Submission to the
Inquiry into Suicide in Australia

November 2009

To:	From:
Committee Secretary **Senate Community Affairs Reference Committee** **PO Box 6100** **Parliament House** **Canberra ACT 2600** **community.affairs.sen@aph.gov.au**	**Freemasons Foundation Centre for Men's Health** **The University of Adelaide** **GPO Box 498** **Adelaide SA 5005** **Contact: Dr Vanessa Glennon** **vanessa.glennon@adelaide.edu.au**

Executive Summary

Summary Point 1:

Male suicide is a very significant problem – research and interventions addressing male suicide must become a higher priority for Australia. Male suicide deaths account for 75% of all suicide deaths and associated costs. Suicide is the second leading cause of premature death for males, accounting for 9.8% of potential life years lost. These deaths are avoidable and have considerable negative effects on families and society, including economic effects. Quantifying the costs of suicide is complex and controversial. The real reason to prevent suicide is because of our humanity.

Summary Point 2:

We advocate development of a public awareness campaign focused specifically on male suicide highlighting the significance of the problem, how to detect risk factors and where to seek help. It seems most people are still unaware of the issue of male suicide as most of the attention in recent years has been focused on youth suicide. While attempts have been made to raise awareness of male depression / anxiety, suicide can occur independent to depression / anxiety and so requires a separate campaign. Effective campaigns for men tend to be those that are conducted where men live, work and recreate including workplaces, barber shops, sporting clubs, and fraternal organisations.

Summary Point 3:

We strongly advocate for a national framework to guide the development of programs and services to prevent male suicide, based on a review of existing evidence about the age and gender related factors that contribute to, and protect from, suicidality, and including evaluations of interventions that have been conducted internationally. We believe such a review would support the development of interventions in the following areas as a matter of urgency:

- **Emotional literacy for boys at school** – to increase the capacity of boys to understand their own and others' emotions and to meet their own and others' emotional needs.
- **Support services for men experiencing significant life stress**, especially relationship breakdown and employment problems – through telephone help lines, peer support programs, and promoted through government agencies in contact with men experiencing life stress.
- **Improved depression diagnosis and treatment for men** – recognising that the experience of depression is different for men than women and that treatment efficacy may also vary.
- **Depression and suicide screening (separately) for the seriously ill**, particularly heart disease patients – recognising that a physical ailment significantly increases the risk for depression and suicide and provides an opportunity for targeted intervention.

Summary Point 4:

The evidence is clear that sex / gender and age play a significant role in suicidality – uncovering the underlying mechanisms remains a research challenge. Dr Kate Fairweather-Schmidt, Freemasons Foundation Research Fellow, Freemasons Foundation Centre for Men's Health and her colleagues at the Centre for Mental Health Research, The Australian National University have conducted one of the few population-based studies on suicidality. A nationally funded research program is needed as a matter of urgency to address the following key questions:

- What are the specific factors that predict suicidality (including suicidal ideation, progression to attempt, and suicide death)?
- What are the specific factors that protect people from suicidality (including suicidal ideation, progression to attempt, and suicide death)?
- What role do sex / gender and age play in this process? What are the underlying mechanisms that link sex / gender and age with other risk factors?

Introduction

The Freemasons Foundation Centre for Men's Health (FFCMH) was launched in 2007 as a joint venture between The University of Adelaide and The Freemasons Foundation. The Centre's vision is to enable men to live longer, healthier and happier lives. The mission is to pursue innovative research programs, significantly improve health services, deliver evidence based continuing education programs, and disseminate the latest health information and education resources.

The Centre's purpose has been enthusiastically embraced by a range of individuals and organisations. The Centre is led by Professor Villis Marshall AC, along with a multidisciplinary team comprised of world renowned experts in men's health. The Centre is guided by a Scientific Advisory Committee (comprised of 9 leading experts in their fields) and supported by a Board of Patrons (comprised of 19 leaders of industry, media and culture, and sports and government). Our principle patron is Sir Eric Neal AC CVO, former Governor of South Australia and current Chancellor of Flinders University.

