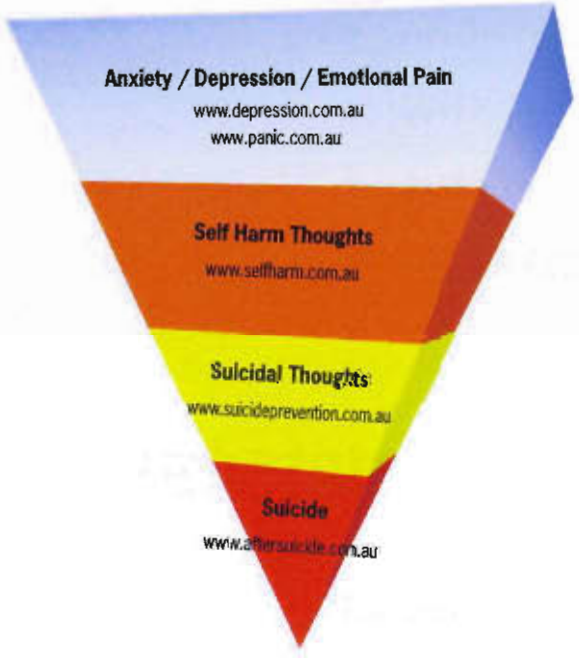
HOLD ON to life

Senate Inquiry Into Suicide in Australia



You would never advise a friend to die!
Tell yourself what you would tell a friend!

Representatives:

Chairman & Medical Director

Clinical Associate Professor David Horgan MB BCH BAO (Dub), MRCPsych DPM (Lon) MPhil (Edin) FRANZCP MD (Melbourne)

Chief Executive

Mr John Hardy;

Tabled on 4/3/10 at 9:05am
Suicide Inquiry by the
Australian Suicide Prevention
Foundation.

CORE SERVICE DELIVERY PHILOSOPHY

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Intervention which is:

- ANONYMOUS
- WITHOUT EMBARRASSMENT
- ALWAYS AVAILABLE
- NEVER ENGAGED

EXPERTISE

- Decades of professional experience
- 15 years providing services & support to Australians with suicidal thoughts

The Real Figures

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FOR EVERY SUICIDE THERE ARE

- **10 additional attempts made**
- **7 further people affected – family, friends, colleagues, team mates**

IT'S NOT JUST THE PERSON IN PAIN, THERE ARE AT LEAST 7 OTHER PEOPLE INVOLVED

At least 50% more deaths through suicide annually than:

- **Road deaths**
- **Deaths from prostate, breast and skin cancer**

YET, FUNDING AND MEDIA COVERAGE IS VERY HEAVILY SKEWED AWAY FROM SUICIDE

WHY DO PEOPLE ATTEMPT SUICIDE?

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EMOTIONAL PAIN & DESPAIR

- 2-5% of the population contemplate suicide in any year
- 60-90% of suicides suffered depression at the time of death.
- People seek suicide prevention information 24 hours a day.
- The 2007 National Survey of Mental Health and Wellbeing identified

2.3% Australians had suicidal thoughts	**> 450,000 Australians every year**
0.4% attempted suicide	**> 75,000 Australians every year**

1. **One-to-one counselling cannot possibly service these numbers.**
2. **The numbers involved are a prohibitively expensive demand to meet manually:**

- **ASPF handles some 20,000 telephone and internet contacts per month**
  - 30% refer to youth and teenage suicide
  - 22% refer to depression
- **ASPF believes - Medically-based information and advice can be delivered appropriately by technology in the first instance:**
  - **at any hour of the day or night**
  - **deterring action until further help can be obtained if necessary.**

AUSTRALIANS NOT RECEIVING BEST PRACTICE MANAGEMENT OF DEPRESSION

- International best practice standards are not promoted in Australia
- "Psychological autopsies" confirm 60-90% of suicides suffered depression at the time of death.
- There is a very variable range of skills among practitioners treating depression:
- Unlike sufferers in USA, Britain, Canada & Europe, Australian sufferers of depression are not given the option of taking 2 antidepressants simultaneously

  ➢The Australian practice to stop one antidepressant (instead of adding a second antidepressant) in the hope that the next antidepressant will work better is dangerous in the case of suicidal patients:

  - *"X was a top HSC student. But X suffered from depression. She is no longer here. The period of changeover from one antidepressant to another is a very dangerous time in the treatment of depression. It was during this time that X died." (extract from a major awareness and fundraiser website set up in memory of X)*
  - *Dr Y got post-viral depression working in a hospital. She was unable to work for 15 years despite treatment by over 10 psychiatrists. She requested "Put me down like a sick dog". She went back to full time work as a doctor taking combination antidepressants.*
  - *Mr Z, CEO of a large organisation reduced to a Disability Pensioner, was told there was nothing more could be done for his depression and believed suicide was his only option. A member of the Medical Board of Victoria requested combination antidepressant therapy for him. Mr Y has earned about $20 million dollars in the past 5 years.*

EFFECTIVELY DEALING WITH THE HUGE NUMBERS INVOLVED

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- People are more open interacting about sensitive topics on a computer, anonymously.
- Those over 65 have the highest statistical rate of suicide.
    - Elderly males are particularly vulnerable to feeling embarrassed seeking help
- Young people often lack the capability/confidence to seek help
- Men are traditionally less likely than women to seek help for emotional problems.
- Youth suicide and young adult suicide are major sources of life years lost
- 10% of adolescents indulge in self-harming behaviours as a manifestation of emotional distress
    - A number of these episodes of self-harm are repeated.
    - About 10% of such episodes eventually result in suicide or nearly-fatal suicide attempts

ENGAGING MALES IN HELP-SEEKING

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- **Males display an unwillingness or fear of confronting their emotional state.**
  - Males as a general rule can't/won't/don't make time in their busy day to seek professional help.
  - For many men at work, it is difficult to access GPs and other professional services.

- **Reasons given for this include:**
  - Pride
  - Unsure where to find help and won't ask
  - Not a priority
  - Embarrassment in discussing

RECOMMENDATIONS

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1. Accept the current major effect of stigma and provide intervention which caters for this issue. Create programmes and media focus funding aimed at providing means of lessening the stigma felt by sufferers and family members recognising the difficulties experienced overseas in their attempts at reducing the stigma associated with depression.
2. Provide a spectrum of help to lessen the risk of depression, of non-fatal self-harm, of suicide, and of family repetition of suicide.
3. Develop an economical means of intervention utilising today's technologies, thereby reducing the costs of providing large numbers of skilled professionals, while making 24 hour help cost -effective and widely available.
4. Focus on the absolute need for readily accessible internet based support, assistance and tools for people suffering from depression and contemplating suicide.
5. Raise awareness of anonymous and practical emotional help available without embarrassment or delay at any time, especially in crisis situations and at times of despair.
6. Provide formal follow-up and intervention for survivors of deliberate self harm.
7. Provide non-embarrassing and non-intrusive support for those, particularly men, following family breakdown and separation from children.
8. Educate the public about appropriate ways to ask friends or family members about suicidal thoughts, and how to respond.
9. Put greater educational focus on raising awareness of extra international medication strategies for treating depression.
10. Retain awareness of alcoholism and schizophrenia as conditions with high suicide and self-harm rates.

CONCLUSION

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Our work and research has demonstrated that people in despair require prompt definitive intervention which is anonymous, non stigmatising and available around the clock. We owe it to those 450,000 Australians who have suicidal thoughts each year to be provided with this level of service through emerging technologies which are becoming more accessible to the community.