Your Ref:
Our Ref: 915

14 October 2022

Kathrine Morgan-Wicks
Secretary
Department of Health

By email: mhadd@health.tas.gov.au

Dear Secretary

Re: Draft Tasmanian Suicide Prevention Strategy (2023-2027)

Thank you for the opportunity to provide feedback on the draft Third Tasmanian Suicide Prevention Strategy (Compassion and Connection, 2023-2027) ("draft strategy").

I commend the Tasmanian Government on its commitment to create:

> *A compassionate and connected community working together to prevent suicide in Tasmania*

It is encouraging to see that the draft strategy elevates the importance of suicide prevention. I commend the commitment to establish a Premier's Mental Health and Suicide Prevention Advisory Council along with an Executive Leadership Group to help provide oversight and governance to suicide prevention strategies in Tasmania.

Suicide prevention demands a thorough and systematic policy approach, beginning in the first 1000 days of life and continuing over a person's lifetime.

I acknowledge that the overall approach of this strategy aligns with the Fifth National Mental Health and Suicide Prevention Plan to "adopt a whole-of-government approach to suicide prevention". However, I feel that the draft strategy as a whole, if released in its current form, would represent a significant backwards step in suicide prevention for children and young people in Tasmania.

At the outset I note that I am especially disappointed at the lack of commitment to a comprehensive follow-up strategy to the *Youth Suicide Prevention Plan for Tasmania (2016-2020)* (Youth Suicide Prevention Plan). In my view, youth suicide prevention needs to be reprioritised through establishment of a dedicated stand-alone 5-year Youth Suicide Prevention Strategy.

I am very grateful for the additional time given to me to provide detailed feedback on the draft strategy. It is in the spirit of usefully contributing to improvement that I provide the following comments on the draft strategy.

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Role of the Commissioner for Children and Young People

As you are aware, my role as Tasmania's Commissioner for Children and Young People is to advocate for the rights and wellbeing of all children and young people in Tasmania. The *Commissioner for Children and Young People Act 2016* sets out the functions of the Commissioner, including influencing policy development in areas relating to children and young people under the age of 18 years.

As Commissioner, I want every young Tasmanian to thrive. To do this, we must ensure that we are meeting the needs of children, their families and their communities. Helping to develop an effective and child-focused suicide prevention strategy is an important way that I can fulfil my function.

Children and young people of all ages may experience the effects of suicide, suicidal distress and/or suicidal behaviours within their families, peer groups and broader communities. Tragically, suicide is the leading cause of death in young Australians aged 15-24.[1] In Tasmania there were 56 suicide deaths of Tasmanians (14-24 years) recorded between 2012-2018. Males represented over three quarters (77%) of young people lost to suicide.[2] Suicides often represents the tragic outcome of a series of missed opportunities to engage with and help young people in suicidal distress. Young people, especially young females aged 0-24, have the highest rates of intentional self-harm requiring hospitalisation (344 hospitalisations per 100,000 population) [3] and young males have the second highest rates of hospitalisation from self-harm (59 per 100,000 population).

In Tasmania, around 1 in 5 suicide deaths had a previous exposure to suicide.[4] Children and young people can be exposed to suicidal distress within their peer groups, families, and communities. Exposure to suicide, suicidal distress and suicidal behaviours can increase the likelihood of a child or young person developing similar suicidal behaviours; this is called suicide contagion.[5]

Under the United Nations Convention on the Rights of the Child (UNCRC), children are guaranteed the right to life and to survival and development, the right to attain the highest possible standard of health, and the right to maintain an adequate standard of living. More importantly, children also have the right to have a say in all matters affecting them, and to have their views taken seriously. It is incumbent on the Government to actively protect and promote the rights of the child under the UNCRC.

I note from my previous conversations with the Chief Civil Psychiatrist, and the General Manager - Mental Health, Alcohol and Drug Directorate (Directorate), a commitment to facilitating the co-design of the youth focused components of this strategy with young people. However, to enable me to support this, significant improvement in the structure and explanation of the overall suicide prevention strategy are needed, especially in those elements relating to youth suicide as I detail below.

[1] ABS all-cause mortality statistics 2018-2020
[2] Garrett A, & Stojcevski V (2021) Report to the Tasmanian Government on Suicide in Tasmania 1 January 2012 – 31 December 2018, Tables 5-6
[3] AIHW Suicide and self-harm monitoring data from Tasmania (Primary Health Network, PHN)
[4] Garrett A, & Stojcevski V (2021) Report to the Tasmanian Government on Suicide in Tasmania 1 January 2012 – 31 December 2018, Table 20
[5] Headspace: (2015) Suicide Contagion, version 2.

General Comments

1. The Tasmanian Approach to Suicide Prevention

The draft strategy does not include an explicit statement of the principle that many suicides are preventable. While I acknowledge that suicide deaths are complex and involve the interplay of protective and harmful factors, it is vital that this strategy clearly communicates that there is hope for people, including young people, in suicidal distress. I know from my consultations with children and young people that they are passionate about mental health and that they recognise the seriousness of suicidal distress in their peer-groups.

