Tasmanian Government Response

to the

Senate Community Affairs References Committee Inquiry into Suicide in Australia

Tasmania
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April 2010

This document has been prepared for the Tasmanian Government by Statewide & Mental Health Services, a business unit within the Department of Health and Human Services, in conjunction with the Tasmanian Suicide Prevention Committee and Tasmania's Inter Agency Working Group for Mental Health.

In December 2009, the Tasmanian Government commissioned the development of a Suicide Prevention Strategy for Tasmania.

The Strategy is due for completion by June 2010.

Contents

Introduction

The Tasmanian Government is committed to reducing the impact and prevalence of suicide and welcomes the invitation to respond to the Australian Government's Senate Community Affairs References Committee Inquiry into Suicide in Australia.

This submission has been drafted in two parts.

Part One provides an overview of the unique characteristics of Tasmania and notes their impact on the broader health and wellbeing of Tasmanians.

Part Two provides an overview of suicide prevention activity in the context of the future direction of mental health service delivery in Tasmania. This direction is in line with the National Mental Health Policy 2008 and the 4th National Mental Health Plan 2009 – 2014 in its call for collaborative and coordinated effort from all levels of government and across the broader community, to strengthen the mental health and wellbeing of all Tasmanians.

This direction is clearly outlined in *Building the Foundations for Mental Health and Wellbeing, A Strategic Framework and Action Plan for Implementing Promotion, Prevention and Early Intervention Approaches in Tasmania (the Framework),* which was released in October 2009. (See attached).

The Framework was released with a companion policy document; *Review of Australian and International Mental Health Promotion, Prevention of Mental Ill Health and Early Intervention Policy* and a *Summary and Government Response* document that outlines the priorities for implementation for the 2009 - 2010 financial year.

An immediate priority under the Framework is the development of a Suicide Prevention Strategy for Tasmania. This work has been commissioned and is due for completion by June 2010. It is anticipated that the Strategy will provide direction for Tasmania for the 2010 – 2014 period and will identify a series of evidence based interventions that can be applied to tackling the complex range of issues associated with suicide.

The Tasmanian Government acknowledges that the Senate Inquiry is operating in line with a specific Terms of Reference. However, the Tasmanian Government has provided a general submission to the Inquiry noting that Tasmania's first Suicide Prevention Strategy is due for completion in June 2010 and therefore any detailed comment would pre-empt the release of the Strategy and the priority areas and actions identified within the new document.

The Tasmanian Government will provide the Senate Inquiry with a copy of Tasmania's first Suicide Prevention Strategy once finalised.

PART ONE:

About Tasmania:

Geography and environment

The island State of Tasmania, including the smaller islands, comprises 68,102 km^2 or approximately 0.9 per cent of the total area of Australia.

The major population centres in Tasmania are Hobart in the South, Launceston in the North and Burnie and Devonport in the North West.

Rurality

The issue of rurality is highly relevant in Tasmania. Based on the Remoteness Structure classification employed by the Australian Bureau of Statistics (ABS), 64.7 per cent of the population live in Inner Regional locations, 33.2 per cent in Outer Regional, 1.5 per cent in Remote and 0.5 per cent in Very Remote. There is considered to be no Major City location in Tasmania.

In addition 27 per cent of the Tasmanian population live in a Major Urban (population of 100,000 or more) section of the State; 45.6 per cent in Other Urban (population of 1,000 to 99,999); 6.9 per cent in Bounded Locality (population of 200 to 999); and 20.4 per cent in Rural Balance (the remainder of the State)[1].

This contrasts with other jurisdictions in which, with the exception of the Northern Territory, between 64 to 99 per cent live in a Major Urban section of the state/territory and between 73 to 99 per cent reside in a Major City.

Climate change

According to the Garnaut Climate Change Review[2], as a result of climate change Tasmania will begin to experience small changes in climate resulting in warmer weather, increasing storm events and decreased livestock capacity. These changes in climate have considerable implications for Tasmania's rural and farming populations, already struggling under the impact of the drought, in relation to agricultural and community sustainability.

Population

As of June 2007, Tasmania's population was 493,300 people[3], and is now estimated to have reached 500,000[4] people, marking an overall population increase of approximately 3.3 per cent since the year 2001. Tasmania's population is projected to increase slowly before levelling out by around 2040 and then decreasing marginally from 2051 onwards (571,000

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[1] Australian Bureau of Statistics (2008). *National Regional Profile: Tasmania.*
[2] Garnaut, R. (2008). *Garnaut Climate Change Review: Final report*. Cambridge University Press.
[3] Australian Bureau of Statistics (March, 2009). *Tasmanian State and Regional Indicators*, Catalogue no. 1307.6.
[4] Tasmanian Government media release, 18 March 2009: www.media.tas.gov.au/release.php?id=26241 (last accessed 3 April, 2009).

people in 2056)[5]. Tasmania's small population is one of the most regionally dispersed of any Australian jurisdiction. More than half the State's population lives outside the capital city.

Age Structure

Tasmania's regions have different age structures. For example the Greater Hobart Statistical Division (SD) has a relatively higher proportion of 15 to 29 year olds, while the Southern SD has a relatively higher proportion of 45 to 59 year olds[6]. This has implications for planning and delivery of services and programs relevant to the needs of local populations. Overall, the median age of the population is approximately 39.1 years compared to the Australian average of 36.9 years.

The Tasmanian population is ageing at a faster rate than all other Australian states and territories. The proportion of the population aged 65 and over increased from 12.8 per cent of the population in 1996 (12.1 per cent Australia) to 14.9 per cent in 2006 (13.3 per cent Australia), and is estimated to be 23 per cent by the year 2021. The proportion of persons aged 85 years and over increased from 1.2 per cent in 1996 to 1.8 per cent in 2006[7,8].

