



SUBMISSION ON VICTORIA'S SUICIDE PREVENTION AND RESPONSE STRATEGY

August 2022

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About

Turning Point is a national addiction treatment centre, dedicated to providing high quality, evidence-based treatment to people adversely affected by alcohol, drugs, and gambling, integrated with world-leading research and education. Turning Point is auspiced by Eastern Health and is formally affiliated with Monash University. Turning Point reduces the harms caused by alcohol, drugs and gambling and promotes recovery through integrated activity that: increases access to support and evidence-based practice using innovative technologies; delivers high quality evidence-based practice and supports health care professionals nationally and internationally to do the same; educates and trains the workforce to deliver programs to a broad range of populations; and underpins policy and practice relevant research and the provision of key national population level data that informs expert comment and policy advice to state and federal governments.

The **Monash Addiction Research Centre (MARC)** brings together world-leading expertise from across Monash University and the sector to provide solutions to the challenges of addiction. MARC draws on the multidisciplinary strengths and capabilities of researchers across the University to develop and test novel, scalable prevention and treatment approaches. MARC's mission is to provide national solutions to addiction, leveraging expertise in basic and social science, clinical, and epidemiological research to develop new knowledge to shape government policy and evidence-based approaches.

1. Summary of recommendations

Turning Point and MARC welcome the opportunity to contribute to Victoria's *Suicide Prevention and Response Strategy*. This submission makes the following recommendations:

1. Include “people experiencing alcohol, other drug, or gambling harms or addiction” as one of the Strategy’s priority groups.
2. Ensure investment in addiction treatment services is sufficient to support treatment demand and put downward pressure on suicide rates.
3. Develop and implement effective training for healthcare providers at all levels of care so that they can identify and appropriately respond to people experiencing alcohol, other drug, or gambling harms or addiction and suicidality.
4. Develop and implement a best practice suicide prevention model of care for alcohol and other drug and gambling helplines in collaboration with service users, providers, and experts, and upskill the helpline workforce through national, online, skills-based training.
5. Scale successful campaigns that tackle addiction-related stigma to promote help-seeking and put downward pressure on suicide rates.
6. Develop, research, test, and evaluate a suite of suicide prevention initiatives tailored to people experiencing alcohol, other drug, or gambling harms or addiction.
7. Review existing data collection and assessment in relation to suicide investigations to determine ways it could be improved to provide a clearer picture of addiction-related suicide numbers.

2. Background

Alcohol, other drug, and gambling harm has to date been notably absent from suicide prevention strategies,¹ so it is a welcome development that the discussion paper for this Strategy has identified people living with substance use or addiction as a priority group. Importantly, while often thought about only in relation to alcohol and other drugs, we support the inclusion of gambling and recommend that the Strategy includes “people experiencing alcohol, other drug, or gambling harms or addiction” as a priority group.

¹ Katrina Witt and Dan Lubman, ‘Effective Suicide Prevention: Where is the Discussion on Alcohol?’ (2018) 52(6) *Australian & New Zealand Journal of Psychiatry* 507, 507.

People experiencing substance use disorders are at an increased risk of suicidal ideation, suicide attempts, and suicide.² Alcohol use and alcohol-related harm is a significant risk factor for suicide. Alcohol dependence is the second most common psychiatric diagnosis (after depression), and one quarter to one third of people who die by suicide meet diagnostic criteria for alcohol use disorder.³ Alcohol consumption increased significantly in response to COVID pandemic related stressors and has remained well above the pre-pandemic average ever since.⁴ Alcohol consumption has been further fuelled in Victoria by the loosening of liquor licensing regulations that have allowed contactless, on demand alcohol delivery to occur at extended hours. Early indications are that these delivery services ignore safeguards in legislation, allowing people to receive alcohol deliveries while intoxicated and without having to provide ID.⁵ This increased consumption corresponded with a surge in alcohol-related harms, with 70% of Victoria's alcohol and other drug services reporting increased severity and prevalence of alcohol-related presentations during the pandemic, and notably, this included many who had never previously engaged in treatment.⁶

This reflects, in part, the fact that while we are unlikely to return to disruptive lockdowns, the pandemic is not over and its effects will be long lasting. This sustained rise in alcohol consumption is of enormous concern because it risks further increases in alcohol harms, addiction, and related suicide. Other drug use also plays a significant role in suicides, especially those caused by overdose. Prescription opioids are implicated in many overdose deaths and are motivated by a desire to escape from physical or emotional pain.⁷ In the United States, 39% of people who presented to an emergency department after overdosing on opioids or sedatives reported either that they wanted to die, or simply did not care about the risk of dying, and another 15% were unsure of their intentions.⁸ Similarly, Australian paramedics attending to people experiencing acute harms related to prescription opioids found that most cases were associated with attempts to cope with psychological distress, physical pain, social stressors, or suicidal thoughts.⁹ Ambulance attendances

² Jalal Poorolajal et al, 'Substance Use Disorder and Risk of Suicidal Ideation, Suicide Attempt and Suicide Death: A Meta-Analysis' (2016) 38(3) *Journal of Public Health* 282, 286.