> *If I could change one thing in the world to improve people's mental health, it would be that everyone is always happy and there would be no emotional breakdowns or any suicide.*
> (CCYP Ambassador 9-17 years)

Australian research shows that providing 'hopeful narratives' in suicide prevention campaigns is valued highly by young people.[6] I note that the suicide prevention strategies of other Australian jurisdictions commonly include an explicit statement of the above principle. For example:

> Suicide is preventable[7]
>
> …focus on lowering the risks and increasing the protective elements many suicide deaths can be prevented[8]
>
> Suicide can be prevented if individuals, communities and government and non-government sectors work together.[9]

I further note that the Tasmanian Communications Charter includes the following statement in section on communicating about suicide prevention:

> Many suicides are preventable[10]

Given this, the draft strategy should include explicit reference to the principle that many suicides are preventable, as articulated in the Tasmanian Communications Charter.

2. The Vision and Goal(s) of the Strategy

In its current form, the draft strategy does not clearly articulate an evidence-based vision for suicide prevention in Tasmania or identify the intended outcomes of the strategy. I acknowledge that there is a general 'vision' statement that provides:

> *A compassionate and connected community working together to prevent suicide in Tasmania*[11]

However, this statement does not identify any measurable outcomes that can be used to determine the success or failure of the strategy, its priorities or actions.

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[6] Ftanou et al., (2021) Int. J. Environ. Res. Public Health (18), 4158.
[7] Victorian Suicide Prevention Framework (2016-2025)
[8] Western Australian Suicide Prevention Framework (2021-2025)
[9] Every life: The Queensland Suicide Prevention Plan (2019-2029)
[10] Tasmanian Communications Charter, p 19
[11] Draft Tasmanian Suicide Prevention Strategy (2023-2027), p 8

It is interesting to note that previous Tasmanian strategies, including the Youth Suicide Prevention Plan, included several measurable or goal-orientated statements. For example, the Tasmanian Suicide Prevention Strategy (2016-2020) outlined:

> *the need to ensure fewer people in our state are affected by distress associated with suicidal thoughts and behaviours*[12]

which is later summarised in the same document under the heading 'Our Goal' as:

> *to work together to reduce suicide, suicidal behaviour and the impact on Tasmanians*[13]

The accompanying Youth Suicide Prevention Plan stated:

> *That goal is to reduce suicide, suicidal behaviour and the impact on young people in Tasmania*[14]

The draft strategy would benefit from the inclusion of a similar vision statement to strengthen the overall approach and increase accountability. I understand that establishing a clear set of goals and associated 'success factors' early on in suicide prevention strategies is common. In fact, all other Australian jurisdictions provide at least one statement on outcomes early in their documents. In contrast, this draft strategy makes no reference to such a statement until the end of the document where it is stated that:

> *…we need to reduce the rate of suicide*[15]

In my view it would be more beneficial to place this statement at the front of the document to focus the strategy. I note its current placement towards the back of the document, within a justification for public reporting on yearly implementation plans (which themselves need further explanation – see comments below). It would be preferrable to create a standalone statement that outlines the overarching goal of this strategy and will provide the necessary yardstick against which successful prevention strategies can be measured**.**

3. The Situational Awareness of Suicide Prevention in Tasmania

Tasmania has had suicide prevention strategies in place for 11 years and in this third iteration, under establishing 'Our Approach in Tasmania', it is stated that the draft strategy:

> *…[builds] on our previous approach and draw together the best available evidence*[16]

In its current form, the draft strategy lacks any explicit 'situational-awareness'[17] of the success (or otherwise) of these previous suicide prevention strategies. There is a lack of detailed analysis of past strategies (see p10), and I could find no systematic review (or comment) about whether these strategies met their intended goals in reducing suicide rates in Tasmania.

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[12] Tasmanian Suicide Prevention Strategy (2016-2020), p 8
[13] Tasmanian Suicide Prevention Strategy (2016-2020), p 10
[14] Youth Suicide Prevention Plan for Tasmania (2016-2020), p 7
[15] Draft Tasmanian Suicide Prevention Strategy, p 28
[16] Draft Tasmanian Suicide Prevention Strategy, p 9
[17] Modified from 'situational-analysis' from the World Health Organisation (2021): Live Life An implementation guide for suicide prevention in countries (Part A).

A comprehensive review of policy on or related to suicide[18] is vital to avoid what the Queensland Suicide Prevention Plan calls 'more of the same'.[19] The lack of situational awareness with respect to young people is particularly concerning given they have been identified as 'a community that we know are strongly affected by suicide' (p9), and so are worthy of additional support without any further justification.

I strongly urge the Directorate to undertake a comprehensive review of previous Tasmanian suicide prevention plans including the Youth Suicide Prevention Plan for Tasmania and incorporates its findings into the current suicide prevention strategy.

4. The Evidence Base

Suicide prevention strategies should be evidence-based. The importance of evidence-based approaches to inform government policy and drive outcomes is consistently recognised as central to achieving intended outcomes. Suicide prevention strategies are no different and the benefit of establishing an evidence-base was outlined in the Final Advice of the National Suicide Prevention Adviser (Connected and Compassionate Report) to the Prime Minister on suicide prevention in Australia[20]. This evidence-based approach underlies the national approach and is explicitly recognised under Recommendation 3 of the Connected and Compassionate Report.[21]

Previous Tasmanian suicide prevention strategies have provided a thorough analysis of the research findings and the suicide data that inform priorities and actions. The current draft strategy provides only a brief catalogue of findings published by the Australian Institute of Health and Welfare (AIHW), and in the Second Report to the Tasmanian Government on Suicide in Tasmania.[22]

I note that the current suicide prevention policies of other Australian jurisdictions are informed by a thorough analysis of research findings and/or suicide data. For instance, the Northern Territory Suicide Prevention (Strategic Framework, 2018-2023) sets out a list of 11 priority groups including young people, and then systematically provides data for each group that relate to:

i) the epidemiology of suicide in the defined population, and/or
ii) analysis of known risk-factors that contribute to suicide in this population, and/or
iii) level of service-engagement[23] by the defined population, and/or
iv) interaction between individual and community level factors that may play a role in suicide deaths within the defined population.

