

# FACT SHEET

## SUICIDE PREVENTION AND MENTAL DISORDERS

The toll of suicide deaths in Australia continues to rise – despite substantial funding provided to the suicide prevention sector.

This FACT SHEET presents some important information that is often over-looked in the current approach to suicide prevention in Australia.

It is vital for effective suicide prevention that information that is presented to the community gives a fair and honest account of the key issues and factors involved in suicide deaths.

SUICIDE – RATES AND NUMBERS

ECONOMIC COST

DEPRESSION/MENTAL DISORDER

DEFICITS OF CURRENT APPROACH

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## A. At A Glance

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### Suicide – Rates and Numbers

- Suicide deaths in Australia now amount to around 3,000 per annum (3,128 in 2017)
- There is common agreement in Australia that the suicide figures are considerably under-reported
- There are a range of factors that contribute to suicide deaths
- The majority of all suicide deaths are people who are not employed
- The majority of Australian suicide deaths are city dwelling adults
- There are significant gender differences in suicide deaths and intentional non-fatal self-harm

### Economic Cost

- As well as the enormous social cost of suicide deaths, there is an enormous economic cost
- There is a significant cost burden on the insurance industry due to suicide
- Current suicide prevention programs and campaigns are costly, and largely ineffectual

### Depression/Mental Disorder

- The rate of anti-depressant use in Australia is amongst the highest in the world
- There is a great deal of disagreement in expert opinion over the effectiveness and dangers of anti-depressants
- Workplace 'mental disorder' claims are misleading because they are due largely to work place stress
- Clinically diagnosed psychiatric disorders are a factor in only a relatively very few suicide deaths

### Deficits of current approach

- There are significant shortcomings in the scope of current suicide research
- There is growing concern about the significant deficits within the current approach to suicide prevention Australia

## B. Information about these facts

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### **Suicide deaths in Australia now amount to around 3,000 per annum. (3,128 in 2017)<sup>1</sup>**

This is about twice the rate of fatalities from all motor vehicle accidents and homicides combined.<sup>1</sup> These numbers have been rising steadily for a decade or more – despite the substantially increased funding into the suicide prevention/mental health sector over this period.

### **There is common agreement in Australia that the suicide figures are considerably under-reported.<sup>2</sup>**

It is generally agreed that the suicide figures are under-reported by 20-30%.

### **There are a range of factors that contribute to suicide deaths.**

These include unemployment, relationship breakdown, isolation, financial stress, history of self-harm, drug and alcohol abuse, and mental health difficulties<sup>3</sup>

### **The majority of all suicide deaths are people who are not employed.<sup>4, 5</sup>**

Suicide deaths among those who are not employed account for at least 55% of all suicide deaths of people of working age. There are even higher rates of suicide deaths among women of working age who are not employed – 68.2%. Many of the suicide deaths of people of working age and who are *not employed* (several hundred per year) are nevertheless not classified as '*unemployed*' and consequently are often simply overlooked altogether.<sup>4, 5</sup> International research shows that unemployment is a significant factor in suicides in many Western Countries<sup>6</sup> and that providing appropriate support for those who are not employed can impact on suicide rates.<sup>7, 8</sup>

### **The majority of Australian suicide deaths are city dwelling adults<sup>1, 9</sup>**

The five (5) cities of Sydney, Melbourne, Brisbane, Adelaide and Perth together make up over half (54.18%) of all suicide deaths in Australia. In general, the rural rate for suicide deaths is higher than for metropolitan areas. However, this is a considerable generalisation: rates of suicide deaths vary enormously if measured by local government areas for both rural and metropolitan areas<sup>9</sup>. Some metropolitan areas have both higher rates of suicide deaths as well as considerably higher numbers of suicides than the general rural rates and numbers.

### **Gender Difference: there is significant gender difference in suicide deaths and intentional non-fatal self-harm<sup>10</sup>**

At least 75% of all suicide deaths in Australia are men<sup>1</sup>; most incidents of intentional non-fatal self-harm are female<sup>11</sup>. Acknowledging gender difference and developing strategies to suit is vital if we are to reduce the numbers of suicide deaths and incidents of intentional non-fatal self-harm.

