Senate Community Affairs Committee

Submission:
Inquiry into Suicide in Australia 2009

Introduction

SANE Australia is a national charity working for a better life for people affected by mental illness – through education, research and campaigning.

This brief submission by SANE Australia outlines three key observations for the Committee to consider when examining the issue of suicide and making recommendations to the Government in 2010.

- Mental illness is the primary common attribute of the majority of people who die by suicide in Australia. This insight provides the key to reduction of suicidal behaviour in our country.

- The unarguable logic of this insight is that improving treatment of, and attitudes towards, mental illness provide our best opportunity to reduce Australia's suicide rate.

- Improving treatment of mental illness, and social attitudes towards it, should be a primary activity of Australia's suicide reduction strategy– using systems and structures already developed and in place.

Mental illness is the primary common attribute of the majority of people who die by suicide in Australia.

Mental illness is recognised as a significant risk factor in the Australian Government's LIFE (Living is for Everyone) Framework Strategy. The review of research and evidence states that:

> A diagnosis of a mental disorder is among the strongest risk factors for both non-fatal and fatal suicidal behaviour, and psychiatric comorbidity (ie a diagnosis of more than one mental disorder) increases the risk even further. The overwhelming majority of people who die by suicide have a diagnosis of a psychiatric disorder, especially affective disorders, substance-related disorders, and schizophrenia.
>
> Psychopathology, particularly affective disorders, substance abuse, anxiety disorders, and personality disorders, is also a serious risk factor for suicide attempts. It has to be noted; however, that only a relatively small proportion of individuals with a psychiatric diagnosis engage in suicidal behaviour, and psychopathology alone is not a sufficient predictor of suicide: other risk and protective factors play a very important role. These include quality and availability of mental health services, effectiveness of treatment, compliance with medication, and availability and quality of social support. Also, being hospitalised in a psychiatric institution tends to increase the risk of suicide, and risk is significantly increased within the first weeks after discharge from a psychiatric hospital, and it remains elevated for up to six months after discharge.

As well as this strong association between suicidal behaviour and mental illness in general, research commissioned for SANE Australia emphasises the especially-high rate of suicide linked to certain diagnoses.

Suicide is the pre-eminent cause of death for people with bipolar disorder, with a lifetime risk of 15% (compared to approximately 1% in the general population). It is estimated that around one in eight of all suicides (12%) are by people with bipolar disorder. Of those who die by suicide, it is estimated that 60% have received inadequate treatment.*

Suicide is a prominent cause of death for people with schizophrenia. Suicidal ideation is common, experienced by 68% of those with this diagnosis. Over 40% attempt suicide at least once, and WHO calculates the lifetime risk of suicide for people with schizophrenia at 10-13% (compared to approximately 1% in the general population). As with bipolar disorder, research indicates that suicide is more likely to occur in those who are not receiving adequate treatment.**

The lifetime suicide risk for people with depression is conservatively estimated at 6% (compared to approximately 1% in the general population). Psychological autopsies and other research studies suggest that many people who die by suicide met the diagnostic criteria for depression but had not an assessment or treatment.***

The primacy of mental illness as the major risk factor for suicidal behaviour dictates that it should be a primary focus of action to reduce suicide in Australia.

* Access Economics; SANE Australia, 2003. *Bipolar Disorder: Costs*.

** Access Economics; SANE Australia, 2002. *Schizophrenia: Costs*.

*** Inskip, H. M., Harris, E. C., Barracough, B., 1998. Lifetime risk of suicide for affective disorder, alcoholism, and schizophrenia. *British Journal of Psychiatry*, 172: 35-37.

Improving treatment of, and attitudes towards, mental illness provide our best opportunity to reduce Australia's suicide rate.

Much attention has rightly been paid to the higher risk of suicide in certain demographic groups, such as those living in rural areas and indigenous people. Mental illness, however, is not only the primary risk factor in all demographic groups, it is *an attribute which is subject to intervention*, and thus our best opportunity to reduce suicidal behaviour across the board. (SANE Australia has recently conducted a major survey of people who have experienced suicidal behaviour, with a report to be published early in 2010. Early results from analysis conducted so far indicate that the most effective action nominated to reduce suicidal behaviour is the improvement of day-to-day mental health services.)

Areas where concerted action need to be taken include:

*Destigmatisation of mental illnes*s
to encourage help-seeking as soon as possible after symptoms appear, so that assessment, diagnosis and treatment are not delayed to the point where suicidal behaviour occurs. (Work already being conducted indicates encouraging results in this area – for example, through the MindMatters and KidsMatters programs in schools, the Mindframe Strategy which includes the SANE Media Centre's StigmaWatch program, a range of suicide prevention and postvention bereavement programs, and the Headspace Youth Mental Health Initiative.)

Early intervention
and access to services for all forms of mental illness, including anxiety disorders and depression as well as psychotic conditions, so that optimal treatment can be provided as well as ongoing support for the person and their family. Research strongly indicates a positive association between improved primary care of depression (with increased prescribing of antidepressants) and reduced rates of suicide.****

Quality of mental health care
requires radical improvement in all areas, including crisis services, in-patient care, community care, forensic services, alcohol and other drug services, and community-based accommodation, rehabilitation and support.

Post-discharge care
requires urgent attention as there is compelling evidence that this is a period of extreme risk for suicidal behaviour.#

While not being explicitly called 'suicide prevention', it is these improvements in mental health services which should form a primary action in our Strategy for reducing suicidal behaviour in Australia.

**** Hall, W. D. et al, 2003. Association between antidepressant prescribing and suicide in Australia, 1991-2000: trend analysis. British Medical Journal, 326: 1008.

Kan C. K. et al, 2007. Risk factors for suicide in the immediate post-discharge period. *Social Psychiatry and Psychiatric Epidemiology* 42: 208-214.

Improving treatment of mental illness, and social attitudes towards it, should be a primary activity of Australia's suicide reduction strategy.

The current National Suicide Prevention Strategy (overseen by the Australian Suicide Prevention Advisory Council) has established a structural foundation and research base to build on, and which will serve us well in the future. It is important to acknowledge that the Strategy has resulted in a wide range of practical initiatives which contribute to the prevention of suicide in Australia.

SANE Australia believes suicide prevention is best served by building on what has been achieved – strengthening, improving, and sustaining the Strategy using systems and structures already developed and in place. Integral to this will be the essential step of moving the improvement of mental health services, and of attitudes towards mental illness, into a central place in the Strategy and its activities.

Suicide prevention is the proper responsibility of the Australian Government (rather than any new, third-party agency which would only add further layers of bureaucracy and governance to the process). It is the Government itself – through the Strategy and existing structures – which is best placed to carry out this responsibility effectively: able to integrate suicide prevention with the Fourth National Mental Health Plan, to liaise efficiently with the States through COAG, to coordinate it with a range of other Government responsibilities (for example, Education, Employment and FAHCSIA), and crucially, to ensure mental health services and suicide prevention activities generally are sufficiently funded to be effective.

Contact details	Barbara Hocking SANE Australia PO Box 226 South Melbourne VIC 3205 (03) 9682 5933	barbara.hocking@sane.org www.sane.org
Date	18 November 2009	