I note in Figure 1, the draft strategy that some attempt has been made to catalogue the risk factors and key 'transition points' in various populations. However, I understand, from the footnote to this figure, that these risk factors have been adapted from the above-mentioned Compassion First Report. In its current form, this figure does not clearly link the key life transitions with vulnerable populations, nor is it clear to what extent these risk factors reflect young Tasmanian's experiences of suicide and suicidal distress.

[18] WHO (2021): Live Life Table 1
[19] *Every life*. The Queensland Suicide Prevention Plan (2019-2029) p 12.
[20] National Suicide Prevention Adviser. Connected and Compassionate: Enabler 3 – Data and evidence to drive outcomes.
[21] National Suicide Prevention Adviser. Connected and Compassionate: Implementing a national whole of governments approach to suicide prevention (Final Advice) Canberra, December 2020.
[22] Garrett A, & Stojcevski V (2021) Report to the Tasmanian Government on Suicide in Tasmania 1 January 2012 – 31 December 2018
[23] For example the number of contacts made by young people to the Kids HelpLine

In my view, the draft strategy would greatly benefit from Tasmanian specific analyses of the nature, prevalence, risk-factors, and/or known short comings in service delivery for all vulnerable populations, including for children and young people.

5. Suicide Prevention in Vulnerable Populations and Persons Experiencing Life Transitions

To best support the health and wellbeing of young Tasmanians under 18 years, suicide prevention needs to support vulnerable populations from birth, especially during key life transitions. In the current draft, it is unclear whether this is the intention, as there appear to be two separate approaches instead of a single integrated approach.

The first approach seems to be based on identifying vulnerable populations that are particularly affected by suicide, suicidal distress and/or suicidal behaviours (e.g., 'young people'). Under this approach, several of these vulnerable populations are specifically mentioned in priority action 1.3 which will

> *Deliver targeted actions that reach particular groups at increased risk of suicide in Tasmania.*

I note that specific action statements are variously described as involving either: a 'community action plan', or an 'action plan', or even will 'use yearly implementation plans to progress community-based activities that meet the needs of particular populations'.[24] This approach uses community-based action plans to support vulnerable populations.

In contrast, under the second approach, a cross agency working group (Figure 2) will review data, evidence, and agency capabilities to set priorities and consider supports for people who are experiencing key life transitions (Action 3.2, p 20). The cross-agency working group will also 'work with other organisations and people with lived-experience to co-design support options to be implemented and evaluated' (p 20).

The draft strategy should integrate both approaches into a single clearly explained approach. This must include explanation of the links between vulnerable populations and key life transitions. There is also a need to better detail the roles and responsibilities of the community-led and cross-agency working group led initiatives in the suicide prevention strategy.

6. Defining Vulnerable Population Groups

There is considerable scope to better define the vulnerable population groups that will receive support over the next five years. These populations are variously referred to as:

> those communities that we know are strongly affected by suicide and suicidal distress (e.g. men, young people Tasmanian Aboriginal people, LGBTIQ+ people, CALD communities, defence force personnel and veterans)[25]
>
> particular population groups in Tasmania – this may include the Tasmanian Aboriginal community, CALD communities, men, defence force personnel and veterans and LGBTIQ+ communities[26]

[24] Draft Tasmanian Suicide Prevention Strategy, p 17
[25] Draft Tasmanian Suicide Prevention Strategy, p 9
[26] Draft Tasmanian Suicide Prevention Strategy, p 17

> that supports working with and engaging, men, the Tasmanian Aboriginal Community, CALD communities, LGBTIQ+ communities, defence force personnel and the veteran community (and others as identified)[27]

The lack of a definition with respect to 'young people' is particularly concerning given youth suicide prevention is being integrated into this omnibus strategy. I note that this population was previously defined in the Youth Suicide Prevention Plan ('The Plan at a Glance') as 'young people aged 12-25 years'.[28]

In my view, suicide prevention should begin before birth as many of the risk factors that affect an individual's vulnerability to experiencing suicide, suicidal distress and suicidal behaviours may begin prior to birth.

In my February 2020 report, *Investing in the Wellbeing of Tasmania's Children and Young People*, I advocated for greater investment in the first 1,000 days to give all children the best start in life and lay the foundations for healthy, happy, and prosperous lives. I reiterated my position again in April 2021, in my comment on Tasmania's Child and Youth Wellbeing Strategy Discussion Paper. I argued that the first 1,000 days should be a discrete component of the Government's wellbeing strategy to ensure that investment in this formative period of a child's life receives appropriate weight. I outlined that this must include dedicated objectives, outcomes and measures linked to tangible efforts to improve wellbeing from conception to two years. To reiterate my recommendations, I advocated that -

- Striving to achieve the very best experience for all children in their first 1,000 days should be a cross-partisan, mainstream undertaking in Tasmania and a key priority for all relevant government agencies.
- Interventions in the first 1,000 days should take an evidence-based, holistic, integrated, and inclusive approach, and be delivered both universally and proportionate to need.