³ Witt and Lubman (n 1).

⁴ e61 Institute, 'Consumer Spend Tracker' *Australian Real-Time Consumer Spending* (Graph, 26 June 2022) <<https://www.e61.in/spendtracker>>.

⁵ 'On-Demand Alcohol Delivery Services and Risky Drinking' *VicHealth* (Research Report, 5 June 2020) <<https://www.vichealth.vic.gov.au/media-and-resources/publications/alcohol-delivery-risky-drinking>>.

⁶ Victorian Alcohol and Drug Association (VAADA), *Equitable Access to Alcohol and Other Drug Treatment For All Victorians* (Election Statement, 30 May 2022) 10 <https://www.vaada.org.au/wp-content/uploads/2022/05/SUB_VAADA-election-statement_12042022.pdf>.

⁷ Dan Lubman, Suzanne Nielsen and Debbie Scott, 'The Uncomfortable Truth About Drug Overdose and Suicide', *Monash Lens* (Research Article, 29 August 2020) <<https://lens.monash.edu/@dan-lubman/2020/08/29/1381165/uncomfortable-truth-about-drug-overdose-and-suicide>>.

⁸ Amy Bohnert et al, 'Overdose and Adverse Drug Event Experiences Among Adult Patients in the Emergency Department', (2018) 86 (November) *Addictive Behaviors* 66, 70.

⁹ James Wilson et al, 'Extreme Personal Stress' and 'a Lot of Pain': Exploring the Physical, Mental and Social Contexts of Extramedical Pharmaceutical Opioid Use in Australian Paramedic Case Descriptions' (2020) 39(7) *Drug and Alcohol Review* 870, 872.

attributed to opioids were also brought on by financial distress, a phenomenon referred to as “deaths of despair,” where poisoning and suicide are linked to economic insecurity and stress.¹⁰

The main motivation behind many people’s substance use and related suicide is to medicate distress so that unwanted feelings go away, regardless of the harms.¹¹ There's currently no clear strategy to prevent these deaths because they don't fall under existing responses for unintentional overdose, and they're not being targeted by current suicide prevention strategies and funding.¹² Likewise, people living with gambling addiction are three to six times more likely than the general population to experience suicidality, with almost one in five considering suicide in the last twelve months.¹³ Indeed, an inquiry held by the Productivity Commission in 1999 found between 35 and 60 Australians who experienced gambling harm died by suicide and another 2900 attempted suicide every year.¹⁴ Given such stark findings, it is surprising that little research has been done to better understand gambling related suicides since.

In addition to the significant human cost measured in lives lost to addiction-related suicide, there are also significant social and economic costs. For example, alcohol-related harms including illness and lost productivity cost Australia more than \$66.8 billion every year.¹⁵ Additionally, Victorians lost \$5.5 billion dollars to gambling in the 2018–19 financial year¹⁶ and a staggering \$66 billion to poker machines alone in the 30 years since they became widely available.¹⁷

3. Improving suicide prevention responses

Co-occurring conditions and gambling must be considered

At least one third of people living with alcohol or other drug use disorders,¹⁸ and between 70–90% of those currently being treated for these conditions, have at least one co-occurring mental health disorder.¹⁹ Poor mental health and compounding risk factors are inherently related to increased

¹⁰ Lubman, Nielsen and Scott (n 7).

¹¹ Ibid.

¹² Ibid.

¹³ Heather Wardle et al, Problem Gambling and Suicidal Thoughts, Suicide Attempts and Non-Suicidal Self-Harm in England: Evidence From the Adult Psychiatric Morbidity Survey 2007 (Report, No 2.1, 17 May 2019) 31.

¹⁴ Productivity Commission, *Australia’s Gambling Industries* (Inquiry Report, No 10, 26 November 1999) 26 <<https://www.pc.gov.au/inquiries/completed/gambling/report>>.

¹⁵ Steve Whetton et al, *Examining the Social and Economic Costs of Alcohol Use in Australia: 2017/18* (Report, 16 December 2021) vii <<https://apo.org.au/node/315745>>.

¹⁶ ‘Gambling in Australia’, *Australian Institute of Health and Welfare* (Topic Summary, 16 September 2021) <<https://www.aihw.gov.au/reports/australias-welfare/gambling>>.

¹⁷ Chloe Booker, ‘Victorians Have Gambled – and Lost – \$66 Billion on Pokies in 30 Years’ *The Age* (online, 17 July 2022) <<https://www.theage.com.au/national/victoria/victorians-have-gambled-and-lost-66-billion-on-pokies-in-30-years-20220714-p5b10e.html>>.

