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.

This is an updated version of the Situational Approach FACT SHEET originally produced in 2019.

SUICIDE – RATES AND NUMBERS

ECONOMIC COST

DEPRESSION/MENTAL DISORDER

DEFICITS OF CURRENT APPROACH

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A. At A Glance

Suicide – Rates and Numbers

- Suicide deaths in Australia now amount to around 3,000 per annum (3,249 in 2022)
- 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 and 'mental health' issues
- 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 due largely to stressful circumstances rather than any internal biologically-based mental challenges
- 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

Suicide deaths in Australia now total consistently greater than 3,000 per annum. (3,249 in 2022)[1]

This is about twice the rate of fatalities from all motor vehicle accidents and homicides combined. Of the 3,249 deaths due to suicide, 2,455 were males and 794 were females. Despite the substantially increased funding into the suicide prevention/mental health sector over this period, these numbers have been rising steadily for about 2 decades. This total of 3,249 deaths in 2022 is an increase of around 40% since 2002.[2]

There is common agreement in Australia that the suicide figures are considerably under-reported.[3]

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.

There is a significant body of research that demonstrates that economic conditions, employment, poverty, social exclusion, and discrimination increase the risk of suicide.[4]

The majority of all suicide deaths are people who are not employed.[5]

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.[4] International research shows that unemployment is a significant factor in suicides in many Western Countries[6] and that providing appropriate support for those who are not employed can impact on suicide rates.[7]

The majority of Australian suicide deaths are city dwelling adults[8]

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[9]. 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[9]

At least 75% of all suicide deaths in Australia are men[1]; most incidents of intentional non-fatal self-harm are female[10]. 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.

There is evidence that many, perhaps the majority, of men, kill themselves on the first attempt.[11]

Economic Cost

As well as the enormous social cost to suicide deaths, there is an enormous economic cost.[12]

The economic cost of suicide deaths is calculated to be $1.75 billion per annum for 2012 – and rising.

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

There are now enormous costs borne by the Life Insurance industry as a result of workplace mental health policies and practices that medicalise distress. On-going support is often conditional upon the workers undergoing a medical pathway and diagnosis of a mental disorder such as depression or anxiety disorder.[12]

Suicide deaths cost the insurance industry in excess of $240 million per year[13] and work related mental disorder claims cost at least $480 million per year[14]. However, the overwhelming majority (almost 90%) of these claims is due to stressful circumstances (situational distress) 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.[15] 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;[15] nor does this figure includes 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.[16]

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 suicide deaths, and diagnoses of depression and prescribing of antidepressants have risen substantially over the last decade.[17]

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... [18]

Depression/Mental Disorder

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

In Australia, antidepressant consumption is now at alarming levels; Australia is amongst the highest consumers of antidepressant drugs in the world.[19] Antidepressant use continues to increase, especially among young people.[20]

There were 44.4 million prescriptions dispensed for mental health-related medications (both subsidised and under co-payment) in Australia, to 4.7 million Australians in 2021–22. The majority of prescriptions were made by general practitioners (85%) and *Antidepressants* (74%) were the most common mental health-related prescriptions dispensed.[21]

There is a great deal of disagreement in 'expert opinion' over the effectiveness and dangers of anti-depressants.[22]

There is growing concern that some anti-depressant use is quite 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 underreporting of negative side effects, including suicide attempts and aggressive behaviour.[23] More recent media coverage gives detailed accounts of some of the harm from antidepressants including the challenges around withdrawal. [24]

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.[25] 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.[25]

More recent research suggests that other key factors such as employment status account for far more suicides than 'mental disorders'.[27]

Many men who suicide have no psychiatric history or known mental disorder.[28]

Deficits of current approach

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 about two decades.

Work has been done to provide detailed descriptions of the deficits within the current approach.[29] 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'* lists key deficits and provides detailed description of each of the listed deficits.[30]

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

There are significant shortcomings in the way suicide research is currently practiced.[31]

Knox K, (2014) Approaching Suicide as a Public Health Issue. Ann Intern Med.;161(2):151-152. doi:10.7326/M14- 0914 http://annals.org/article.aspx?articleid=1887035

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.[32]

Links to useful papers and resources:

You Can Help Publishing

https://youcanhelppublishing.com/

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

www.abs.gov.au/AUSSTATS/abs@.nsf/allprimarymainfeatures/47E19CA15036B04BCA2577570014668B?opendocument

Torrens University – Social Health Atlases

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

AIHW. Deaths by suicide over time https://www.aihw.gov.au/suicide-self-harm-monitoring/data/deaths-by-suicide-in-australia/suicide-deaths-over-time

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https://www.theage.com.au/politics/victoria/unions-urge-mps-to-ditch-appalling-workcover-bill-as-claims-soar-20231212-p5eqyx.html
From the article:
Over the past three years, Victoria has spent $1.3 billion on payouts to WorkCover to make sure it kept up with the rising cost of meeting claims and providing services. Mental health claims once made up 2 per cent of all injuries but have risen to 16 per cent and are expected to reach as much as a third of all claims.

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