In response to these recommendations, the Government announced several actions in its Child and Youth Wellbeing Strategy, *It Takes a Tasmanian Village* that target and increase support for the first 1000 days of a child's life.

In my view, there is much more that can be done to promote the health and wellbeing of children and young people from before birth, through infancy and childhood. Empowering parents, carers and communities through education plays an important role in reducing the likelihood of a child experiencing mental illness, including by reducing the occurrence and impact of adverse children experiences (ACEs) such as violence, sexual abuse, and neglect among others.

The importance of the first 1000 days, and beyond, was recently emphasised in the *National Children's Mental Health and Wellbeing Strategy*. As noted in this document,

> it is relatively common for children to experience or be at risk of experiencing poor mental health.[29]

Suicide prevention strategies should begin from the first 1000 days of life, and I suggest that reference to 'young people' in the draft strategy should be changed to reflect this.

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[27] Draft Tasmanian Suicide Prevention Strategy, p 23
[28] *Youth Suicide Prevention Plan for Tasmania (2016-2020)*, p 9
[29] The National Children's Mental Health and Wellbeing Strategy (2021)

Efforts to prevent suicide need to begin before birth and continue over the entire lifespan, proportionate to risk.

7. Reliance on Yearly Implementation Plans

The draft strategy outlines a co-ordinated 5-year approach to suicide prevention in Tasmania. To achieve the vision, I note that the strategy uses a new approach that relies on 'yearly implementation plans'. These plans are introduced as follows:

> Rather than including separate priorities and plans, we have taken a more integrated approach that allows us to identify and respond to the range of factors contributing to suicidal behaviour across and within groups in Tasmania. Yearly implementation plans provide an opportunity for clear actions to be taken within these priority areas[30]

It appears that the intended benefits of yearly-implementation plans are to 'identify and respond to the range of factors', but as I mention above, these factors should be established before defining the approach to suicide prevention. I can see no precedent for yearly implementation plans in the suicide prevention strategies of other Australian jurisdictions. As this approach is a substantial departure from well-established co-ordinated multi-year approaches, and mindful of the limited resourcing allocated to suicide prevention in Tasmania, I would welcome further information so that I can better understand the rationale for this approach.
Further, significantly more detail needs to be provided on the structure and purpose of yearly implementation plans than is available in the current draft. In the following part, I identify four questions that require clarification.

7.1 What will be the 'focus' and prioritisation of yearly implementation plans?

I have several questions about the 'focus' of the yearly implementation plans that require clarification. These include:

- Will specific population groups be the focus of only one yearly implementation plan? (e.g., 2023 Youth, 2024 Men, 2025 Defence force personal and veterans etc).
- Will vulnerable populations receive sustained focus over the course of the five-year strategy, or will focus be limited to the life of the relevant yearly implementation plan?
- Will yearly implementation plans be generated for all vulnerable populations each year using a co-design approach?[31]

When the yearly implementation plans are introduced in the draft strategy, their intended purpose is unclear. It is stated that:

> Yearly implementation plans provide an opportunity for clear actions to be taken within these priority areas[31]

- Does this mean that the implementation plans target 'priority-areas' rather than vulnerable populations?
- If so, what are the priority areas referred to on page 15?
- Are the vulnerable populations, outlined on page 9 (Our approach in Tasmania) the

> …genders, age groups and workplaces, as well as communities identified through culture, identify or geography that are overrepresented in our suicide and suicide attempt data

[30] Draft Tasmanian Suicide Prevention Strategy, p 15
[31] Draft Tasmanian Suicide Prevention Strategy, p 15

- Or, alternatively, do the priority-areas instead refer to the five priorities that are outlined on pages 15-25 of the strategy?

I also have questions about the yearly implementation plans and the proposed governance structure (Figure 2, p27). For example,

- Which agency and/or body will be responsible for co-ordinating the development, implementation, and review of yearly implementation plans? Is it:

  i) the cross-agency working groups (refer to Action 3.2)
  ii) the new Premier's Mental Health and Suicide Prevention Advisory Council (the Council),
  iii) the Directorate, or
  iv) other groups including Primary Health Tasmania and the Tasmanian Suicide Prevention Community Network.

I strongly suggest that further detail be provided to address the above questions and reduce confusion in the final strategy**.**

7.2 What is the anticipated timeline for developing yearly implementation plans?

The draft strategy provides no detail around the timelines for each yearly implementation plan, except for a reference to the development and release of an implementation plan for 2023. Under Action 5.2 (p24) and again on page 28 it is stated that:

> An implementation plan for 2023 will be developed and released with the TSPS by the end of 2022[32]

If my understanding is correct, this means that all the below actions (at a minimum) would need to be completed within approximately 8 weeks:

> i) review of the evidence-base (including accessing the Tasmanian Suicide Register database, Ambulance and Tasmanian hospital data [Action 5.3]),
> ii) community consultation,
> iii) stakeholder engagement,
> iv) planning and co-design,
> v) resource allocation including establishing funding arrangements, and
> vi) community and stakeholder feedback on the implementation plan

I do not think this short turn-around time is feasible for community consultation and engagement. In my experience engaging with children and young people in Tasmania, including through my established programs (i.e., the CCYP Ambassador Program), a lead time of several months is necessary to meaningfully engage with young people and listen to their views on complex policy issues. Consultation on suicide prevention will need to be undertaken with great sensitivity and care.