Health and mental health

The Australian Institute of Health and Welfare has reported that, compared to those living in Major Cities, people in Inner Regional, Outer Regional and Remote/Very Remote areas have 20 per cent higher reported rates of fair or poor health[9]. Life expectancy at birth for males in Tasmania is 77.4 years (79.0 years Australia) and for females is 82.3 years (83.7 years Australia)[10]. The standardised death rates for most causes of death have fallen in the last 10 years with the exception of:

- Mental and behavioural disorders - up from 15.9 deaths per 100,000 population to 27.7 deaths per 100,000.
- Intentional self-harm - up from 11.2 deaths per 100,000 to 14.7 deaths per 100,000.
- Diabetes mellitus and transport accidents[11].

It is widely recognised that mental illness is a substantial burden for individuals and communities in Australia. In brief:

- At any one point in time, 2-3 per cent of the Australian adult population will be affected by severe mental illness, 4-5 per cent by moderate to severe mental illness, and 9-10 per cent by moderate mental illness[12].

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[5] Australian Bureau of Statistics. *Population Projections, Australia, 2006-2101*, Catalogue no. 3222.0.
[6] Australian Bureau of Statistics (March, 2009). *Tasmanian State and Regional Indicators*, Catalogue no. 1307.6.
[7] Australian Bureau of Statistics. *Population Projections, Australia, 2006-2101*, Catalogue no. 3222.0.
[8] Australian Bureau of Statistics (April, 2008). Feature Article: 'Ageing in Tasmania 2006 (selected indicators)' in *Tasmanian State and Regional Indicators*, Catalogue no. 1307.6.
[9] Australian Institute of Health and Welfare (2008). *Rural, Regional and Remote Health: Indicators of health status and determinants of health*. Rural Health Series no. 9. Catalogue no. PHE 97.
[10] Australian Bureau of Statistics (2008). *Tasmania at a Glance, 2008*, Catalogue no. 1305.6.
[11] Australian Bureau of Statistics (March, 2009). 'Health' in *Tasmanian State and Regional Indicators*, Catalogue no. 1307.6.

- In the years 2001-2005, Tasmania had rates of suicide 39 per cent above the national rate[13].
- The 2004/05 National Health Survey found that over two-thirds of Tasmanians experienced low levels of psychological distress, 20.1 per cent reported moderate levels of stress, and 8.8 per cent reported high levels of stress[14].

Tasmanian Aboriginal People

In 2006, 3.5 per cent of the Tasmanian population identified as Aboriginal and Torres Strait Islander (16,900 people)[15]. Of this total number, approximately 88 per cent identified as Aboriginal, 7 per cent identified as Torres Strait Islander, and 3 per cent identified as both Aboriginal and Torres Strait Islander[16]. In this submission, the term 'Tasmanian Aboriginal people' is used to refer to all Aboriginal and Torres Strait Islander populations in Tasmania.

The majority of Tasmanian Aboriginal people are located in the South (47.9 per cent), followed by the North West (31.9 per cent) and the North (20.1 per cent). The Aboriginal population has a younger age structure than the general population. Among Tasmanian Aboriginal people in 2006:

- Children (aged 0 to 14 years) accounted for 36.3 per cent of the population, nearly double the proportion of children in the general Tasmanian population (19.7 per cent).
- More than half (57 per cent) of Tasmanian Aboriginal people are under the age of 25 years.
- The working age population (aged 15 to 64 years) accounted for 60.4 per cent compared with 65.3 per cent for the general Tasmanian population.
- Older persons (aged 65 years and over) accounted for 3.4 pr cent compared with 14.9 per cent for the general Tasmanian population.
- The median age of Tasmanian Aboriginal people was 20 years compared with 40 years for the general Tasmanian population[17].

Alcohol and other drugs

The use of drugs in Australia contributes to significant illness and disease, injuries, workplace concerns, violence, crime, breakdowns in relationships and families, and other social

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[12] Mental Health Standing Committee (2008). Council of Australian Governments National Action Plan for Mental Health 2006-2011: Progress Report 2006-07. Canberra: Australian Health Ministers Advisory Council.

[13] Australian Bureau of Statistics (2007). Suicides Australia 2005, Catalogue no. 3309.0.

[14] Australian Bureau of Statistics (March, 2009). 'Health' in Tasmanian State and Regional Indicators, Catalogue no. 1307.6.

[15] Australian Bureau of Statistics (2006). Population Characteristics, Aboriginal and Torres Strait Islander Australians, Tasmania, Catalogue no. 4713.6.55.001.

[16] Australian Bureau of Statistics (2006). Population Distribution, Aboriginal and Torres Strait Islander Australians, Catalogue no. 4705.0.

[17] Australian Bureau of Statistics (April, 2008). Feature Article: 'Ageing in Tasmania 2006 (selected indicators)' in *Tasmanian State and Regional Indicators*, Catalogue no. 1307.6.

problems within communities. Prevention and early intervention activities seek to improve social, health and economic outcomes by preventing the uptake of harmful drug use and reducing the harmful effects of licit and illicit drugs[18].

In 2004, 15 per cent of Tasmanians reported illicit drug use in the previous 12 months. This is a higher percentage than reported in NSW and Victoria. Among Tasmanian males (14 years or older) in 2007, more than 12 per cent were at risk of alcohol-related harm in the long-term. After the Northern Territory, this was the highest proportion of all Australian states and territories. For females, more than 11 per cent were at risk of alcohol-related harm in the long-term. The proportion of Tasmanian males and females at risk of alcohol-related harm in the short-term was also higher than the Australian average[19].

Community Groups at Higher Risk of Mental Ill-Health

Tasmania's culturally and linguistically diverse populations

The World Health Organization estimates that more than 50 per cent of migrants worldwide have a mental health problem. These range from severe mental illness to trauma and distress. This is more prominent in those who have fled persecution[20].

