SOUTH AUSTRALIA

AUSTRALIAN MEDICAL ASSOCIATION
(SOUTH AUSTRALIA) INC.
ABN 91 028 693 268

17 February 2021

Dr John Brayley
Chief Psychiatrist
Office of the Chief Psychiatrist

E: Meredith.Lee@sa.gov.au

Dear Dr Brayley

RE: Request for feedback on the draft Suicide Prevention Bill 2020

On behalf of the Australian Medical Association in SA (AMA(SA)), thank you for the opportunity to provide feedback on the Draft Suicide Prevention Bill 2020, as detailed in your letter to CEO Dr Samantha Mead of 23 December 2020. AMA(SA) members recognise and understand the enormous impact of suicide in our society, and its toll on individuals, families and communities, and we greatly appreciate your attention to this matter, as demonstrated by this draft legislation.

In preparing this submission we have sought the opinions of Council members, including those with significant expertise in mental health and suicide. The comments below examine specific elements of the Bill. However, they all return to one core question: what is the purpose of, and evidence for the effect of, this or any similar Bill designed to prevent suicide? It is our belief – based on evidence that includes the sources referred to below – that the resources that will be required to introduce, enact and evaluate this legislation and its components will be better directed at funding suicide prevention and support services, and to improving the social and living conditions of people at risk of suicide.

More detailed comments on this and other points are provided below.

1. The purpose of and evidence for such a Bill.

As noted above, AMA(SA) and our members understand and are deeply concerned about the impact of suicide on individuals and communities. Our support for more resources for people with mental health issues, including those issues that may lead to suicide, across South Australia is well known.

However, it is our position that suicide should not be separated from other outcomes of mental health issues; that as one of many ramifications of mental health issues, suicide should not be managed legally in a different manner than other outcomes of mental ill-health, and that specific legislation designed to 'prevent' suicide is unlikely to achieve the intended reduction in suicide rates.

We note that the Discussion Paper suggests that the Bill will 'provide a measure to ensure that a solid foundation and structure is in place; and that strategies are closely monitored, reviewed and improved and other innovations in suicide prevention and postvention practice are introduced in a timely way'. It is our recommendation that such measures and strategies can and should be established, but according to a clinical pathway. It is our view that placing such frameworks in legislation could have a punitive impact, where the focus is on ensuring bureaucratic directions are followed instead of focusing on treating people in need.

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As noted above, we question why such a Bill has been developed, when similar legislation has not been proposed for other issues in mental health or physical health. In preparing this submission, we have not found evidence that enacting legislation such as this Bill will help people with mental health issues or reduce the likelihood of preventing people from attempting suicide. In fact, we have found only one jurisdiction that has introduced such a measure: in Japan, where the Suicide Prevention Act was introduced in 2006 – and a study[1] of its impact on reducing suicide rates has found 'the difference in trend between before and after implementation of the Suicide Prevention Act was not significant for overall and for sex-age/-specific populations'.

As such, we question the reason for introducing this legislation in South Australia. We welcome and support strategies, policies and funding that focus on effective training and evidence-based responses, and the collection and analysis of suicide-related data to help governments and health practitioners understand the scope and patterns of suicide and to evaluate prevention efforts – but we are unconvinced that legislation is needed to enact these approaches.

2. Suicide rates change little within a specific sociocultural context.

There have been many interventions, plans and strategies at national and state levels that have attempted to reduce the rate of suicides in Australia. However, as a review[2] by internationally renowned psychiatrist Professor Anthony Jorm posited, 'the striking impression is that past efforts appear to have made no discernible difference'.

In 2020, Professor Jorm again examined the impact of interventions on suicide rates[3] and why interventions do not have a major effect on suicide rates. In this paper, he referred to recent papers that found that 'there are major social factors affecting the suicide rate (and that) mental health interventions are not likely to have a major impact on these social factors', which include the loss of employment, financial crisis, relationship breakdown, trouble with the law, and the availability of alcohol and other substances.

As a result of his review, Professor Jorm recommends[4] that resources be directed to:

- developing and evaluating treatments that specifically target suicide reduction
- interventions that operate 'on the spot' to reduce risk where suicidal feelings arise suddenly and actions may be impulsive, including those that help people in the suicidal person's social network develop the capacity to intervene and technological solutions such as mobile phone apps.

It is the belief of mental health professionals that the significant resources that would be required to implement this Bill and the many plans entailed would be better directed at developing such interventions, and at examining and improving the conditions that may lead people with mental health issues to contemplate suicide.