Many men (probably the great majority) who kill themselves do so at their first attempt<sup>12</sup>

## Economic Cost

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### **As well as the enormous social cost to suicide deaths, there is an enormous economic cost.**<sup>13</sup>

The economic cost of suicide deaths is calculated to be \$1.75 billion per annum for 2012 – and rising. The estimated cost to the community of suicide deaths for people who are NOT Employed (over 55% of all suicide deaths) is at least \$800 million per year – yet for this target group we spend very little in prevention.

On top of this there is an increasing economic cost attributable to the rising numbers of diagnoses for 'mental health' issues such as depression.

### **There is a significant cost burden on the insurance industry**

These increasing costs are having a significant impact on particular industries, especially the insurance industry<sup>14</sup>

Suicide deaths cost the insurance industry in excess of \$240 million per year<sup>15</sup>, and work related mental disorder claims cost at least \$480 million per year<sup>16</sup>

The overwhelming majority (almost 90%) of these claims is due to stress in the workplace rather than a pre-existing 'mental illness'.

There is now a good deal of concern within the insurance industry itself that this already substantial and further escalating cost of mental health claims is impacting on the viability of the industry. A genuine attempt at a new approach to the issue of suicide prevention and mental health is required; simply adopting activities and partnerships of the current approach will only exacerbate the problem and support status quo outcomes.

### **Current suicide prevention programs and campaigns are costly and ineffectual**

Huge budgets are dedicated to suicide prevention. The figure has been rising steadily since the mid-1990s to almost \$50 million per year for 2015-16.<sup>17</sup> This is the federal government figure alone for the National Suicide Prevention Strategy (NSPS). It doesn't include substantial federal funding for suicide prevention in broader programs and services across social welfare and mental health services;<sup>17</sup> nor does this figure include substantial funding from state governments. More recently, the level of funding has increased dramatically with the 2019-20 Budget and a \$461 million investment in youth mental health and suicide prevention strategy.<sup>18</sup>

Despite this substantial and continually increasing funding for suicide prevention and mental health, improvement in these areas have not been achieved; in fact, the numbers of both suicide deaths and diagnoses of depression have risen substantially over the last decade.<sup>1,19,20</sup>

The current approach to suicide prevention often includes program activity such as 'mental health literacy' and 'mental health first aid' – these programs are often favoured as work place training programs. However, their content and approach generally serves to perpetuate the paradigm of 'treatment of mental disorder'. The delivery of these programs is an enormous cost burden on the workplace.

A key strategy that has been used as suicide prevention has been expensive 'awareness-raising' campaigns – despite the fact that the World Health Organisation (WHO) itself reports:

*There is little evidence linking awareness campaigns to a reduction in suicide...*<sup>21</sup>

## Depression/Mental Disorder

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### **The rate of anti-depressant use in Australia is amongst the highest in the world**

In Australia, antidepressant utilisation nearly trebled between 1990 and 1998, and has continued to increase.<sup>19, 20</sup> Of OECD nations, Australia is currently the second-highest prescriber of antidepressant drugs.<sup>22</sup>

### **There is a great deal of disagreement in 'expert opinion' over the effectiveness and dangers of anti-depressants.**<sup>23</sup>

There is growing concern that some anti-depressant use is actually harmful. An article in the *Scientific American*, 2016, '*The Hidden Harm of Anti-depressants*', offers an in-depth analysis of clinical trials and reveals widespread under-reporting of negative side effects, including suicide attempts and aggressive behaviour.<sup>24</sup>

### **Workplace 'mental disorder' claims are largely due to work place stress.**

The vast majority, close to 90%, of mental disorder claims are attributed to workplace issues such as work pressure, work related harassment and/or workplace bullying and exposure to workplace or occupational violence.<sup>16</sup> It is increasingly common that workers needing support for workplace stress, regardless of the cause of the stress, are advised to consult with GPs – where the outcome is often a diagnosis of mental disorder, particularly depression.