The Australian Government Department of Immigration and Citizenship recognises that Humanitarian Program refugee arrivals generally have the highest settlement needs due to their pre-arrival experiences[21].

'The fact that most refugees have survived horrific experiences, and yet have re-established their lives in Australia, is evidence of their enormous survival strengths. Nevertheless they suffer a higher incidence of physical and mental health problems than migrants and people born in Australia'[22].

Furthermore, refugees who are ageing face additional risks to their health and wellbeing including mental health vulnerability, family stress, social and emotional isolation and more barriers to accessing services[23].

In 2006, 10.6 per cent of Tasmania's population was born overseas. This compares with 22.2 per cent of Australia's total population. In 2007-08 the top five countries of origin of permanent additions to Tasmania were the United Kingdom (263 persons), New Zealand (131 persons), the Peoples Republic of China (130 persons), India (102 persons), and South

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[18] Ministerial Council on Drug Strategy (2004). The National Drug Strategy: Australia's integrated framework: 2004-2009. Canberra: Australian Government.

[19] Australian Institute of Health and Welfare (AIHW) (2008). 2007 National Drug Strategy Household Survey: State and territory supplement. Drug Statistics Series no. 21. Catalogue no. PHE 102.

[20] Multicultural Mental Health Australia (MMHA) (2007). *Mental Health in a Changing World: The impact of culture and diversity.* MMHA.

[21] Department of Immigration and Citizenship (DIAC) (2007). *Tasmania: Settlement trends and needs of new arrivals 2007*. Canberra: DIAC.

[22] Forum of Australian Services for Survivors of Torture and Trauma (FASSTT) (2006). *Out of the Abyss: Australia's program of assistance to survivors of torture and trauma.* Brunswick: FASSTT, p.3.

[23] Atwell, R.S., Correa-Velez, I. & Gifford, S.M. (2007). Ageing Out of Place: Health and well-being needs and access to home and aged care services for recently arrived older refugees in Melbourne, Australia. *International Journal of Migration, Health and Social Care,* 3(1), 4-14.

Africa (80 persons). In addition, of the 244 Humanitarian Program permanent additions, 15.6 per cent were born in Sudan, 14.3 per cent in the Democratic Republic of Congo and 13.9 per cent in Burma (Myanmar).

Of all immigration categories, Tasmania accepts the highest proportion of Humanitarian Program settlers of all jurisdictions[24]. The health issues of refugee arrivals to Tasmania have been identified as 'a critical concern', especially in relation to accessing services such as appropriate counselling in relation to their pre-arrival experiences of torture and trauma[25].

Gay, lesbian, bisexual, transgender and intersex populations

There is a growing awareness in Australian and international literature of sexual orientation and gender identity as key social determinants of health and mental health. Gay, lesbian, bisexual, transgender and intersex (GLBTI) populations experience high rates of social exclusion and discrimination as a result of their sexual orientation or gender identity. Social determinants such as socio-economic status, geographic location, racial background, and physical and intellectual disability interact with sexual orientation and gender identity to produce health concerns specific to GLBTI communities.

A Tasmanian study focusing on the experiences of GLBT populations in Tasmania, found similar levels of stigma, discrimination and social exclusion as reported in the international literature. However, given the small, decentralised and rural nature of Tasmania's population, GLBT individuals expressed an increased sense of isolation.

Key health and wellbeing issues for GLBT populations identified in the study included, lack of support networks and a sense of 'community', the need for access to support services during the critical 'coming out' life stage for individuals, the impact of homophobia/transphobia ranging from underlying apprehension to violence and bullying, and discrimination and ignorance by health workers resulting in reduced access to health services by GLBT populations[26].

Adults and young people in custodial settings

Adult prison and juvenile detention centre populations are widely recognised as one of the most disadvantaged and stigmatised populations in society. Individuals from disadvantaged backgrounds, low educational achievement, histories of unemployment, and high rates of substance use are over-represented among these populations in Australia[27]. Furthermore, Aboriginal and Torres Strait Islander adults are 13 times more likely to be imprisoned relative to the general Australian population[28]. More than half of young people aged 10 to 17

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[24] Department of Immigration and Citizenship (DIAC) (2009). *Population Flows: Immigration Aspects 2007-08.* Canberra: Economic Analysis Unit, Migration and Visa Policy Division, DIAC.

[25] Ibid.

[26] Blanch Consulting Pty Ltd. (2003). *Gay, Lesbian, Bisexual and Transgender Health and Wellbeing Needs Assessment*. Tasmanian Department of Health and Human Services' Gay, Lesbian, Bisexual and Transgender Reference Group.

[27] Butler, T. & Allnutt, S. (2003). *Mental Illness Among New South Wales' Prisoners.* NSW Corrections Health Service.

[28] National Indigenous Drug and Alcohol Committee (2009). *Bridges and Barriers: Addressing Indigenous incarceration and health*. Canberra: Australian National Council on Drugs.

years in juvenile corrective institutions in Australia in 2006 were Aboriginal and Torres Strait Islander[29].

In Tasmania:

- The average daily adult prison population (2008-09) (inclusive of all Tasmanian prisons including Risdon Prison, Hobart Reception Prison, Launceston Reception Prison, Hayes Prison Farm, and the Women's Prison) was 490 males and 40 females.
- Of the total 530 prisoners, 85 per cent were identified as non-Indigenous, and 15 per cent Aboriginal and Torres Strait Islander[30].
- The average age of adult prisoners was 34 years and the average sentence was 4.7 years.
- Among a ten per cent sample of men who presented at prison health services in March - April 2008, 25 per cent exhibited suicide and self-harm behaviour, 13 per cent exhibited major mental illness (psychosis and bipolar disorder), up to 56 per cent reported illicit drug use (of various types), and 82 per cent reported alcohol use. Only 1.5 per cent of this sample did not exhibit suicide and self-harm behaviour, mental illness, or drug and alcohol use[31].
- In a study which examined one year of data (2004-2005) on young people remanded in custody in Tasmania, it was reported that juveniles placed in detention on remand were predominantly male and three quarters of them were aged between 15 and 17 years (however the age range was between 11 to 18 years). 19 per cent of juveniles identified as being of Aboriginal and Torres Strait Islander origin. Just under one half (45 per cent) of the juveniles were placed on remand more than once during the one year period.