Looking more closely at the six points above (i-vi) it appears that they deal only with the *development phase* of a single yearly implementation plan which presumably would occur in the year prior to implementation. Regarding the priorities and actions, yearly implementation plans will also include the following:

[32] Draft Tasmanian Suicide Prevention Strategy: Developing and reporting publicly on yearly implementation plans, p 28

Action 1.3:	using yearly implementation plans to progress community-based activities[33]
Action 4.2	using yearly (sic) plans[34] to identify priority workforces and to plan, implement and evaluate training[35]
Action 5.2	Develop and report against yearly implementation plans, with transparent reporting on actions, outcomes, and challenges[36]
Action 5.4	using yearly implementation plans to … [5 dot points follow][37]

Every year of the 5-year strategy will therefore need to include some degree of development, identification (of other priorities), implementation and evaluation (of strategies), and reporting. This list does not include other activities such as liaising with the National Suicide Prevention Office (refer *Actions 3.1, 4.4, 5.4*) or co-designing new approaches to suicide prevention such as the 'early response service' (refer Action 2.4) which each require a significant investment of time and resources.

The strategy should include more detail around the timing of the yearly implementation plans with specific reference to community / stakeholder engagement timeframes, co-design timeframes, and expected outcomes

A further issue is that there appears to be no reference to recurrent funding or additional resourcing for the strategy itself. I do note however that there is a commitment ($200 000) in the State Budget 2022-2023 for 'the initial implementation of the Tasmanian Suicide Prevention Strategy in 2022-2023'.[38] My concern is that this level of resourcing may limit the implementation of actions under the plans.

7.3 Duration of implementation plans.

It is well established from analysis of data within the National Self Harm and Suicide Monitoring System that multiple psychosocial risk factors may contribute to suicidal ideation, non-fatal self-harm incidents, and death by suicide.[39] Data published by the Tasmanian Suicide Register (2021) showed that over 90% of all suicide deaths between 2012-2018 had at least one interpersonal[40] or contextual stressor[41]. Simply put, suicide is complex and it is this complexity that likely underlies the large variability in the annual number of suicide deaths.

There is significant yearly variation in the number of suicides across multiple countries, including Australia[42]. Illustrating this, analysis of the annual number of suicide deaths between 2012 and 2018 reveals over 35%[43] variation over the 7-year reporting period. A similar pattern of variability

[33] Draft Tasmanian Suicide Prevention Strategy, p 17
[34] I am assuming that this reference to yearly plans refers to 'yearly implementation plans'
[35] Draft Tasmanian Suicide Prevention Strategy, p 23
[36] Draft Tasmanian Suicide Prevention Strategy, p 24
[37] Draft Tasmanian Suicide Prevention Strategy, p 25
[38] 2022-23 Tasmanian State Budget Paper 2, 5 Dept of Health p 105, https://www.treasury.tas.gov.au/budget-and-financial-management/2022-23-tasmanian-budget
[39] https://www.aihw.gov.au/suicide-self-harm-monitoring/data/behaviours-risk-factors/psychosocial-risk-factors-suicide
[40] Garrett & Stojcevski (2021) Table 19.
[41] Garrett & Stojcevski (2021) Table 20.
[42] Lewitzka et al., (2019) BMC Psychiatry (19): 158
[43] In 2012 there were 61 deaths, in 2016 there were 87 deaths. The percentage difference between these numbers is 35% *(Cole & Altman **2017** BMJ (358):j3683*)

emerges from the annual numbers of youth suicides in the same reporting period (95%[44] annual variation).

I am therefore concerned that yearly implementation plans will not provide enough time to observe meaningful change. The variability in annual Tasmanian suicide rates underlines this point, as does research showing that national suicide prevention plans[45] take at least 2 years of operation before significant reductions in suicide rates are detected.[42] I believe that more time needs to be given to individual strategies, and that sufficient time is allowed for community-based suicide prevention strategies to take effect (e.g. suicide action plans under Action 1.2, p16).

Finally, while the commitment to annual reports (Action 5.2, p 24) is commendable, if sufficient time is not provided for strategies to take effect, this may result in incorrect conclusions being drawn and published.

7.4 Reviewing yearly implementation plans

Given the new approach of supporting the 5-year strategy through yearly implementation plans, I would encourage an independent analysis/review of this approach. In Action 5.2 it appears that annual reports will be generated, however these reports are intended to:

> Develop and report against yearly implementation plans, with transparent reporting on actions, outcomes and challenges[46]

To ensure future situational awareness, it would be useful to include provision for a review of the whole strategy and its reliance on yearly implementation plans to identify what worked, and what will require revision.

8. The Premier's Mental Health and Suicide Prevention Advisory Council

I commend the commitment to establish a new governance structure which will include the Premier's Mental Health and Suicide Prevention Advisory Council (the Council). Establishing this governance structure should be a priority. This will bring together key decision makers from the Department of Premier and Cabinet and other senior figures in the Tasmanian Government and will prioritise suicide prevention in Tasmania. The governance structure of the new strategy should reflect the Tasmanian context to enable us to work to our strengths. As it stands there is a lack of detail about the proposed governance arrangements. It would be helpful for the strategy to include further detail on:

i) What role will the Chief Psychiatrist play on the Council?
ii) Is there a role for the Director of Public Health on the Council?
iii) Will the suicide prevention co-ordinators sit on the Council?
iv) Will representatives of the Directorate sit on the Council, or only with the Executive Leadership Group?
v) What are the roles of the cross-agency working groups?

