

FACTS ABOUT SUICIDE

- At least 75 per cent of all suicides in Australia are men.
- Almost two thirds of men will die on their first attempt of suicide.
- Suicide in Australia, exceeds the national road toll, yet attracts little comparable publicity.
- Suicide is the number one killer of men under 44 years.
- Suicide rates in rural and remote areas are significantly greater than in urban populations, with farmers and indigenous men at high risk.
- Unemployment is a significant factor in male suicide.
- Most 'youth' suicide (15 – 24) are young men aged 20 – 24.
- Male Suicide has a significant impact on families, communities and the workplace; it is about the lonely and tragic death of much loved fathers, sons, husbands, brothers, uncles, grandfathers, and friends.
- The majority of men at greatest risk of suicide are not engaged by mental health services.

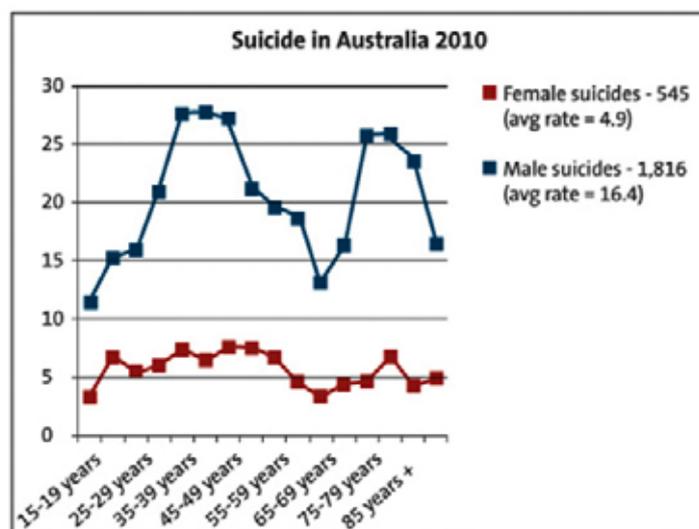


Figure 1. Male and female suicide rates per 100,000 population across age groups in 2010 (ABS, 2012)

- ✓ We need to empower key people in communities to provide support, information, and referral to other men experiencing psychological distress.
- ✓ We need to work to resolve the causes of distress (including depression) rather than merely treating the symptoms.
- ✓ Health/Mental Health Services should ensure they have an appropriate 'men-friendly' approach to working with men who may be in distress, because inappropriate interventions from services may lead to further compounding difficulties for men already in distress.
- ✓ Community based promotion, prevention and early intervention to ensure appropriate support for men, is essential.

SUICIDE IS LARGELY A MALE TRAGEDY

At least 75 per cent of all suicides in Australia are male (2,292 of 3,027 in 2015). Suicide is the cause of death with the highest gender disparity (333 male deaths for every 100 female deaths according to the Australian Bureau of Statistics, 2012).

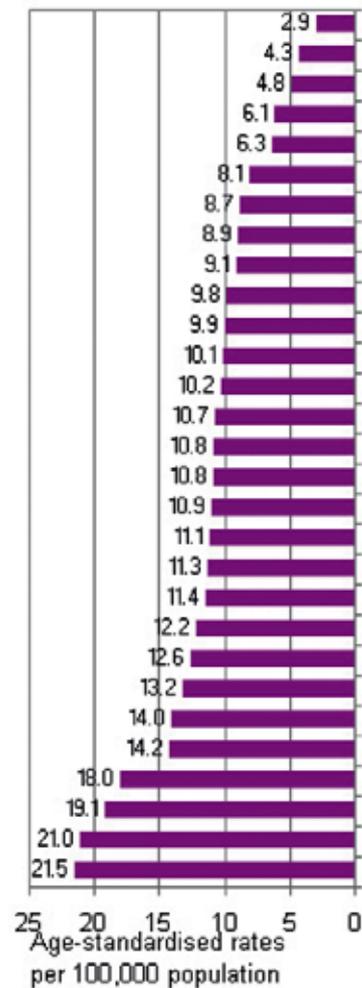
Suicide is the number one killer of men under 44 years, with the highest death rate in 2010 occurring in the 35 to 49 years age group. The next most at risk age group is 75 to 84 year old men. Though male suicide in the 15 to 24 years age group occurs at a lower rate (13.4 per 100,000) it accounts for nearly one quarter of all male deaths in this age group.