Tasmania's Social Context

In 2005-06 more Tasmanians were living below the poverty line than in any other jurisdiction. 13 per cent of Tasmanians were living in households earning less than 50 per cent of the median equivalised disposable income, and 24 per cent were living below the 60 per cent median poverty line[32].

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[29] Australian Institute of Criminology (AIC) (2008). *Australian Crime Facts and Figures 2007*. Canberra: AIC.

[30] Tasmanian Department of Justice, Annual Statistics, www.justice.tas.gov.au/__data/assets/pdf_file/0009/87957/Prison_Statistics_ROGS.pdf#Annual%20Statistics

[31] Wake, C.J. (2008). *Risdon Prison: Are we up to speed?* Presented at: First Annual ATDC Conference: ATOD Practice, Integration and Development. 28-30 April, 2008. Hobart, Tasmania: http://www.atdc.org.au/uploaded_pdf/ATDCConferenceCWake.pdf

[32] Saunders, P., Hill, T. & Bradbury, B. (March, 2008). *Poverty in Australia: Sensitivity Analysis and Recent Trends*. SPRC Report 4/08, Social Policy Research Centre, Table 23, p.44.

Homelessness

The rate of homelessness in Tasmania has remained fairly consistent between 2001 and 2006 Census counts. In 2006 there were 2,507 homeless people in Tasmania. This represents a rate of 53 per 10,000 which is consistent with the Australian rate[33].

The number of homeless young people aged 12 to 18 years in Tasmania decreased between 2001 and 2006 from 1,008 to 770 individuals. It has been suggested that this decline is mainly due to an increase in early intervention services targeting homeless and at risk young people since 2001.

In 2006, the homeless youth rate in Tasmania was 16 per 1,000. This is higher than the Australian rate of 11 per 1,000[34].

Level of disadvantage

In 2005-06, Tasmania had the highest proportion of households dependent on welfare as their main source of income (31.5 per cent)[35]. Low-income households are experiencing additional hardship with the rising cost of essentials (food, electricity, housing, transport and health).

Tasmania had one of the highest average Deprivation Index scores of all states and territories in a 2006 study. The study analysed the extent to which people are unable to access essentials such as medical treatment if needed, warm clothes and bedding, a substantial meal at least once a day, and a reasonable quality and secure home[36].

Tasmania had the second-highest proportion of people living in disadvantaged communities of all states and territories in 2006, after the Northern Territory. 38,600 people (or 8.2 per cent of the Tasmanian population) lived in the most disadvantaged 5 per cent of Census Collection Districts in Australia[37].

Literacy

The 2006 Adult Literacy and Life Skills Survey found that the literacy skills of Tasmanians aged 15 to 74 years were consistently below the national average across all domains. Less than half of Tasmanians were assessed as having adequate numeracy skills to effectively manage and respond to the mathematical demands of diverse situations. Around one-third were assessed as having sufficient health literacy skills to understand and use information relating to health issues such as drugs and alcohol, disease prevention and treatment, first aid

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[33] Chamberlain, C. & MacKenzie, D. (2008). *Counting the Homeless, Australia, 2006.* Australian Bureau of Statistics, Catalogue no. 2050.0.

[34] MacKenzie, D. & Chamberlain, C. (2008). Youth homelessness 2006. *Youth Studies Australia,* 27(1), 17-25.

[35] Australian Bureau of Statistics (2008). *Australian Social Trends*, Catalogue no. 4102.0.

[36] Saunders, P., Naidoo, Y. & Griffiths, M. (November, 2007). *Towards New Indicators of Disadvantage: Deprivation and social exclusion in Australia*, Social Policy Research Centre, University of New South Wales, Table 7, p.58.

[37] Australian Bureau of Statistics (2006). *Census of Population and Housing: Socio-Economic Indexes for Areas (SEIFA), Australia - Data only*, Catalogue no. 2033.0.55.001.

and staying healthy. Only approximately one-quarter of Tasmanians were assessed as having sufficient problem solving skills to meet the complex demands of everyday life and work[38].

Summary

The information in the section above identifies several key factors of relevance to Tasmania. These include the issue of rurality and the distribution of a relatively small population across a number of population centres and rural areas; the impact of climate change and drought on the productivity, health and wellbeing of individuals and communities; the growing ageing population; unique features of the Tasmanian Aboriginal and culturally and linguistically diverse populations; and a range of significant social issues including poverty, homelessness, substance use, isolation and disadvantage.

These factors in combination have a deleterious affect on the mental health and wellbeing of Tasmanians.

[38] Australian Bureau of Statistics (2008). Feature Article: 'Adult literacy in Tasmania' in *Tasmanian State and Regional Indicators*, Catalogue no. 1307.6.

PART TWO:

Suicide Prevention in Tasmania

Suicide Statistics

Between 1978 and 2006 suicide was recorded as the cause of death for 1,987 persons in Tasmania, including 9 unconfirmed. Males represented 79.6% of the total for the period.

