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Submission to the Senate Inquiry into Suicide in Australia

Orygen Youth Health Research Centre

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We are pleased to take this opportunity to make a submission to the Senate Inquiry into Suicide in Australia, and, in particular, to be able to comment on the adequacy of the current program of research into suicide and suicide prevention and the effectiveness of the National Suicide Prevention Strategy in achieving its aims and objectives.

In short we call for:

1. **A national research agenda for suicide prevention, prioritising intervention research**
2. **An adequate system of monitoring suicides by people in contact with mental health services and by people who have recently presented to health services after a suicide attempt or deliberate self-harm**
3. **A program of nationally funded activity targeting those most at risk of suicide, including indicated interventions that can be readily evaluated**
4. **A review of the guidelines on the media reporting of suicide**

Suicide rates

It is now widely accepted that suicide is a major public health problem accounting for almost 1 million deaths worldwide[1]. Suicide is one of the leading causes of mortality in Australia, accounting for a greater number of deaths per year than road traffic accidents. In 2007 (the year for which the most recent data are available) 1,881

Australians died by suicide. In the case of young people aged 15 to 24, suicide accounted for 245 deaths, which represents around 20% of all deaths in this age group[2].

High-risk populations: people with mental illness and previous suicidal behaviour

People with mental illness and previous suicidal behaviour are at increased risk of suicide. Psychological autopsy studies have shown that almost 90% of people who die by suicide were suffering depression at the time of their death. Overall, the mortality associated with suicide in people with various forms of mental illness is estimated to be as high as 15%[3]. The relative risk of suicide among individuals who have had contact with psychiatric services has been estimated at more than 12 times that of the general population[4]. This risk is highest in the early stages of illness and following hospital discharge[3].

Suicidal behaviour is prevalent among young Australians[5] and is also a major risk factor for suicide; the rate of suicide in the year following an episode of deliberate self-harm is significantly higher than that in the general population. Fifteen percent of people who commit suicide will have attended emergency departments for deliberate self-harm during the preceding 12 months[6] and the majority of these will not have received a psychiatric assessment.

Data monitoring – high risk populations

The accuracy of suicide reporting in Australia is currently under scrutiny and indeed falls under the terms of reference for this Senate Review. However to our knowledge, whilst the reduction of suicide in certain high risk groups is a goal of the Strategy, there is no discussion regarding the development of accurate systems for monitoring suicides that occur in some of these high risk groups, namely people with a mental illness and people with a recent history of a suicide attempt or deliberate self-harm.

Whilst the Australian Bureau of Statistics and the National Coronial Information System collect valuable data about the rate of suicide in the general population they cannot tell us precisely how many suicides occur within psychiatric services or following deliberate self-harm. In contrast, such datasets are available in the UK. For example, the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness[7] collects detailed information on *all* suicides that occur within psychiatric services, including the number of suicides that occur in inpatient units and the number of suicides that occur following discharge from inpatient care. Further, because of its national scope the Inquiry is able to examine these groups in detail and can tell us when (for example, during an inpatient stay or during the post-discharge period) most suicides occur. This information has led to a series of recommendations which form an important part of the suicide prevention strategy for England. Because of its long term funding the Inquiry is also able to monitor suicide rates over time and

can advise both services and policy makers of changes in rates following the implementation of these recommendations.

Suicide attempts and deliberate self harm are significant problems and are the greatest indicators of future suicide, however estimating the extent of these problems is hampered by a lack of standardized record keeping and significant under-reporting. Whilst the accuracy of suicide reporting in Australia is currently under scrutiny, the recording of suicide attempts is not. Failure to record this information restricts our ability to accurately monitor progress towards reducing suicide and significantly hampers research in this area. Examples of accurate monitoring of suicide attempts and deliberate self-harm exist in other countries (e.g. the UK: http://cebmh.warne.ox.ac.uk/csr/resmulticentre.html) and we recommend that Australia learns from these examples and prioritises the development of similar systems.