Almost two thirds of men will die on their first attempt of suicide (Isometsa, 2008).

Suicide ranks second to coronary heart disease as the cause of potential years of life lost by Australian males (Australian Institute of Health and Welfare, 2010).

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Suicide rates, total population, 2006 (or latest year available)



Suicide rates, males & females, 2006 (or latest year available)

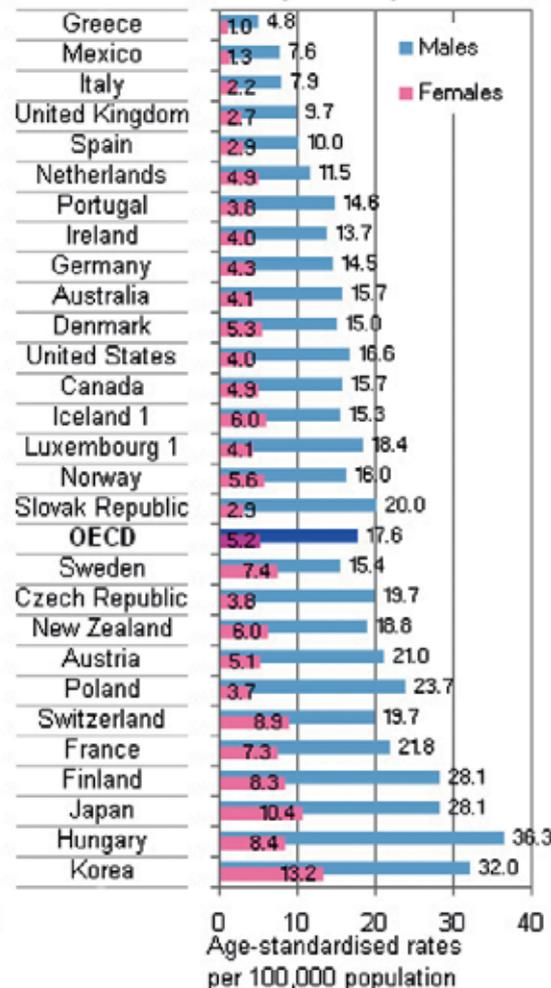


Figure 2. Suicide rates for males and females from around the world, 2009 (Organisation for Economic Cooperation).

FACTORS ASSOCIATED WITH MALE SUICIDE

If we are to understand suicide in men we must acknowledge the psycho-biological and cultural realities and demands on men's lives:

The practice of blaming men for 'holding in their emotions' and 'not seeking help', and calls for changes to the traditional male role, sounds plausible but is, at best, lazy and simplistic. It is a view that conveniently avoids dealing with the more complex issues of male suicide, and is one that is ignorant of biology, and offensively dismissive of the lived reality of most men's lives – what society expects of them, and what they must try to be to meet these expectations (Ashfield, 2010).

We must also take into consideration the range of factors associated with male suicide, including:

UNEMPLOYMENT

Unemployment (in particular, for more than six months), early retirement, or homemaker status have been found to be associated with significantly increased suicide risk, independently of categorized psychiatric diagnosis. In addition, adverse psychosocial working conditions, such as monotonous work, increased responsibility and pronounced mental strain due to contact with work clients, significantly increased suicide risk as well, again independent of categorized psychiatric diagnosis (Schneider et al., 2011).

Employment and a positive modification of working conditions, may possibly be preventive to important adverse mental health outcomes, including suicidality (Schneider et al., 2011).

Based on studies of the effects of unemployment, Gunnell, Platt and Hawton (2009) speculate that financial crises will lead to elevated levels of suicide, particularly among men.