We are actively engaged in research programs in the areas of male ageing, male obesity and diabetes, prostate cancer, male androgens / hormones, sexual and reproductive health, and health promotion. In addition to our core research programs, we are engaged in two strategic projects including: GIRTH: Get Involved, Reach Top Health! (male oriented healthy lifestyle intervention); and development of a demonstration men's health service.

Further details about the Centre, including recent publications, can be found on our website: www.adelaide.edu.au/menshealth

The FFCMH has a particular interest in male mental health and suicide prevention. In 2009, we appointed Dr Kate Fairweather-Schmidt as our second Freemasons Foundation Research Fellow to develop a research program in the area. Through her PhD, Dr Fairweather Schmidt has published significant research findings about the factors influencing suicidal ideation and about factors that may predict why a suicide ideator progresses to a suicide attempt. Her work provides a basis for further population-based studies on the factors influencing suicidality.

We have restricted our comments to those areas we know best, and so have not addressed all the terms of reference. Specifically, we are commenting on a), d), f), and g), and we are not commenting on b), c), e), h).

Response to Terms of Reference

a) Personal, Social and Financial Costs of Suicide in Australia

Male suicide is a very significant problem – research and interventions targeting male suicide must become a higher priority for Australia. Male suicide deaths account for the vast majority of all suicide deaths and associated costs. In 2007, over 75% of all suicide deaths were among males (1,453 male suicide deaths / 1,880 total suicide deaths; ABS, 2007). For more than 10 years, the age-standardised suicide death rate for males (13.9 per 100,000 standard population) has been 4 times higher than females (4.0 per 100,000 standard population; ABS, 2007).

Suicide is a significant cause of premature death, accounting for 9.8% of potential years of life lost (PYLL) for males, ranked 2nd behind coronary heart disease accounting for 11.1% PYLL (AIHW, 2008). For example, if life expectancy is 75 years, then a person dying at the age of 40 years would have died prematurely and lost 35 potential years of life. These deaths have considerable, negative effects on families and society because they occur prematurely and often have economic consequences. Furthermore, many untimely deaths may be avoidable (AIHW, 2008).

On the whole, male suicide deaths account for a relatively small proportion of all male deaths (approx 2.5%), but explain a much greater proportion of all deaths within specific age groups. For example, in 2007, 21% of all male deaths under 35 years were due to suicide (ABS, 2007). The median age of death by suicide for males in 2007 was 41.7 years compared to 77.5 years for deaths from all causes (ABS, 2007).

Quantifying the cost of suicide is complex and controversial. In 2005, New Zealand's Ministry of Health produced a report, *The Cost of Suicide to Society,* in which it concluded that the cost per suicide was NZ$2,483,000 (O'Dea and Tucker, 2005). This figure included economic costs such as lost work productivity; medical and other services used; non-economic costs such as lost years of disability-free life; and grief of family and others.

Using the NZ estimate as a guide, we can roughly estimate that the cost of suicide in Australia might be $2,000,000 per suicide. With 1,880 suicide deaths in 2007, the total cost to Australia could be approximated at AUS$3,760,000,000, of which male suicide deaths would account for AUS$2,906,000,000.

However, these figures are crude, and would be hotly debated. In fact, some researchers argue that there is a net economic gain from a suicide death as a result of potential savings from not having to treat depressive or other psychiatric disorders of those who suicide, and from not having to pay pensions, nursing home costs and other older age related costs.

Can we really say how much a life is worth in financial terms? Even attempting to do so may be a distraction from the main point. We should aim to prevent suicide because of our humanity.