Between 1978 and 2004, the number of suicides within the following age groups was:

- 27.7% aged 15-29
- 30.5% aged 30-44
- 22.5% aged 45-59
- 13.5% aged 60-75
- 5.8% aged 75 and over

A regional breakdown indicates that:

- 49.7% of cases in the Greater Hobart/Southern Region
- 28.7% of cases in the North
- 21.1% of cases in the North West.
- 0.4% was not identified in any particular region

The most common cause of death was hanging/asphyxiation (38.7%) followed by carbon monoxide poisoning (20.0%) and poisoning (14.7%).[39]

Data Collection and Reporting

The Tasmanian Suicide Prevention Steering Committee reports on suicide statistics every three years. From 2010, Tasmanian suicide statistics will be updated annually and are soon to be made publicly available on the Internet. The figures that are reported in Tasmania differ to ABS figures (as at 1 March 2010) as they are reported in year of death and are updated as the numbers are confirmed. The ABS reports on the year that deaths are reported and previously has not updated the number of deaths as they are confirmed by the Coroner's Office.

The last detailed Tasmanian report for 2006/2008, published by the Tasmanian suicide Prevention Steering Committee, was released in April 2009. The Tasmanian report refers to the difficulties in reporting and interpreting trends.

> *"Suicide is essentially a rare event and there are difficulties inherent in attempting to interpret trends involving low levels of incidence. Where the number of cases is lower, annual variation, as well as variation within sex, age and geographical boundaries, causes difficulty with some comparisons. For Tasmania, where the annual number of cases reported is*

[39] Tasmanian Suicide Prevention Steering Committee 2006/2008 Report, Department of Health & Human Services, pp. 14-15

between 60 and 100, the data should be interpreted cautiously. Trends are discernable and robust only for types of analysis where the number of cases is sufficiently high."[40]

In March 2010, the Australian Bureau of Statistics released the Causes of Death 2008 Report. The release coincided with the ABS noting the introduction of new processes to ensure the collection of more complete and accurate suicide data across Australia. The availability of more accurate figures will be of benefit in the development of targeted suicide prevention activities and will contribute to continuous improvement in suicide prevention strategies across Australia.

Mental health service delivery in Tasmania: a new direction

It is well recognised that one of the greatest risk factors for suicide is mental ill-health, therefore any investment made in a system that supports mental health promotion, mental ill-health prevention, early intervention and effective treatment is investment that supports those at risk of suicide.

In 2004, the mental health service delivery landscape in Tasmania changed dramatically through the Bridging the Gap reforms.

Mental health services policy continued its evolution through the release in October 2009 of Tasmania's first mental health promotion, prevention and early intervention framework. This Framework brings mental health service delivery in Tasmania in line with contemporary mental health policy directions both nationally and internationally.

Bridging the Gap Reforms

In October 2004, a statewide review of mental health service delivery in Tasmania was completed. The Bridging the Gap (BtG) report provided Mental Health Services with a series of recommendations which focused on mental health service directions in key areas such as quality and safety, provision of community based care, strengthening specialist resources and developing the capacity of the non government sector to provide supported accommodation, packages of care and recovery programs.[41]

As a result of the review, the Tasmanian Government committed $47 million over four years to improving mental health services. This was the largest ever funding increase in the 170 year history of Tasmania's mental health service taking the service forward to become a contemporary community based service.

Through the implementation of the BtG recommendations the service system in Tasmania continues to move towards a recovery-focused model of care. Other key benefits for mental health consumers have been the increased focus on, and increase in, specialist staffing for community mental health services. For example, the North West Older Persons Mental Health Service was developed and there was a 100 per cent increase in the resource base in the Child and Adolescent Mental Health Services (CAMHS) staffing numbers across the

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[40] Tasmanian Suicide Prevention Steering Committee 2006/2008 Report, Department of Health & Human Services

[41] Bridging the Gap Evaluation, Department of Health & Human Services, KPMG: May 2008, pp 1-2.

State. While there is ongoing work in terms of workforce development and the exploration and provision of appropriate supported accommodation, the way forward for mental health service delivery has been well established.

Release of *Building the Foundations for Mental Health and Wellbeing in Tasmania*, a Strategic Framework and Action Plan for Implementing Promotion Prevention and Early Intervention Approaches (PPEI) in Tasmania

Over the past decade in Australia, promoting mental health and preventing mental ill-health has been a developoing priority of national mental health policy and reform. This has necessitated changes in the mental health sector to embrace a social view of health and recognise the broader determinants of health.

In line with national and international directions, Tasmania is committed to ensuring that mental health services focus on promoting the mental health of the community, preventing, where possible, the development of mental ill-health and reducing the impact of mental disorders on individuals, families and the community as well as providing high quality treatment and rehabilitation services.

In October 2009, the Tasmanian Government released *Building the Foundations for Mental Health and Wellbeing, a Strategic Framework and Action Plan for Implementing Promotion, Prevention and Early Intervention (PPEI) Approaches in Tasmania*[42] (The Framework).

The aim of the Framework is to enhance positive mental health and wellbeing for Tasmanians, reduce the prevalence of mental health disorders, and minimise the impact of mental illness on individuals, communities and families by employing a whole of government, community, business and industry approach.

The Framework will be implemented across public mental health service units in mental health promotion, suicide prevention, early intervention, and recovery and relapse prevention. Although the Framework has been developed in the context of the Mental Health Services sector, it also provides direction for the development and further strengthening of inter and intra sectoral partnerships that are essential to achieving the desired outcomes.

The five priority areas of the Framework are:

1. **Promote mental health and wellbeing across whole of government and whole of community.**

   This priority addresses an important foundation of 'building support for mental health and wellbeing at the government level' through developing a coordinated policy framework, effective intra and intersectoral partnerships and investing in research. The responsibility for promotion, prevention and early intervention approaches is not limited to one sector or one discipline and requires collective action across a range of government departments.

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42 *http://www.dhhs.tas.gov.au/mentalhealth/publications/strategic_documents/PPEI_Strategic_Framework.pdf*

2. **Build capacity across sectors and in the community to implement programs and initiatives to support mental health and wellbeing.**

   This priority addresses the foundation of 'building support for mental health and wellbeing in the community' through education, training and the implementation of evidence-based programs and intervention strategies.