A national research agenda

The need for robust data collection mechanisms and rigorous research has long been recognized and building an evidence base in the field of suicide prevention has been cited as a priority area in many of the documents associated with the National Suicide Prevention Strategy, most notably the Living is for Everyone Framework[8]. However despite this we are yet to see a strategic and coordinated program of research developed in this country. Although suicide and its associated sequelae represent a significant health problem, in research terms suicide remains a low base rate (rare) event which means that large numbers of participants are required for intervention studies to have sufficient power to enable meaningful conclusions to be drawn. For this reason suicide research would benefit from the development of research networks[9] which would facilitate the development of multi-site studies. The development of such networks could form part of a nationally coordinated and strategic approach to suicide research in this country.

Related to this is the fact that research to date has largely being epidemiological in nature, focusing upon rates and risk factors. Whilst this is important as it tells us where preventive efforts need to be directed, it is now widely acknowledged that a greater emphasis needs to be placed upon intervention research. This is the case both internationally[10] and here in Australia, despite the fact that stakeholders in the field have clearly stated that future priority should be given to intervention research[11]. In a study we conducted that examined research priorities in suicide prevention in Australia we found that while the studies financed by the key funding bodies (the National Health and Medical Research Council, the Australian Research Council and the Australian Rotary Health Research Fund) during the period 1999-2006 were largely intervention studies, the journal articles published during the same period were mainly epidemiological in nature. A similar examination of conference abstracts from two of the largest regular international conferences held in consecutive years from 2003 to 2008 — the International Association for Suicide Prevention's Congresses

and the European Symposia on Suicide and Suicidal Behaviour — revealed that only 12% of these abstracts described intervention studies[12].

In the case of youth suicide prevention there is also limited evidence regarding effective strategies[13]. Research efforts could focus upon a range of areas which could include, but are by no means restricted to, the following:

- Examining the effects of discussing suicide using modern forms of media such as social networking sites, which should also inform a review of media reporting guidelines to include web-based media
- The development of appropriate SMS or web-based interventions for young people at risk
- Trialing models of early detection that can be implemented in a range of clinical and community-based settings (such as schools)
- Indicated interventions for people known to be at risk (those who have expressed suicidal thoughts, who deliberately self-harm, or who have made suicide attempts), including cognitive behavioural therapy-based interventions and alternative contact-type interventions such as e-cards or text messaging
- Thoroughly evaluating and then disseminating evidence-based training models in a range of settings

Promising research is occurring in many of these areas, however more work is needed. A commitment to the funding of studies that are large enough to generate statistically significant results and a strategic approach to the dissemination of findings is also required.

Similar rigour should also be applied to the evaluation of projects funded under the auspices of the National Suicide Prevention Strategy. We reviewed the 156 projects that were funded under the original National Suicide Prevention Strategy[14]. These projects employed a range of universal, selective and indicated interventions, and were aimed at various high-risk groups. The Strategy recognized that the evaluation of these projects provided a useful opportunity to examine the effectiveness of different approaches to suicide prevention and the organizations that received funding were required to evaluate their projects. However, in general the majority of the evaluations were too methodologically weak to contribute much to the evidence base regarding effective strategies for suicide prevention.

Conducting intervention research in suicide prevention presents methodological challenges, however as noted by Goldney[15], we need to be more intelligent about the way in which we evaluate suicide prevention interventions. We need to recognise that while some interventions by their very nature will not be amenable to randomised controlled trials, we can still apply the most rigorous designs possible to their evaluation. Indeed, it seems crucial that if the government intends to spend significant sums of money on projects targeting suicide prevention (as indeed it should) adequate and methodologically rigorous evaluations are a necessity. In our

experience (cited above) those nationally-funded projects that were able to conduct methodologically stronger evaluations generally employed external evaluators and perhaps this should be a future requirement. Again this could be supported by a national suicide research network. We would also like to see a commitment to resourcing and supporting the roll-out of effective interventions as all too often research findings remain unimplemented and a lack of evidence-based practice persists.