Summary Point 1:
Male suicide is a very significant problem – research and interventions addressing male suicide must become a higher priority for Australia. Male suicide deaths account for 75% of all suicide deaths and associated costs. Suicide is the second leading cause of premature death for males, accounting for 9.8% of potential life years lost. These deaths are avoidable and have considerable negative effects on families and society, including economic effects. Quantifying the costs of suicide is complex and controversial. The real reason to prevent suicide is because of our humanity.

d) The Effectiveness of Public Awareness Programs

In recent years, most of the facilitation of public awareness has been around the issue of 'youth suicide'. In our work at the Freemasons Foundation Centre for Men's Health, anecdotally, we find that many people are still largely unaware that males account for the majority of all suicide deaths and that it is the second leading cause of premature death among males. The vast majority are ignorant of the risk factors associated with male suicide, with the obvious implication that loved ones are unable to detect a problem early enough if someone is in trouble.

There have been some attempts by the government's depression initiative, Beyond Blue, to draw attention to the issue of depression / anxiety among males. While this work is a 'step in the right direction', it needs to be more specific and more focused. And given that there appear to be other factors independent of depression / anxiety that contribute to suicidality, we would advocate a purpose designed campaign to raise awareness of male suicide as a significant problem, and in particular to inform about how to identify someone at risk and where to seek help. This effort should begin with developmental work to better understand current knowledge and attitudes in relation to male suicide and so, inform the messages and delivery mechanisms that will be appropriate to this issue.

We are aware of the potentially damaging impact of discussing suicide in the media, particularly for young people. Other effective mechanisms for raising awareness of health related issues among men are being successfully trialled around the world. These methods are based on the principle of taking the message to the men, where men live, work and play. For example, there are interesting examples of health related campaigns being conducted through male dominated workplaces, barber shops, sporting clubs, business groups, and fraternal organisations such as Freemasonry.

The FFCMH is currently developing a model health promotion program to be delivered to a general male audience, but through Freemasonry. This model, once developed, could easily be used for on-the-ground delivery of a male suicide campaign. Further, this model can be extended to other male clubs and organisations that attract men. This approach has the additional advantage of opportunities for encouraging social support by peers.

Summary Point 2:
We advocate development of a public awareness campaign focused specifically on male suicide highlighting the significance of the problem, how to detect risk factors and where to seek help. It seems most people are still unaware of the issue of male suicide as most of the attention in recent years has been focused on youth suicide. While attempts have been made to raise awareness of male depression / anxiety, suicide can occur independent to depression / anxiety and so requires a separate campaign. Effective campaigns for men tend to be those that are conducted where men live, work and play including workplaces, barber shops, sporting clubs, and fraternal organisations.

f) Role of Targeted Programs and Services

There have been relatively few targeted suicide prevention programs and services for men, especially considering the magnitude of the problem. There are a few very good resources available such as *Mensline Australia*, a national 24 hour telephone helpline for men with family and relationship problems. And given recent attention to male depression, the Beyond Blue website has some material available specifically on men and depression. Aside from these two nationally available resources, there are a few local resources and initiatives serving small pockets of men.

We strongly advocate for a national framework to guide the development of programs and services to prevent male suicide. This framework should be based on a review of existing evidence about the age and gender related factors that contribute to, and protect from, suicidality, including evaluations of interventions that have been tried internationally.

We believe such a review would support developing interventions in the following areas as a matter of urgency:

- **Emotional literacy for boys at school**
    - Emotional literacy is the ability to express feelings with words and is a basic precursor to being able to understand your own emotions and those of others. We need emotional literacy to get our emotional needs met and to help meet the emotional needs of others. In most western societies, we still do a poor job of educating boys about their emotions. Boys and girls develop differently, and we should be paying more explicit attention to the emotional development of boys.
    - Pioneers in the field, psychologists Dr Michael Thompson and Dr Dan Kindlon have been working with troubled boys for decades and write eloquently about the need to address the emotional literacy needs of young boys as a matter of urgency. In their book, *Raising Cain: Protecting the Emotional Life of Boys* they discuss cutting through outdated theories of "mother blame," "boy biology," and "testosterone," and shed light on the destructive emotional training our boys receive which they call 'the emotional miseducation of boys'. Readdressing this 'emotional miseducation', through structured learning programs in schools, could be an essential part of a strategy to prevent male suicide (and other forms of violence too).
- **Improved depression diagnosis and treatment for men**
    - While mental health problems including depression are not the only factors that lead men to suicidality, it is still a significant contributor. For years, a myth has been propagating that depression is less prevalent in men than women. Finally, a significant movement of researchers and practitioners is pursuing the view that depression prevalence is not necessarily lower among men; rather the male experience of depression symptoms is different and effective treatment may vary by gender as well.
    - Depression is not detected or diagnosed in men as often as women partly because current diagnostic standards may not be sensitive enough to the depression symptoms that are more common among men and partly because men are generally less emotionally expressive and reveal fewer overt signs of depression. We need to improve detection and