   The goal of this priority is to develop a shared understanding of positive mental health and improved mental health literacy across different workforces, embedding this knowledge in service provision, and creating community settings—such as schools and workplaces—that support mental health and wellbeing.

3. **Invest in the early years and families.**

   This priority addresses the foundation of 'building support for mental health and wellbeing in families' through strengthening family relationships, enhancing parenting skills and establishing strong parent/child attachment in the early years.

   The evidence is clear that investment as early as possible in the developmental cycle will have the most significant impact on mental health and wellbeing.

4. **Consolidate and further strengthen reorientation of Mental Health Services and Community Sector Organisations to support mental health and wellbeing.**

   This priority addresses the foundation of 'building support for mental health and wellbeing in the mental health service system' through ensuring Mental Health Services and Community Sector Organisations enhance mental health and wellbeing for people with mental illness or 'at risk' of mental illness, and empower consumers and carers to achieve a better quality of life.

   Mental Health Services need to be seen as a key driver of promotion, prevention and early intervention approaches that support mental health and wellbeing.

5. **Reduce mental health inequalities.**

   This priority addresses the foundation of 'building support for mental health and wellbeing in society for people disadvantaged or disempowered in the community' through identifying the key social and environmental determinants that impact on the mental health and wellbeing of these population groups and exploring ways to ameliorate their impact. These include cultural dislocation, discrimination, poverty, homelessness, isolation, trauma, climate change and drought. The goal of this priority is to enhance social inclusion, reduce discrimination and stigma, and increase economic participation in society.

A population health approach

The Framework has been developed in line with contemporary directions in mental health promotion and prevention policy which includes a population health approach. This model focuses on the status and needs of whole populations and implements interventions to promote health and reduce mental ill health across whole population groups.

A population health approach notes that the majority of risk and protective factors for mental health lie outside the sphere of mental health services such as in workplaces, families, schools, correctional facilities, recreational facilities and cultural settings.

This approach is consistent with the social determinants of health, that is, the conditions in which people are born, grow, live, work and age. This includes influences such as employment and working conditions, housing, education and literacy, social network supports, gender and culture. A number of factors which have been identified as increasing the sensitivity of health to the social environment include: the social gradient, stress, social exclusion and social support, addiction, work and unemployment.

Implementation of the *Building the Foundations Framework*

The Inter Agency Working Group for Mental Health was established to oversee the implementation of the *Building the Foundations* Framework.

The Working Group has membership from across government and community including the Department of Premier & Cabinet (Policy Unit and the Social Inclusion Unit), the Department of Police & Emergency Management, the Department of Education, the Department of Health & Human Services, the Department of Primary Industries and Water, the Mental Health Council of Tasmania and the Local Government Association of Tasmania. The Group is chaired by the CEO of Statewide & Mental Health Services.

Through this cross sectoral approach, portfolios across government and the broader community can work together to support each other's efforts in promoting mental health and wellbeing and reducing suicide.

The Need for a Suicide Prevention Strategy for Tasmania

The Tasmanian Suicide Prevention Steering Committee

The Tasmanian Suicide Prevention Steering Committee (TSPSC) was established in 1993 in response to growing national and state concern about the high rate of suicide among youth. The scope was later broadened beyond youth to a whole of population approach to suicide prevention. Since 1995 this Committee has acted as Tasmania's clearing house and central reference point for local, state and national suicide prevention policies and initiatives.

In 2000, the TSPSC agreed to work in line with the LIFE (Living is for Everyone) Framework which underpinned the National Suicide Prevention Strategy. In July 2004, the TSPSC was restructured to capture a broader membership base. This enabled the Committee to consider a greater diversity of issues and initiate cooperative activity across a range of sectors. The Committee created a two-tier structure; the Steering Committee (TSPSC) and a Reference Group. The governance of the Committee was transferred to Mental Health Services in June 2006 and the Director of Mental Health Services became the Committee Chair.

Membership of the TSPSC is drawn from Tasmanian State Government agencies including the Department of Health and Human Services, Department of Premier & Cabinet and the

Department of Education. There is also representation from the Department of Health & Ageing, the Local Government Association of Tasmania, the Mental Health Council of Tasmania, General Practice and three community representatives.

Joint Standing Committee on Community Development

In 2004, the Tasmanian Joint Standing Committee on Community Development agreed to conduct an inquiry into strategies for the prevention of suicide in response to Tasmania's high rate of suicide. The Committee's aim was to "provide guidance for how Tasmania should proceed to put in place the necessary strategies and mechanisms that will, hopefully, reduce suicide in the State."[43]

(Membership of the Committee as at 2007, included the Hons Kerry Finch MLC, Terry Martin MLC, Alison Ritchie MLC, Jim Wilkinson MLC, Mr Brenton Best MHA, Mrs Heather Butler MHA, Mr Tim Morris MHA and Mr Brett Whiteley MHA.)

The findings of the inquiry were released in 2007*: Joint Standing Committee Report on Strategies for the Prevention of Suicide in Tasmania.*[44]

A number of key recommendations were made in the report, some of which include:

- The Tasmanian Government urgently needs to put in place a suicide prevention strategy for Tasmania. Such a strategy should have the flexibility to be relevant to local communities and the general population, and should also aim to change community attitudes.
- The State Government must seek to expand its suicide prevention role beyond its present scope as an area of priority if it wishes to address the unfortunate high prevalence of suicide in Tasmania.
- The distribution and allocation of funding for suicide prevention in Tasmania has to be improved. The TSPSC may be able to assist and advise how governments at all levels could find solutions to this problem.
- Efforts of employers to care for the wellbeing of employees should be intensified. Suicide prevention must be treated as a higher priority workplace safety issue.
- NGOs should be encouraged to expand their suicide prevention services, and measures should be taken to reduce and overcome unnecessary impediments to suicide prevention activities, including through the provision of:
    - Government funding for long-term (rather than short-term) periods of time for suicide prevention activities;
    - Improved access to resources, current research, and training opportunities;
    - Increased promotion and recognition

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[43] Joint Standing Committee on Community Development Report on Strategies fro the Prevention of Suicide, Parliament of Tasmania, 2007.