RELATIONSHIP BREAKDOWN

Separated males, especially younger males (Cantor et al., 1995; Wyder, Ward & De Leo, 2009); men who have experienced the breakdown of a marriage or de facto relationship (Kolves, Ide and De Leo (2011), and elderly widowed or divorced males (Harwood, Hawton, Hope and Jacoby (2000), are particularly at risk of suicide.

ALCOHOL USE

High levels of alcoholic intoxication predict the use of more lethal means for suicide. Intoxication (compared with abstinence) increases suicide risk by up to 90 times. It has been suggested that all individuals with alcohol dependence or alcohol use disorders should be risk assessed for suicide (Sher, 2006). Males are more prone than females to substance use disorder (Schneider, 2009), particularly an alcohol-related disorder (Kim et al., 2003).

One major meta-analytic Canadian (Arsenault-Lapierre et al., 2004) study indicates that: On average, suicide associated substance problems (mainly alcohol) represented 41.8 % (SD 21.1 %) of the male diagnoses and 24.0 % (SD 16.5 %) of the female diagnoses ($\chi^2 7.29 p = 0.007$), whereas affective disorders represented 59.4 % (SD 13.9 %) of the female diagnoses and 47.4 % (SD 12.7 %) of the male diagnoses ($\chi^2 2.88 p = 0.089$).

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RURAL LOCATION

Men in rural and remote locations experience a higher rate of suicide than their metropolitan counterparts (Caldwell, et al., 2004). Some of the factors associated with this increased risk include: greater access to firearms, lack of appropriate support services, social isolation, problematic alcohol use, climatic variability and economic fluctuations (Page et al., 2007).

The farm suicide rate has been found to be 33.8 for men, 6.7 for women and 21.6 per 100,000 persons, much higher than the rural suicide rate for South Australia in 2001 (23.8 for men, 5.6 for women and 14.5 per 100,000 persons) according to the Australian Bureau of Statistics (Miller et al., 2008).

DIAGNOSIS OF MAJOR DEPRESSION

Males experiencing major depression are at increased risk of suicide. Males experiencing depression may tend to express it behaviourally in a different way to females (Brownhill et al., 2003 & 2005; Rutz & Rihmer, 2009).

SEXUALITY

Evidence suggests a correlation between gay men and suicide (Russell & Toomey, 2013). There is a well-established body of research showing significant variations in the prevalence and patterns of mental ill-health between gay, lesbian, bi-sexual, and trans-sexual individuals and mainstream communities (Corboz, Dowsett et al., 2008; Herek & Garnets, 2007). Research also suggests that these individuals are at increased risk of a range of mental health problems, including depression, anxiety disorders, self-harm and suicide due to their experience of discrimination and abuse (Hillier, Jones et al., 2010; Suicide Prevention Australia, 2009).

PARTICULAR CONSIDERATIONS OF MALE DEPRESSION

Much emphasis is put on depression in relation to suicide in males. However, not only is the diagnosis of depression in males a vexed question in psychology and psychiatry, it is only one of a number of correlates of suicide.

Experiencing powerlessness or psychological distress for males can also give rise to a whole range of symptoms and changes in behaviour. Commonly, men who present with a flat mood, sleep disturbance, chronic stress, exhibiting anger, feeling overwhelmed, or experiencing suicidal thoughts, are arbitrarily diagnosed with depression, when in fact they are experiencing significant powerlessness or psychological distress (evidenced by the fact that when powerlessness or distress is ameliorated, symptoms quickly resolve).

In an article on men and suicide in the Melbourne Age newspaper, Professor Ian Webster declared that, *Depression has become almost a ubiquitous expression when in fact we might be describing other things.*

<http://www.theage.com.au/articles/2006/05/14/1147545204806.html>

The term depression is itself ambiguous, because it is used to refer to a state of mood, a symptom present in many mental disorders, a syndrome measured by psychiatric rating scales (DSM and ICD), and a clinical diagnosis operationalized in

diagnostic classifications (reviewed by Lehtinen & Joukamaa, 1994). Being depressed does not necessarily equate to having a mental illness marked by distinct impairment of psychological, somatic, and social functioning (Akiskal, 2000).

