this plan occurs over an 18-month period, annual reporting will be completed to align with reporting on Rethink 2020, with the first strategy report delivered in June 2023 (6-month period) and the second in June 2024 at the end of this implementation period.

Figure 5 Source: Tasmanian Suicide Prevention Strategy Implementation Plan - January 2023-June 2024 (https://www.health.tas.gov.au/sites/default/files/2023-05/Tasmanian%20Suicide%20Prevention%20Strategy%20%20Implementation%20Plan%20-%20accessible%20web%20V2%202023_0.pdf)

The Tasmanian strategy is overseen by the Premier's Mental Health and Suicide Prevention Advisory Council and driven through the Executive Leadership Group. It's not clear to MHCT if this is the most effective approach. The South Australian council appears to have sole responsibility for their strategy and for reporting to government. It also meets regularly whereas the meeting tempo for the Tasmanian council and ELG are unclear.

Tasmania's third strategy builds on and extends previous work to enable a whole-of-community, whole-of-service-system and whole-of-government approach.

The strategy notes people can expect reduced suicides and attempts, as well as improved wellbeing and focus on whole of population: "We want to see a sustained reduction in suicide deaths which will, in turn, reduce the impact felt across our communities. We also want to see a significant and sustained reduction in suicide attempts. This means a shift towards prevention and early intervention across settings to ensure we are not waiting for someone to experience a suicidal crisis before support is provided," says the strategy.

However, the strategy does not make clear what the government is seeking to measure itself against – such as reducing deaths by suicide, attempts or suicidal distress.

The South Australian Act by contrast requires the state's suicide prevention plan to include performance indicators that can be tracked over time.

The South Australian legislation also requires provisions in the plan to address prevention of suicide among priority population groups. Tasmania's strategy (Action 3.3) only calls for targeted actions for groups who may be at increased risk of suicide.

The Tasmanian strategy says it represents a joint approach across government agencies, the state's primary health network, agencies and services and community networks. It invites all sectors, services, and communities to play a role. For example, the strategy says the Tasmanian government will invest in suicide prevention through a range of government agencies and funded services. This includes hospitals and health services, emergency services, child and community services, and action across justice, housing, education and employment. It says Tasmania wants to build capability across government agencies to understand suicide prevention and apply a suicide prevention lens to new policies and programs.

This appears less effective than having government authorities commit -- under legislation -- to suicide prevention plans that set out strategies to prevent suicide among staff and the public as is the case with South Australia. Or in NSW, legislation that could include a requirement for agency-based suicide prevention action plans to reduce distress in communities they service and support.

The Tasmanian strategy notes each implementation plan will have a strong focus on joint planning and priority setting as well as on the co-design of new initiatives and the evaluation and monitoring of existing initiatives. It says the Premier's Mental Health and Suicide Prevention Advisory Council and the Tasmanian Suicide Prevention Community Network (TSPCN), together with peak organisations and lived experience networks in Tasmania, will work with government agencies to make sure actions and progress meet the expectations of people with lived experience of suicide and the community more broadly. Despite the best of intentions, this is not as strong as a legislative commitment.

MHCT notes the various priorities and actions from the Tasmanian Suicide Prevention Strategy. These include:

- Building capability across government agencies to understand suicide prevention and apply a suicide prevention lens to new policies and programs.
- Establishing a cross-agency working group to develop, implement and review processes and supports that enable new policies to include suicide prevention responses.
- Reviewing data, evidence and capabilities to set priorities and consider supports for people who are: recently unemployed or unable to work; experiencing housing stress or are in insecure housing; experiencing a relationship breakdown or conflict; in contact with, or transitioning out of, the justice system; transitioning out of the Australian Defence Force; being supported through the child protection system.

It will be important to see how these measures have been implemented in the annual reporting plan. Did they meet community expectations? Would the response of government agencies have been more effective had the plan been legislated? Was the annual report delivered to parliament and debated? Similarly, it will be important to measure the rollout and effectiveness of training. The South Australia Act requires provisions relating to the education and training of people in relation to suicide prevention.

Data

The Tasmanian Suicide Prevention Strategy calls for the availability and real-time use of suicide and self-harm data. It says data and evidence will guide the strategy. This is consistent with the South Australia plan and what NSW is proposing to do. Tasmania's strategy also notes the state needs to improve timeliness and specificity of data to track progress.

MHCT suggests a Suicide Prevention Act would help achieve that outcome.

The Tasmanian Suicide Register contains core data and enhanced data. Core data contains socio-demographic information (mainly age, sex, location, occupation, Indigenous and CALD status) which is coded when police first report a suspected suicide to the Coroner's Office. This information, known as surveillance data, is up to date on the Tasmanian Suicide Register. The data is shared with the Australian Institute of Health and Welfare each month to inform the National Suicide and Self-Harm Monitoring System, and members of the Research and Data Cross-Agency Working Group under the Tasmanian Suicide Prevention Strategy. NSW and Victoria publish monthly reports of this data as they report a larger number of suicide deaths. In comparison, Tasmania does not because of confidentiality concerns arising out of the relatively smaller number of deaths. Enhanced data is more comprehensive and typically coded once an investigation is finalised and the death has been determined as a suicide. This is more time consuming as the coder needs to go through an entire coronial file and identify and code the full extent of stressors, such as any mental health diagnosis and service engagements. Enhanced coding up to 2020 has been completed, and subsequently used to inform the next Suicide Report to the Government. The Department of Health is funding an additional coder under the draft second implementation plan of the Tasmanian Suicide Prevention Strategy to increase the capacity of the Tasmanian Suicide Register. [26]

A Black Dog Institute White Paper on preventing suicide describes potential innovations involving the use of real-time data registers of suicide and self-harm, including the National Suicide and Self-Harm Monitoring system. It notes that in the international context, a "real-time system to track suicides or suspected suicides within the UK allowed timely sharing of information with public health networks and a rapid response to contagion effects."[27]

MHCT did a briefing paper last year on the National Outcome and Casemix Collection (NOCC). One question that emerged from that research was whether there was potential value utilising data on suicides in Tasmania in combination with NOCC, if this is not being done already. Use of all relevant data is important for joining the dots in a whole-of-government, whole-of community response to suicide prevention. This might be something to consider in the context of both a Suicide Prevention Act for Tasmania and development of the strategy's second implementation plan.

For instance, a recent study by researchers at Sydney University found that 41 percent of suicide attempts, 35 percent of self-harm and 21 percent of cases of depression in Australia were caused by child maltreatment, which includes child sexual abuse. This alarming research provided the first estimates of the casual contribution of child maltreatment to mental ill health

in Australia.[28] This study was published a year after the landmark Australian Child Maltreatment Study (ACMS) showed 28.5 percent of Australians had suffered child sexual abuse. The ACMS found a large percentage of Australians had experienced some form of child maltreatment and were substantially more likely to have mental health disorders, health risk behaviours and use health services as a result.[29]

Use of this sort of data shows how the government's 10-year Change for Children Strategy and Action Plan can, and should be, linked with the Tasmanian Suicide Prevention Strategy.

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