I am also eager to understand the timeline for establishing this new governance structure, given that so many of the priorities will require new agreements between:

[44] Please note there were fewer deaths by suicide in this age group so the variability between individual years will appear larger.
[45] Including Australia.
[46] Draft Tasmanian Suicide Prevention Strategy, p 24

i) the state and federal government (Actions: 1.4, 3.1, 4.4, 5.4),
ii) different state government entities (Action 5.3), or
iii) the government and non-government groups such as the Tasmanian Suicide Prevention Network (Action 1.2) or, as yet-unnamed academic institutions (Action 5.1)

Greater clarity should be included in the strategy around the specific roles and responsibilities of the: (i) Executive Leadership Group, (ii) Premier's Mental Health and Suicide Prevention Council, (iii) cross-agency working groups, and (iv) Tasmanian Suicide Prevention Community Network).

9. Accountability of the Suicide Prevention Strategy

I note that page 14 of the draft strategy provides a list of 'sectors, services and communities' that will play a role in this suicide prevention strategy. While it is appropriate to receive a general overview of those with a role in this context, this list does not identify their specific roles. For example, it is not clear who is responsible for the development, implementation, co-ordination, and review of the priorities under the strategy (and the associated yearly action plans). I note that other Australian jurisdictions provide this information either in an appendix *(refer ACT – Appendix A, p 30; VIC – Appendix 2, p 31)*, or alongside each action statement *(see QLD – Every life, The Queensland Suicide Prevention Plan Phase 1)*. To ensure robust accountability mechanisms are established, I encourage inclusion in the strategy of the specific roles that sectors services and communities will play over the course of the strategy.

Specific Comments on Priorities

In addition to the above general comments on the draft strategy detailed above, below I provide some specific comments regarding the five priorities outlined (pp 5-25). I acknowledge that there may be some overlap between my comments above, especially in relation to priority action 5.

Priority 1: Empowering our people and communities to lead suicide prevention plans.

Children and young people have the right to be heard and make significant contributions to matters that affect them[47]. The inclusion of lived-experience in suicide prevention strategies under this priority will provide valuable insight into guiding suicide prevention strategies in Tasmania.

Action	Action summary	Comment	Issue	Suggestions
1.1	Support people with lived experience of suicide to contribute to priority setting, program design, and suicide prevention leadership in Tasmania	Lived experiences should be included at all stages of the design, implementation, and review stages of the strategy.	Action 1.1 appears to repeat statements made in Action 4.3 ('implementing support structures, training and supervision for lived experience workers in Tasmania').	Consider additional avenues of engaging with young Tasmanians in addition to persons with lived experience. Ensure extreme care is taken when engaging with young people, particularly those with lived-experience, to inform suicide prevention strategies. Rationalise Actions 1.1 and 4.3 to avoid repetition.
1.2	Further enhance the capacity of communities to implement suicide prevention action plans	This action builds upon Action 11.3 of the previous suicide prevention strategy (2016-2020/22).	What are 'suicide prevention plans'? Are they the same as 'community action plans' (Action 1.3) or do they represent something different? This action does not adequately define the term 'community'. Is this according to Local Government Area (LGA) or will	This action would benefit from editing and a review of language to ensure a consistent approach to definitions. Provide a definition of community.

[47] UNCRC Article 12

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			another Australian Statistical Geographical Standard (ASGS) be applied? What role will children and young people play in developing suicide prevention action plans in collaboration with the Tasmanian Suicide Prevention Network / Primary Health Tasmania. Children and young people must be appropriately and responsibly included in developing suicide prevention plans in their communities.	Provide evidence-based guidance on appropriate and safe youth engagement during the development of community (or suicide) action plans.
1.3	Deliver targeted actions that reach particular groups at increased risk of suicide in Tasmania	Part of this action is similar to action 4.5 of the previous suicide prevention strategy (2016-2020/22).	This section should comment on whether existing networks will be leveraged in developing the youth action plan, or if there will be a commitment to exploring and incorporating contemporary youth suicide prevention approaches. This action does not sufficiently account for the intersection between different vulnerable populations and known risk factors. This action does not outline the timeframe for targeted actions. Will they be implemented in a particular year and then sustained (until the end of the 5 years)?	Clarify the role and structure of community action plans, and how they fit within the yearly implementation plans. This will help clarify the intended approach(s) to suicide prevention in each vulnerable population. Clarify if youth suicides will be covered by a single action plan or multiple action plans (which are presumably progressed by the yearly implementation plan). Clarify whether the targeted actions will also investigate the intersectionality between different populations and risk factors (Action 3.2)
1.4	Provide coordinated and proactive supports across all community settings for people impacted by suicide.	Parts of the draft strategy appear to build upon Action 10.2 or are similar to Action 5.2 of the previous suicide prevention strategy (2016-2020/22).	Extreme caution must be made if localised notifications relating to youth suicides are to be adopted. Local notifications are a very high-risk strategy (depending on context), and in populations such as young people run	Keep a consistent nomenclature communities / people. Provide more detail on 'localised notification and communication protocols' and how risk for community distress will be mitigated.