Is there a strong link between depression and suicide?

In many cases there appears to be a link. However, such a link should not be immediately assumed, because there are also many cases where no such link is evident.

As Norman Swan commented in an ABC radio national interview with Helen Christensen (Executive director of the Black Dog Institute):

Norman Swan: *And of course the other myth which has really been revealed over the last few years, and your research has helped here, is that the link between suicide and depression is not as tight as some people have thought.*

Helen Christensen: *We think from the research that we're doing, looking at the trajectories of how people change in terms of depression and suicide ideation and in response to evidence-based components of what is being offered, that they are not strictly tethered.*

<http://www.abc.net.au/radionational/programs/healthreport/is-there-a-link-between-depression-and-suicide3f/4835120#transcript>

Previous suicide attempts and self-harm

Self-harming behaviour and a previous suicide attempt may be a strong predictor for suicidal behaviour (Skogman, Alsen & Ojehagen, 2004; Beghi & Rosenbaum, 2010); Suicide risk among people who self-harm are up to 200 times greater risk of suicide than the general population across the lifespan (Owens et al., 2002). Bereavement also increases the risk of suicide.

Indigenous heritage 2010 ABS data indicate that the age-standardised death rate for suicide was 2.5 times higher for Aboriginal and Torres Strait males compared to non-Indigenous males. Queensland Indigenous suicide data indicate a 2.3 times higher rate for Indigenous males (De Leo et al., 2011). Indigenous males are also at high risk of suicide contagion (Elliott-Farrelly, 2004; Hanssens, 2007).

The majority of men at greatest risk of suicide are not successfully engaged by mental health services

Most suicide victims who see their GP prior to death (even on the day of their death) present solely with physical complaints (Aus & NZ J Psychiatry., 2006).

In a study by Caldwell, et al., (2004) although the proportion of young men reporting mental health disorders did not differ significantly between rural (23.5%; z, -0.5) and remote (18.8%; z, -1.6) areas compared with metropolitan (25.6%) areas, young men with a mental health disorder from non-metropolitan areas were significantly less likely than those from metropolitan areas to seek professional help for a mental health disorder (11.4% v 25.2%; z, -2.2).

The 'Men-friendly' approach?

'To improve men's mental health (it will be necessary to) focus on education, employment and providing services that men want to use.' Australian of the year 2010, Professor Patrick McGorry. **Building on the strengths' of men is not just a slogan; it reflects a profound shift in many providers' attitudes. When**

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practitioners are conscious of the need to be male friendly, the impact is very noticeable. Professor John Macdonald **Men are much more likely to access help if it's not branded as mental health or counselling.** [Federal Government – LIFE living is for everyone Suicide Prevention Fact Sheet 17 Suicide and men]

Effective Prevention

Shortcomings of the current 'mental health' approach

A recent Australian report for *Advances in Mental Health* on stakeholder's views on suicide prevention concluded that, 'Most saw limited value in continuing to explore individual-level risk factors ad infinitum, and felt that the time had come to move on to considering wider societal influences on suicide and individual-level protective factors'.

A study on the psychological autopsies in suicide published in the *informahealth* Journal of Mental Health concludes, 'A predominately medicalised view of suicide may prevent the

adequate consideration of influences other than diagnosis which may have more importance in analytical and practical terms for prevention and policy in the area of suicide'

An article from *World Psychiatry*, the Official Journal of the World Psychiatric Association declares that, 'Although antidepressants may be effective in the treatment of depressive symptoms, the current evidence does not suggest that they have an effect in reducing the risk of suicide attempts or completions. Antidepressants do not address the variety of psychosocial factors that are strongly related to suicide and depression'. In a more general sense, the effectiveness of any suicide prevention work that focuses on 'mental health' to the exclusion of social factors is further reduced by the reliance on terminology that is clouded with ambiguity and confusion.

www.swytch.org.au/your-stories-1/suicide-prevention-taking-a-new-approach

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