[44] http://www.parliament.tas.gov.au/CTEE/REPORTS/Strategies%20for%20the%20Prevention%20of%20Suicide.pdf

- Any future suicide prevention strategy (or strategic planning) in Tasmania must seek to address the prevalence of male suicide and male attitudes to approaching personal problems.
- More research into suicide in Tasmania, whether funded by government or non-government sources, would be useful, though it should not be excessive and overshadow actual suicide prevention activities.

Voices of Tasmanians on Suicide Prevention

In response to the impact of Tasmania's suicide rate, an extensive statewide community consultation was undertaken under the broad direction of the TSPSC to gauge the opinion of the Tasmanian community on suicide prevention in their local community. In 2009, the TSPSC released the findings from the consultation in a report titled, *Voices of Tasmanians on Suicide Prevention*.[45]

Some of the key recommendations from the consultation include:

- The need to reduce isolation through improved transport and to increase community connectedness through community-based social opportunities, programs and activities.
- Programs, activities and awareness campaigns that:
    - help reduce the stigma associated with depression and mental illness / promote help-seeking behaviour; and promote greater acceptance of differences in our society, in particular racial and sexual orientation.
- Promote awareness of how to identify, respond to and support a family member, friend, neighbour or colleague experiencing depression or crisis.
- Specifically targeted suicide prevention policies and programs for groups identified to be at risk of suicide.
- More support programs or support groups particularly for men, youth, people who have lost someone to suicide and those experiencing financial difficulties.
- Improved access to GP services in rural and urban areas.
- Revision of public hospital emergency department admission and discharge policies and processes for individuals identified to be suicidal or in crisis.
- Improved access to confidential counselling services, especially in rural areas.
- Raise awareness of suicide prevention and depression and to increase training for health and service providers.

[45] Voices of Tasmanians on Suicide Prevention, Tasmanian Suicide Prevention Steering Committee, April 2009

The Tasmanian Government's Approach to the Development of Tasmania's first Suicide Prevention Strategy

In 2007, the Joint Standing Committee on Community Development Report on Strategies for Prevention of Suicide Report was released. The Joint Standing Committee's report and the findings recorded in the *Voices of Tasmanians on Suicide Prevention*, called for the development of a Suicide Prevention Strategy for Tasmania.

The Tasmanian Government's approach to the development of a Suicide Prevention Strategy has been shaped by contemporary mental health promotion, prevention and early intervention policy in which embedding strategies to strengthen the mental health and wellbeing of Tasmanians is identified as an essential first step. This work was commissioned by the Government in 2009 with the subsequent release of the *Building the Foundations Framework* later in the year.

The Framework identifies five priority areas, as noted above, and outlines strategies and actions which, when implemented, will increase the positive mental health and wellbeing of Tasmanians and reduce the prevalence of mental ill health within our community. These actions can broadly be described as suicide prevention activity.

However, it was recognised that there would be gaps and that the Framework would not provide specific targeted suicide prevention strategies for communities and high risk groups; therefore, the development of a suicide prevention sub strategy, in line with the *Building the Foundations* Framework and the National LIFE Framework, was required.

This work was commissioned in December 2009, is due for completion in June 2010 and for release soon after.

Social Inclusion Report

In September 2009, Tasmania's Social Inclusion Commissioner released his report, *A Social Inclusion Strategy for Tasmania.*[46] An excerpt from this report:

> *Whilst all of us experience some setbacks in life, for about 13 per cent of Tasmanians there are complex and enduring barriers that exclude them from having a fair go. These barriers include personal factors (such as health or homelessness), access factors (such as to transport and health services), and structural factors (such as intergenerational poverty and locational disadvantage).*
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> *Those groups most at risk include children in low income households; older persons living alone; people with a mental illness; Aboriginal people; gay, lesbian, bisexual, transgender and intersex people; people with a disability; refugees from culturally and linguistically diverse backgrounds, women subject to domestic violence and people experiencing addiction.*
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> *Those places most at risk include the outer fringes of cities and towns that once were rural areas, rural towns in decline and older industrial areas. Whilst some people choose to live in*

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46 http://www.dpac.tas.gov.au/__data/assets/word_doc/0003/109947/Social_Inclusion_Strategy_Report.doc

these 'disadvantaged' areas many are pushed there, driven by access to the only housing they can afford.

Personally social exclusion plays out as lives unfulfilled, unhappiness and stigma. Socially it is playing out as higher levels of violence, substance abuse and mental illness. Economically it plays out as talent wasted and productivity lowered.[47]

Development of Tasmania's Suicide Prevention Strategy has been informed by the social inclusion policy context in Tasmania.

Suicide Prevention Initiatives in Tasmania

There are a number of dedicated organisations within Tasmania providing suicide prevention programs, care and support that are funded by the Australian Government through the National Suicide Prevention Program. These programs include:

Organisation	Program
OzHelp Foundation	A work based suicide prevention, early intervention and social capacity building program implemented in the building and construction industry and other industries.
CORES (Community Response to Elimination Suicide)	Community capacity building program centred on the prevention and intervention of suicide.
Rural Alive and Well	Aims to build the resilience and capacity of men, their families and the community to react to challenging life experiences with a specific focus on suicide.
Migrant Resource Centre (Southern Tasmania) Inc.	Reduces the suicide risk and increases the capacity to respond to suicide crises within culturally and linguistically diverse (CALD) communities and for CALD individuals.