diagnosis of male symptoms by improving the diagnostic tools available and by educating primary care providers on the differences between male and female manifestation of depression symptoms.

- For example, on it's website, the (UK) Royal College of Psychiatrists described male depression like this: "There is no evidence for a completely separate type of 'male depression'. However, there is evidence that some symptoms of depression are more common in men than in women. These include:

  - irritability
  - sudden anger
  - increased loss of control
  - greater risk-taking
  - aggression."

  http://www.rcpsych.ac.uk/mentalhealthinfo/problems/depression/mendepression.aspx

- Further evidence that sex / gender plays a significant role in depression comes from studies of the efficacy of common antidepressant drugs. Researchers at the University of Michigan Depression Centre published a report indicating that men and women responded differently to citalopram even after accounting for many complicating factors (Young et al, 2009). In this large and robust study, women were 33% more likely to achieve full remission from their symptoms than men despite the fact that the women were more severely depressed (Young et al, 2009). This study adds to the mounting evidence that the experience and treatment of depression for men is different than for women.

- **Support services for men experiencing significant life stress, especially relationship breakdown and employment problems**
  - There is clear evidence that relationship difficulties and employment problems are two very highly ranked risk factors associated with suicidality among men. We need to develop acceptable ways to reach out to men in these circumstances and offer support. There are some indications that men will use anonymous telephone help lines and that they respond well to peer support approaches. But much further work is needed in this area to understand what forms of support men would find most useful and the best mechanisms for delivery.
  - The FFCMH is currently developing a qualitative research project to analyse men's interactions with ***healthdirect Australia***, the national health call centre. This project holds considerable promise for enhancing our understanding of men's support needs and communication styles, and for improving our capacity to offer relevant and acceptable telephone help line services.
  - Many men experiencing relationship breakdown or employment problems will make contact with a government agency at some point during the course of their difficulties (eg Family Court or Centrelink). It would be useful to explore the potential for promoting the use of male oriented support services through these channels.

- **Routine depression and suicide screening for the seriously ill, particularly heart disease patients**
    - Research is clearly pointing to the role of serious illness in both suicidality and depression, independently. There is mounting evidence that routine screening and follow-up for men facing serious illness, particularly heart disease (the leading cause of death among men) is likely to save lives and reduce suffering. Suicidality and depression should be screened separately as there is evidence that someone can become suicidal without a depression diagnosis.
    - Depression is 3 times more common in patients after a heart attack than in the general community (Lichtman et al, 2008). Based on increasing evidence of the link between depression in cardiac patients and poorer long term outcomes, in 2008 the American Heart Association recommended that all heart patients be screened for depression (Lichtman et al, 2008). It should be noted that the recommendation was also endorsed by the American Pediatric Association.
    - Similarly, there is a growing body of evidence to support the link between serious physical illness and suicidality (independent to mental health). Fairweather et al (2006; 2007) reported that study participants suffering from a physical medical condition were 2.5 times more likely to report suicidal ideation and this factor was more significant for males than females. Furthermore, suicide ideators with a physical medical condition were nearly twice as likely to have made an attempt on their life compared to those with no medical condition (independent of mental health status).