		The first sentences contain ideas at two different population levels (communities and people).	the risk of suicide contagion[48] which must be avoided. This action suggests that real-time data / monitoring of suicide deaths and self-harm will be undertaken. It is unclear where this information will be collected, or if any of this data will be sent as part of the 'localised notifications'. How will 'dedicated resources' be allocated. Where in the proposed governance structure (Figure 2 p 27) does this responsibility sit.	Clarify if resources in this section refer to aftercare/ postvention services only, or if all stages of prevention will receive dedicated resources. This section should outline what data will be monitored in real-time or, if unknown, provide a statement stating minimal datasets will be created in consultation with other stakeholders (AIHW, National Suicide Prevention Office, Tasmanian Suicide Register) Provide more detail on where responsibility for resource allocation will reside.

Priority 2: Delivering compassionate and connected services that meet people's needs

This priority outlines several important approaches to suicide prevention in Tasmania.

Action	Action summary	Comment	Issue	Suggestions
2.1	Increase the availability, accessibility and quality of aftercare services in Tasmania to support people following a suicide attempt or suicidal crisis.	This action does not specify if youth-oriented aftercare services will receive attention.	Aftercare services for young Tasmanians should reflect their patterns of health-seeking behaviours, and traditional aftercare services may not be appropriate to meet their complex needs.	Including specific statements regarding expanding youth-oriented aftercare services in Tasmania.

[48] https://www.headspace.org.au/assets/School-Support/Suicide-contagion-web.pdf

2.2	Expand the availability of community-based models of care for people experiencing suicidal distress.	This action does not mention the Child and Adolescent Mental Health Service (CAMHS) which is undergoing reform and is vital in linking youth workers and schools with mental health professionals. While mental health Integration Hubs and Safe Havens present a viable alternative to emergency departments it is unknown if these are tailored to meet the needs of children and young people in suicidal distress.	This section should reiterate the role of CAMHS in providing care to young people in suicidal distress.	Consider including reference to CAMHS and its role in suicide prevention for young Tasmanians Comment on the role of mental health integration hubs / safe-havens on young people in suicidal distress. If these services are not tailored to help young people, then alternate options should be included in the yearly implementation plans.
2.3	Increase the capacity of alcohol and other drug (AOD) services in Tasmania to provide integrated support for clients experiencing suicidal distress.	Under Article 24 of the UNCRC every child has the right to the best possible health. Governments must work to provide good quality health care. This right includes access to youth-oriented alcohol and other drug services.	This section does not clarify if youth oriented alcohol and other drug services will be included.	Include specific statements on reviewing and implementing youth specific alcohol and other drug services. See also my comments on the draft Tasmanian Drug Strategy.
2.4	Design, deliver and evaluate an early distress response service for Tasmania.	Adopting an early distress response system represents a novel approach that may help prevent suicides in Tasmania.	No such system currently exists and therefore it is unknown if this is best practice in the Tasmanian context The suitability for using an early distress system for young Tasmanians should be investigated.	Include comments on assessing the suitability for an early distress warning system for youth suicides in Tasmania.

Priority 3: Expanding our approach to enable collective action across multiple agencies and sectors

This priority outlines several additional approaches to establishing suicide-prevention programs within Tasmania. Consideration of suicide prevention in all policies should be supported in all government departments, especially in departments that work with children and young people. Furthermore, young people should be included in all stages of policy development.

Action	Action summary	Comment	Issue	Suggestions
3.1	Support government agencies in Tasmania to apply suicide prevention considerations to all new policies.	Parts of this priority are similar to action 11.3 in the previous suicide prevention strategy (2016-2020/22)	Much of the detail surrounding the cross-agency working groups and their position within the larger 5-year strategy is lacking. It is unclear whether the two cross agency working groups outlined in this Action (3.1 and 3.2) are in addition to the four working groups outlined in Figure 2 (p27), or if they are included in the overall number of cross-agency working groups.	Provide more detail on the cross-agency working groups including their duration and their potential roles in suicide prevention. Provide more detail on how the working groups in 3.1 and 3.2 relate to the total number of working groups (Figure 2)
3.2	Prioritise and implement interventions that provide proactive support to Tasmanians experiencing key adverse life events or transitions.	The list presented in this action represents a subset of known risk factors for suicidal distress and suicidal behaviours. This action is dependent on Action 1.4 and Action 2.4 for early identification, and early intervention.	The title of this action does not make it clear whether 'proactive supports' are provided in an aftercare setting. It is also unclear what inclusion/ exclusion criteria were used to generate this list of adverse life events. Why were these prioritised over others? It is unclear whether this action is intended to be a stand-alone measure or if this specific action relates to Action 2.4 (Early Distress Response Service), and is dependent on Action 1.4 (real-time data monitoring).	Undertake a significant revision of Action 3.2 by: (a) defining its role in the larger suicide-prevention strategy, or by clearly showing this action as being an integration between multiple other priorities (e.g., 1.4 and 2.4). (b) relating key life-transitions to vulnerable populations (if appropriate) (c) outlining inclusion/exclusion criteria for the key-transitions listed in this action (d) establishing clear links with Action 1.4 which refers to *proactive responses informed by the 'real-time data'* identify emerging priorities and life events
3.3	Enhance actions to promote best-practice reporting and	This action builds upon actions 9.2 and 9.3 of the	Reporting on suicides is particularly challenging and it is encouraging to see	The directorate should evaluate and develop, in consultation with children and young people and recognised experts, a

	communication about suicide in Tasmania.	previous suicide prevention strategy (2016-2020/22).	implementation of the *Tasmanian Communications Charter*	young person friendly guide to communicating about suicide and suicide prevention.
3.4	Implement cross-agency actions to reduce access to means of suicide.	Reducing access to the means of suicide is consistently recognised in international, national and state level suicide prevention strategies as an important component to reducing the rates of suicide. This strategy was previously established under Actions 8.1 and 8.3 of the previous suicide prevention strategy (2016-2020/2022).	The lack of situational awareness means readers are unsure of what measures have been taken previously (and therefore what measures have been unsuccessful in reducing suicides).	No comment