Targeted interventions and the National Suicide Prevention Strategy

Whilst considering evidence-based practice, it is probably fair to say that whilst previous suicide prevention strategies have strived to achieve a balance of universal, selective and indicated interventions, to date much of the funded activity has adopted a primary prevention or universal approach. Whilst these sorts of interventions have some value, a raft of methodological limitations, such as lack of control groups, the need for large sample sizes to gain sufficient statistical power, and short funding cycles, mean that it is hard to demonstrate their impact upon suicide rates. We have previously argued for a more targeted approach whereby a greater proportion of funded activity specifically targets those most vulnerable to suicide[16].

We believe that there is an urgent need for suicide prevention activity to actively target people known to be at high risk in such a way that reduced suicidal behaviour is a measurable outcome. Current knowledge about the risk factors and service utilisation associated with suicide has contributed to the identification of high-risk groups who may benefit from selective and indicated prevention efforts. Such approaches are well placed to demonstrate reductions in the rate of suicide in these populations because the incidence of the problem among an already high-risk group is high enough to yield sufficient power with a relatively small sample size.

We advocate that more attention be given at a national level to evidence-based, targeted interventions addressing those at risk during peak periods of risk, with general health and associated mental health services being the most obvious (although not the only) channels for intervention. While approximately 15% of individuals who die by suicide have been in recent contact with public mental health services, many more people at risk could be identified through emergency departments, by crisis teams and in primary care settings, and still more by conducting case detection or screening programs in settings such as secondary schools. Examples of specific interventions for people with a mental illness who present to emergency departments with suicidal behaviour are outlined below and whilst it may not be possible for each of these interventions to be implemented nationally, in our view the Commonwealth has an important role to play in terms of identifying these as national priorities. The adequate identification and treatment of depression should also be a priority; depressive symptoms are a key predictor of suicide risk and treatments such as cognitive behavioural therapy and anti-depressant medication can be successful.

Possible interventions for people with mental illness:

- Early intervention approaches that facilitate access to, and engagement with, services
- Further development of non-stigmatising youth-friendly early intervention services (such as headspace) for young people in need of support
- The provision of intensive and early follow-up following hospital discharge
- The appropriate use of medication such as clozapine
- Specific forms of cognitive therapy targeting cognitions known to be associated with suicide
- A commitment to the development and evaluation of web-based interventions and information sites (such as ReachOut).

Possible interventions following presentation at emergency departments for suicidal behaviour:

- Thorough assessment, referral and early follow-up after a presentation at an emergency department
- Low cost and transferable interventions that facilitate continued contact with at-risk individuals following presentation for suicidal behaviour or deliberate self-harm.
- Ready access to services for people following deliberate self-harm (e.g. emergency access card interventions)
- The development of youth-friendly sites which young people can attend following a suicidal crisis.

These interventions are based upon current evidence, but could readily be subject to further evaluation. Addressing this at a national level, with an embedded program of research, would not only focus attention on those at high risk but would allow for rigorous evaluation, thereby adding to the body of evidence on effective interventions for suicide prevention and ensuring that work funded under the auspices of the National Strategy lends itself to adequate evaluation.

We know that a gap exists between those who are at risk and those who seek help from traditional services, particularly for young people, and that if we rely upon young people approaching health services we fail to identify and support many of those at risk. This is partly a product of the stigma associated with mental illness, and partly due to the inability to recognise when help is required. Hence we need to find new ways of encouraging young people to seek help. This can be achieved by the continued commitment to the development of youth friendly services such as Orygen Youth Health and headspace, the further development of youth-friendly web-based resources such as Reach Out, and by going that one step further and actively working to identify young people who may be at risk in community settings such as schools.

Media reporting of suicide

We would further argue that the help-negating effect of stigma is exacerbated by the taboos around media reporting of suicide. Whilst the current guidelines for the reporting of suicide in the media were developed with the best of intentions and with good reason (http://www.mindframe-media.info/) it is now time for these to be reviewed. Whether we like it or not young people are talking about suicide in the media – they simply use different forms of media than those to which the current guidelines refer. Social networking sites such as My Space and Facebook are the means by which young people communicate. Such communication should not be discouraged; rather, healthy ways of using the internet for communication and information sharing need to be found and promoted. Such investigations need to form part of a national suicide prevention research agenda and the findings should inform a review of the current practice around media reporting.