Summary Point 3:

We strongly advocate for a national framework to guide the development of programs and services to prevent male suicide, based on a review of existing evidence about the age and sex / gender related factors that contribute to, and protect from, suicidality, and including evaluations of interventions that have been tried internationally. We believe such a review would support the development of interventions in the following areas as a matter of urgency:

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g) Adequacy of the Current Program of Research

Given the obvious sex / gender and age differences in patterns of suicide, and the magnitude and severity of the problem of male suicide death, a funded research program is urgently needed. This program should be based on a comprehensive review of the existing evidence on sex / gender, age and suicidality and should encourage the development of population-based evidence.

Over the past 20 years, there has been considerable emphasis on 'youth suicide', and thereby on younger age as a key determinant. In March 1999, the NHMRC and the Australian Department of Health and Ageing jointly published a report, *National Youth Suicide Prevention Strategy: Setting the Evidence Based Research Agenda for Australia (1999)*. This report appropriately identifies two of the central questions involved in suicide prevention research:

- What is causing young males to be increasingly taking their own lives; and
- What contributing factors are protecting our young females?

We believe these questions should be extended as follows:

- What are the specific factors that predict suicidality (including suicidal ideation, progression to attempt, and suicide death)?
- What are the specific factors that protect people from suicidality?
- What role do sex / gender and age play in this process? What are the underlying mechanisms that link sex / gender and age with other risk factors?

The epidemiological evidence is clear that sex / gender and age are important factors, uncovering the underlying mechanisms remains a research challenge. There have been few population-based studies examining age and sex / gender related factors associated with suicidality. Dr Kate Fairweather Schmidt, Freemasons Foundation Research Fellow, and colleagues at the Centre for Mental Health Research, The Australian National University have conducted one of the few population-based studies attempting to answer these questions. Their study analysed data from the PATH Through Life Project, a community survey of 7485 (Wave 1) people in Canberra, Australia to identify factors associated with suicide ideation, and which factors may predict why a suicide ideator becomes a suicide attempter. Their analyses highlight the importance of age and sex / gender, in combination with a range of other factors, on suicidality. Their results were reported in two publications (Fairweather et al, 2006; 2007) with some of the highlights summarised below:

- Being male was associated with an increased level of suicidal ideation - specifically females in their 20s and 60s were approximately 30% and 65% less likely than males in the same age groups to experience suicidal ideation.
- Participants suffering from a medical physical condition were 2.5 times more likely to report suicidal ideation, and this factor was more significant for males;
- Participants who are unemployed or looking for more work in their 60s were almost 7 times more likely to experience suicidal ideation than those in full time employment;
- Mental health status did not distinguish suicide ideators from ideators who attempt suicide.

- Suicide ideators with a physical medical condition were nearly twice as likely to have made an attempt on their life compared to those with no medical condition (independent of mental health status);
- Suicide ideators who reported negative interactions with their friends had 20% greater odds of suicide attempt;
- Suicide ideators in the 40-44 year old age group who were unemployed were nearly 9 times as likely to attempt suicide as their employed counterparts;
- Two factors were significant for males, but not females including:
    - Male ideators who considered themselves to be more masterful (ie being in control) were significantly (20%) less likely to have attempted suicide; and
    - Male ideators with a physical medical condition had an increased chance of suicide attempt.
- Among ideators, the odds of suicide attempt are increased by experiencing a number of factors simultaneously (ie a dose response relationship between ideation, a range of proximal contributing factors and ultimate suicide attempt).

Dr Fairweather-Schmidt is the second Freemasons Foundation Research Fellow, based at the Freemasons Foundation Centre for Men's Health, the University of Adelaide. Her work adds considerably to our understanding of factors that may predict suicidality. She is currently developing a program of research to further this work. A dedicated research funding program should be created to support this type of research as a matter of priority.

Summary Point 4:

The evidence is clear that sex / gender and age play a significant role in suicidality – uncovering the underlying mechanisms remains a research challenge. Dr Kate Fairweather-Schmidt, Freemasons Foundation Research Fellow, Freemasons Foundation Centre for Men's Health and her colleagues at the Centre for Mental Health Research, The Australian National University conducted one of the few population-based studies attempting to answer these questions. A nationally funded research program is needed as a matter of urgency to address the following key questions:

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