Such an approach would align with recent reporting by The Royal Australian and New Zealand College of Psychiatrists (RANZCP).[5] RANZCP notes that 'clinical interventions remain a crucial component of suicide prevention' and that '(p)sychosocial treatments and coordinated,

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[1] Miharu Nakanishi, Kaori Endo, Shuntaro Ando and Atsushi Nishida, 'The Impact of Suicide Prevention Act (2006) on Suicides in Japan', *Crisis* (2020), 41(1), 24–31 (hogrefe.com)

[2] Professor Anthony F Jorm, 'Lack of impact of past efforts to prevent suicide in Australia: Please explain', *Australian & New Zealand Journal of Psychiatry* (2019), Vol. 53(5) 379–380 DOI: 10.1177/0004867419838053

[3] Professor Anthony F Jorm, 'Lack of impact of past efforts to prevent suicide in Australia: A proposed explanation, *Australian & New Zealand Journal of Psychiatry* (2020), Vol. 54(6) 556-557 doi.org/10.1177/0004867420924104 (sagepub.com)

[4] Ibid.

[5] The Royal Australian & New Zealand College of Psychiatrists, 'Executive Summary - Suicide Prevention and COVID-19', June 2020

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proactive, aftercare have been shown to be the most effective treatments for supporting patients in suicidal distress'. RANZCP recommends that the most effective approaches include 24-hour crisis care; the training of frontline health and community workers in mental health, suicide and suicide prevention; and efforts to systematically reduce societal inequalities are the critical factors in preventing suicide. These comments were offered in the COVID-19 context because of their known effectiveness in supporting suicidal patients more broadly.

3. Proposed establishment of the Suicide Prevention Council

AMA(SA) acknowledges the importance of collecting and sharing information and expertise in suicide-related matters in the form of a group such as the Suicide Prevention Council proposed in Part 3 of this Bill. We welcome the establishment of a Council as outlined in Section 12, and would appreciate the opportunity to participate in its development and operations. However, we do not believe legislation is required to establish or operate such a group. Many groups have been formed in South Australia and elsewhere to manage aspects of significant and even terminal health issues, without legislative action.

In particular, we do not support the inclusion of Section 14, which outlines procedures that we suggest are not appropriate for legislation and are more commonly included in the terms of reference of such a group.

4. Suicide prevention plans

AMA(SA) notes the importance of strategies designed to prevent suicide, including the recent many and varied attempts to prevent suicide at a national level. While we are not aware of evidence demonstrating that these strategies have influenced suicide rates, we support a state approach that provides services for people with mental health issues, including suicide, and which leads research, training and data collection through a plan or strategy – although, as noted above, we do not believe this requires legislation.

In addition, we are concerned that this Bill, which proposes the introduction of prevention plans within an unknown number of 'prescribed State authorities', will be cumbersome, costly and punitive. For example, each agency would have to allocate funding and resources to developing and implementing these plans, and then possess the expertise to monitor and evaluate compliance and results. Again, we recommend that the funding that would be required to implement this proposal be directed at mental health services and training, and the improvement of social conditions for those at risk of mental ill-health.

We also question how any 'prescribed State authority' could be expected to 'prevent suicide by members of the community that engage with it', as section 24 (3) suggests – and what would happen when subsequent evaluation found that it had failed.

5. Suicide register and data collection

AMA(SA) welcomes and supports the collection of data that will inform strategies, services and training designed to prevent suicide and help people at risk. However, we suggest the collection and analysis of such data can and should be a component of broader improvements in data collection, analysis and sharing within and across the South Australian health system.

We would welcome the introduction of a data collection and management system, including a register that ensures suicide-related data is collected and made available, along the lines of that launched[6] in NSW. We would hope to be involved in developing such a register, to ensure it

[6] NSW Suicide Register major step towards saving lives - Suicide Prevention Australia

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meets professional and community standards in data privacy and security and to guarantee there is no possibility of unintended consequences for mental health patients, their carers or health practitioners.

6. Reporting and publication

Medical experts understand that suicide is a complex and distressing event that may be motivated by one or more unknown issues or circumstances. AMA(SA) is concerned that the proposals in sections 27 and 28, and in the powers of the Tribunal as outlined in the corresponding sections, are unwieldy and may have unintended consequences for individuals, organisations and agencies that are possibly not equipped to implement and manage the proposed provisions. It would concern us if the introduction of legislation designed to minimise suicide did, in fact, create bureaucratic procedures that divert attention and resources from the individuals suffering mental health issues and those trying to help them.

In summary, AMA(SA) recognises and appreciates that the intention of this Bill is to reduce the incidence of an event that is always complex and distressing. However, in light of the points above, we question whether legislation is required to implement the approach and establish the strategies and policies that this legislation would demand; rather, we suggest that this is not an approach that evidence indicates has been successful elsewhere in the world, but that existing health legislation and frameworks exist and can be adapted as needed to introduce the measures proposed in this Bill.

We welcome the opportunity to have our members who have expertise in mental health participate in forums that may emanate from this feedback process, including the establishment of any group that may be developed to support suicide prevention strategies. Please contact me via my Executive Assistant, Mrs Claudia Baccanello (claudia@amasa.org.au), to discuss this at any time.

Yours sincerely

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President

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