There are also a number of initiatives funded and delivered nationally that have relevance / linkages to Tasmania. These include:

Organisation	Program
The LifeForce Community Networks Project	Aims to educate, empower and resource Australian communities to be aware of the issue of suicide, to recognise the signals of suicide and to be sufficiently resourced to refer individuals with thoughts of suicide to appropriate and qualified help.
Peer Support	School based promotion, prevention program targeting children and

47 http://www.dpac.tas.gov.au/__data/assets/word_doc/0003/109947/Social_Inclusion_Strategy_Report.doc, p8.

Program	young people to enhance resilience and resourcefulness, respect, interconnectedness and mental health in young people.
Reach Out! web-based service	A web based service that inspires young people, 16 – 25, to help themselves through tough times.
Mindframe Media Initiative	Mindframe's Education and Training Projects enhance the media capacity's to report responsibly, sensitively and accurately on issues relating to suicide and mental health/illness.
Standby Suicide Bereavement Support Service	Provides an integrated, comprehensive responsive support system built on existing emergency and community response mechanisms for people at risk of suicide and self harm, their family, friends, associates and those affected by suicide bereavement.

There are a number of initiatives either planned for Tasmania or underway which contribute to strengthening the mental health and wellbeing of Tasmanians and therefore contribute broadly to the prevention of suicide. These include but are not limited to:

Organisation	**Program**
Department of Health & Human Services (DHHS) and the Tasmanian Suicide Prevention Steering Committee	Each year the TSPSC coordinates the Tasmanian LIFE Awards which recognise individuals and organisations for effort in suicide prevention activity in Tasmania.
DHHS	DHHS supports the Tasmanian Media Awards, hosted by the Media, Entertainment and Arts Alliance, through sponsorship of an *Excellence in Mental Health Reporting* category. The award began in 2008 and has been the most heavily subscribed category both years.
Rural Support Network of Tasmania (Tasmanian Farmers and Graziers Association)	This is a network established primarily to support Tasmanians affected by the drought but has since broadened its scope to support Tasmanians in rural areas. Representation is drawn from local state and national service providers.
DHHS – National Partnerships Agreement: Taking Pressure Off Hospital Emergency Departments Initiative	Work is currently underway to establish a psychiatric emergency nurse liaison service within the Departments of Emergency Medicine at the Royal Hobart Hospital and Launceston General Hospital to significantly strengthen community based emergency crisis, assessment and treatment services ('E-CAT') to the Departments of Emergency Medicine in Hobart, Launceston and Burnie. One of the initiatives objectives is targeted at improving the interface between the Departments of Emergency Medicine and Mental Health Services to improve patient outcomes.

Inter Agency Working Group for Mental Health (DHHS lead agency)	An initiative under the *Building the Foundations* Framework is the development of a social marketing strategy to reduce the stigma and discrimination experienced by Tasmanians with a mental illness. Initial planning for the development of the strategy is underway.

CONCLUSION

Tasmania has the second highest suicide rate behind the Northern Territory. The causes of suicide are varied and complex but it is known that one of the key risk factors is the presence of a mental illness. With this in mind, Tasmania commissioned the development of a Suicide Prevention Strategy that sits within a broader mental health promotion, mental ill health prevention and early intervention framework.

The Tasmanian Government looks forward to the release of Tasmania's first Suicide Prevention Strategy which it is anticipates will provide clear evidence and actions for suicide prevention within Tasmania over the next four years.

But clearly the suicide prevention effort is not the work of a specialist mental health service alone. In line with the 4th National Mental Health Plan, effort should be coordinated, collaborative, well resourced and occur at all levels of government and throughout the community, industry and business sectors.

One of the key challenges is to identify an appropriate level of funding to support suicide prevention activity across all jurisdictions. In addition, the establishment of very clear mechanisms for coordination and communication across all levels of government and most importantly, with the Tasmanian community, is critical for effective suicide prevention intervention.

The Tasmanian Government notes that suicide prevention is a key priority under the 4th National Mental Health Plan and that the Australian Government provides important investment in suicide prevention programs and activity across Australia. The Tasmanian Government also notes and applauds the efforts of the Australian Bureau of Statistics to implement new mechanisms for more accurate collection and reporting of suicide data.

Tasmania's Suicide Prevention Strategy will be developed in line with the National LIFE Framework. The development and subsequent refinement of the LIFE Framework is important and ongoing work at a national level. There is also clearly a role for national leadership in suicide prevention interventions that have an impact at a jurisdictional level, for example, reducing access to certain medications and the inclusion of catalytic converters in cars, but that necessitates a national legislative and regulatory framework. This will involve strong cross sectoral collaboration and an ongoing commitment to a comprehensive research and evaluation agenda to review the impact of such interventions at a local level.

The Tasmanian Government is happy to provide to the Inquiry a copy of Tasmania's first Suicide Prevention Strategy when released later this year.

APPENDIX

Figure 1: Tasmanian Mental Health Services major service components:

The key service components funded by Mental Health Services include:

Child and Adolescent Mental Health Services for consumers aged from birth to 17 years. Most services are delivered as community based services.

Adult Mental Health Services which are divided into Community and Inpatient/Extended Care Services. Acute inpatient services are provided in the three general hospitals: Royal Hobart, Launceston General and North West Regional as well as a State-wide psychiatric intensive care unit at the Royal Hobart Hospital and additional extended care facilities in Hobart and New Norfolk.

There are a number of adult community centres across the state delivering a range of mental health services to urban and rural communities. In Launceston and Hobart there are also specialist community based teams delivering crisis, intensive support and rehabilitation services.

Mental Health Services for Older People consist of acute inpatient assessment and treatment services, day centre and community services as well as a Dementia Support Unit which is part of the Commonwealth Government Psycho geriatric Unit Program.

Community Sector Services such as supported accommodation, rehabilitation, peer support and carer support which are provided by community sector organisations such as Aspire and Richmond Fellowship.