### **Clinically diagnosed psychiatric disorders are a factor in only a relatively very few suicide deaths**

Statistical data that has been relied on in the past, has been largely based on the Psychological Autopsy method, and has been discredited.<sup>25</sup> More recent research suggests that other key factors such as employment status account for far more suicides than 'mental disorders'.<sup>4</sup> Many men who suicide have no psychiatric history or known mental disorder.<sup>5</sup>

## Deficits of current approach

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### **There is growing concern about the significant deficits within the current approach to suicide prevention in Australia.**

Clearly, the current approach to suicide prevention is not working – despite enormous increases in funding, not only is the current approach **not** helping reduce the toll of suicide deaths in Australia, but the figures have been rising at an alarming rate for a decade or more.

Work has been done to provide detailed descriptions of the deficits within the current approach.<sup>3, 26</sup> These deficits are described as fundamental to the narratives and activity of suicide prevention as it is currently practised and that these deficits are systemic, pervasive, and deeply entrenched. A paper on this topic, *The Situational Approach to Suicide Prevention and Mental Health Literacy – Challenging the Deficits of the Current Orthodoxy*<sup>26</sup> lists key deficits and provides detailed description of each of the listed deficits.

### **Deficits the Situational Approach highlights and critiques include:**

- The unnecessary and potentially harmful medicalisation and pathological categorisation of human distress – and disregard for the situational and dimensional nature of human experience
- The conflation of mental illness and suicide
- The conflation of intentional non-fatal self-harm with suicidality
- The disempowerment of communities in their capacity to take a leadership role in local and regional suicide prevention and preventative mental health

- Disregard for important implications of gender specificity and differentiation in program and service design and subsequent service and program delivery
- Significant neglect of primary and secondary prevention efforts in favour of crisis intervention, which leaves those most vulnerable to mental health difficulties, and suicide to simply ‘fall through the slats’
- Over-reliance on mental illness perspectives from the mental health sector in suicide prevention, and disregard for expertise relevant to a broader perspective on suicide and effective suicide prevention
- Lack of appropriate support for GPs in primary care settings.
- Community ‘engagement’, whether focused on mental health literacy or suicide prevention, that is dominated by mental illness information sessions, and awareness raising. Informing and raising the awareness of the public about mental illness, can in fact discourage engagement, because illness suggests the need for a medical or professional intervention
- Lack of innovation and relevance of some research in the fields of mental health and suicide
- The increasing phenomenon of non-health and non-mental health organisations (influenced by mental health literacy messaging) directing clients to GPs rather than other more appropriate support services
- Suicide prevention and mental health training programs that continue to present limited and orthodox perspectives without enough critical analysis of their inherent problems, contradictions, or outcomes for consumers

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## There are significant shortcomings in the way suicide research is currently practiced.<sup>27</sup>

*To date, research has been insufficient to explain why men, especially during middle age, are particularly vulnerable to taking their own lives. The shortcomings of prior studies include lack of longitudinal follow-up, failure to measure such factors as social integration and dimensional indicators of stress, over-reliance on categorical measures of psychopathology, and a focus on proxy outcomes instead of death by suicide.*

Much of the research in Australia is still focused on depression.

Research that is targeted on men is often built on unhelpful stereotypes and simplistic methodologies.

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## Links to useful papers and resources:

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### **Male Suicide Prevention Australia – Resources**

<http://malesuicidepreventionaustralia.com.au/resources/resources/>

### **Mad in America – Science, Psychiatry and Social Justice**

<https://www.madinamerica.com/>

### **PsychWatch Australia – Scrutinising Mental Health Policy + Practice**

<https://www.psychwatchaustralia.com/>

### **Australian Bureau of Statistics – Causes of Death, Australia, 2017**

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### **Torrens University – Social Health Atlases**

<http://www.phidu.torrens.edu.au/social-health-atlases/maps#social-health-atlases-of-australia-local-government-areas>