Key recommendations:

- **A national research agenda for suicide prevention, including the development of a national suicide research network**
- **Adequate monitoring of suicides that occur by people in contact with mental health services and those who have recently presented to emergency departments after deliberate self-harm**
- **A program of activity targeting those most at risk of suicide, including indicated interventions that can be readily evaluated**
- **A review of media guidelines including an examination of the use and effects of talking about suicide on the Internet**

References

1. World Health Organisation. (2009). *Mental Health: The Bare Facts*. Retrieved from http://www.who.int/mental_health/en/
2. Australian Bureau of Statistics. (2009). *Causes of Death, Australia, 2007.* (ABS Catalogue No. 3303.0). Canberra, Australia: ABS.
3. Hawton, K., & van Heeringen, K. (Eds.). (2000). *The International Handbook of Suicide and Attempted Suicide.* Chichester, UK: John Wiley & Sons Ltd.
4. Ruschena, D., Mullen, P.E., Burgess, P., Cordner, S.M., Barry-Walsh, J., Drummer, O.H. et al. (1998). Sudden death in psychiatric patients. *British Journal of Psychiatry, 173*, 331-336.
5. De Leo, D., & Heller, T.S. (2004). Who are the kids who self-harm? An Australian self-report school survey. *Medical Journal of Australia, 181(3)*, 140-144.

6. Gairin, I., House, A., & Owens, D. (2003). Attendance at the accident and emergency department in the year before suicide: retrospective study. *British Journal of Psychiatry, 183*, 28-33.
7. Appleby, L., Shaw, J., Sherratt, J., Amos, T., Robinson, J., et al. (2001). *Safety First: Five Year Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness.* England, Department of Health.
8. Commonwealth Department of Health and Ageing. (2007). *Living is for everyone (LIFE) – A Framework for Prevention of Suicide in Australia*. Canberra, Australia: Australian Government.
9. Goldsmith, S.K., Pellmar, T.C., Kleinman, A.M., & Bunney, W.E. (Eds.). (2002). Barriers to Research and Promising Approaches. In *Reducing Suicide: A National Imperative* (pp. 375-422). Washington, D.C: The National Academic Press.
10. Mann, J.J.Apter, A., Bertolote, J., Beautrais, A., Currier, D., Haas, A., Hegerl, U., et al. (2005). Suicide prevention strategies: A systematic review. *Journal of the American Medical Association, 294(16)*, 2064-2074.
11. Robinson, J., Pirkis, J., Krysinska, K., Niner, S., Jorm, A., Dudley, M., et al. (2008). Research priorities in suicide prevention in Australia: A comparison of current research efforts and stakeholder-identified priorities. *Crisis, 29(4)*, 180-190.
12. Huisman A, Pirkis J, Robinson, J, Intervention studies in suicide prevention research, submitted to Crisis, 2009.
13. Burns, J., Dudley, M., Hazell, P., & Patton, G. (2005). Clinical management of deliberate self-harm in young people: The need for evidence-based approaches to reduce repetition. *Australian New Zealand Journal of Psychiatry, 39(3)*, 121-128.
14. Headey, A., Pirkis, J., Merner, B., VandenHeuval, A., Mitchell, P, Robinson, J., et al. (2006). A review of 156 local projects funded under Australia's National Suicide Prevention Strategy: Overview and lessons learned. *Australian e-Journal for the Advancement of Mental Health, 5(3)*, Retrieved from www.auseinet.com/journal/vol5iss3/headey.pdf
15. Goldney, R. (2005). Suicide prevention: A pragmatic review of recent studies. *Crisis: The Journal of Crisis Intervention and Suicide Prevention, 26(3)*, 128-140.
16. Robinson, J., McGorry, P., Harris, M.G., Pirkis, J., Burgess, P., Hickie, I., et al., (2006). Australia's national suicide prevention strategy: The next chapter. *Australian Health Review, 30(3)*, 271-276.