Priority 4: Developing a skilled, supported, and sustained workforce in Tasmania

It is encouraging that this strategy aims to improve the skills and wellbeing of all workforces across the state, especially those that will be called to help young people in suicidal distress. It is however unclear what 'sustained' in the title of this priority refers to. Generally, the priority also fails to acknowledge workforces that directly support children and young people in Tasmania.

Action	Action summary	Comment	Issue	Suggestions
4.1	Scale up the delivery of contemporary and evidence-based risk mitigation education, training and tools to support clinical, non-clinical and emergency services staff across Tasmania	Parts of this action are the same as action 12 of the previous suicide prevention strategy (2016-2022/22)	There are no references to youth-oriented clinical and non-clinical service providers.	This action should include clear references to workforces that directly provide clinical, non-clinical, and emergency health to young people such as school nurses, and school psychologists.

4.2	Co-design and deliver education and training across workforces that builds capability to better engage and work with particular population groups.	This action outlines the need to engage with workforces that deal with particular population groups including those engaging with men, Tasmanian Aboriginal population, CALD (and others).	There is no mention of workforces that interact with young people despite their being listed as a vulnerable population.	This action should acknowledge and include workforces that provide support young people (for example: specialist homelessness services, afterschool care providers, early childhood learning centres, sports and community clubs).
4.3	Increase and support the lived experience of suicide prevention workforce.	This action largely repeats Action 1.1 of the draft *Tasmanian Suicide Prevention Strategy (2023-2027)*.	--	Consider integrating Actions 1.1 and 4.3 to avoid repetition. Outline what additional supports will be provided for young Tasmanians with lived-experience.
4.4	Develop a suicide prevention workforce plan for Tasmania, drawing on the national suicide prevention workforce strategy.	--	This action is vaguely worded and does not establish how the second point is different from current workforce monitoring. The second point does not fully establish the relevance of monitoring on staff recruitment, retention, and wellbeing to suicide prevention.	Revise and clarify the roles of the Tasmanian Government and the National Suicide Prevention Office in identifying and implementing aspects of the national suicide prevention workforce strategy. Clarify how the second item in 4.4 represents a significant departure from current workforce monitoring practices. Regarding Item 2 in action 4.4. Clarify: (a) what will be monitored? (b) who will perform the monitoring, and (c) how this action will be coordinated in the new governance structure?

Priority 5: Enhancing whole-of-government mechanisms to coordinate our approach

Action	Action summary	Comment	Issue	Suggestions
5.1	Implement new governance arrangements for coordinating and monitoring suicide prevention action under the Tasmanian Suicide Prevention Strategy.	Establishing the Premier's Mental Health and Suicide Prevention Advisory Council is intended to elevate suicide prevention as a priority area in Tasmania. It is encouraging to see the appointment of a Suicide Prevention Coordinator within the Department of Health.	See section 8 above. It is unclear from Figure 2 if the suicide prevention coordinators (Tasmanian suicide prevention coordinator, regional suicide prevention coordinator) will sit on the Premier's Mental Health and Suicide Prevention Advisory Council, or the cross-agency working groups (as required)	See Section 8 above. Provide more information on how the suicide prevention coordinators will be integrated into the new governance structure.
5.2	Develop and report against yearly implementation plans, with transparent reporting on actions, outcomes and challenges.	Yearly implementation plans will improve transparency and may contribute to the ongoing evidence base.	Refer to section 7 above.	Refer to section 7 above.
5.3	Enhance the availability and real-time use of suicide and self-harm data in Tasmania.	The use of data on suicide and self-harm is important in allocating resources to at risk communities and/ or populations.	It is unclear whether data-sharing arrangements exist between the Department of Health and other agencies (e.g. Ambulance Tasmania [Dept. of Police, Fire and Emergency Services], the Tasmanian Suicide Register [Dept of Justice], etc).	Provide specific details on (a) who will coordinate the monitoring and reporting for self-harm, and suicide-related data (b) when and how data-transfer agreements will be established.
5.4		Integrating Tasmanian suicide prevention strategies with national strategies will improve information transfer and help increase resourcing of suicide prevention measures.	It is unclear who in the governance arrangements will lead these linkages with national suicide prevention offices.	Provide details on who in the new governance arrangements will coordinate and undertake these linkages.

Thank you again for the opportunity to provide comment on the draft strategy. I would be pleased to discuss my feedback in more detail should that be of assistance.

Yours sincerely,

Leanne McLean
Commissioner for Children and Young People

cc The Hon Jeremy Rockliff, Premier, Minister for Health, Minister for Mental Health and Wellbeing
cc The Hon Roger Jaensch, Minister for Education, Children and Youth
cc Acting Chief Psychiatrist, Dr Anthony Cidoni
cc *General Manager, Mental Health Alcohol and Drug Directorate*

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