¹⁸ Tim Slade et al, ‘2007 National Survey of Mental Health and Wellbeing: Methods and Key Findings’ (2009) 43(7) *Australian and New Zealand Journal of Psychiatry* 594, 599.

¹⁹ Mark Deady et al, *One Person, Diverse Needs: Living With Mental Health and Alcohol and Drug Difficulties* (Report, 2013) 3 <<https://www.mentalhealthcommission.gov.au/getmedia/8bff246f-4ffd-4eda-9716-db8c19d8d01b/One-person-diverseneeds-Living-with-a-mental-illness-as-well-as-the-challenges-from-difficulties-with-alcohol-and-drugs-use>>.

suicide risk, so people experiencing co-occurring addiction and mental health conditions are a cohort who require focused attention and tailored prevention and response options.

Our response to suicide must also address gambling harms and addiction. Two known risk factors contributing to suicidality – financial distress and relationship breakdown – are often seen in cases of gambling disorder and are directly caused by it. Likewise, protective factors for suicide such as social support, employment, and physical health are also often compromised by a person’s gambling disorder.²⁰ Treatment services for gambling disorders need to be bolstered and wraparound support including financial counselling made readily available.

Greater investment in treatment services and research will reduce suicides

One in four Australians will struggle with alcohol, other drugs, or gambling in their lifetime.²¹ While some 200,000 Australians are currently in treatment for substance use or addiction, roughly 500,000 cannot access the treatment they need and deserve.²² This large unmet treatment demand inevitably underpins suicide statistics, which are greater than they otherwise would be if treatment demand were being met. Investment in addiction treatment services should be sufficient to enable them to meet demand in a timely way.

There is a limited evidence base on effective suicide prevention responses that target people experiencing alcohol, other drug, or gambling harms or addiction, and many current responses to suicide prevention, including Hospital Outreach Post-Suicidal Engagement (HOPE) services, frequently exclude people if they have a co-occurring addiction. Indeed, while the relationship between alcohol and other drug use and suicidal behaviour is robust, and alcohol is commonly involved in suicidal presentations, individuals experiencing alcohol and other drug issues are typically excluded from randomised controlled trials of novel interventions for the prevention of self-harm and/or suicide.²³ The exclusion of these participants from intervention research to date has therefore resulted in a systematic blindness to addressing alcohol, other drugs, or gambling as a core component of suicide prevention efforts. We must invest in research to test and evaluate suicide prevention strategies that specifically target this priority group and use the findings from this work to inform service design and delivery.

²⁰ Suicide Prevention Australia and Financial Counselling Australia, *Gambling and Suicide Prevention: A Roadmap to Reduce Harm* (Report, 9 September 2022) 3, 14 <https://www.suicidepreventionaust.org/wp-content/uploads/2022/02/Gambling-Report_2022.pdf>.

²¹ Timothy Slade et al, *The Mental Health of Australians - Report on the 2007 National Survey of Mental Health and Wellbeing* (Report, No 2, 2014) 5 <https://www.researchgate.net/publication/236611613_The_Mental_Health_of_Australians_2_Report_on_the_2007_National_Survey_of_Mental_Health_and_Wellbeing>.

²² Alison Ritter, Jenny Chalmers and Maria Gomez, ‘Measuring Unmet Demand for Alcohol and Other Drug Treatment: The Application of an Australian Population-Based Planning Model’ [2019] (18) *Journal of Studies on Alcohol and Drugs, Supplement* 42, 46.

²³ Witt and Lubman (n 1).

Tailored suicide prevention responses from better trained professionals are needed

Men comprise 75% of suicide deaths²⁴ and are more likely than women to experience harms related to alcohol and other drugs.²⁵ Understanding the complexities in the way men in particular present for treatment is important. For example, men experiencing depression and at risk of suicide are less likely to report classical symptoms of depression and more likely to report alcohol-related harm.²⁶ This means that when men seek help, they are usually referred to alcohol and other drug (AOD) services rather than mental health services. This is one of the reasons AOD services must be capable of identifying people at risk of suicide, delivering effective prevention and intervention strategies, and providing efficient and supportive referral pathways between AOD and mental health services.²⁷

There is also a need to improve the responses of other healthcare providers so that they better identify and respond to patients who present with substance use, gambling or addiction and co-occurring mental health conditions. For example, more than half of paramedics are not able to recognise affective disorders like depression, and identification becomes even more difficult when alcohol and other drug use is also present.²⁸ Patients of ambulance services have also reported feeling that they weren't taken seriously or treated with empathy and compassion by paramedics when their mental health conditions also involved substance use.²⁹ This behaviour may be driven by stigma, which is heightened when alcohol and other drug use is involved³⁰ and is especially prevalent in suicidal patients' experiences with emergency department staff.³¹

When people struggling with addiction and suicidality have negative experiences like these, it leaves them feeling stigmatised and misunderstood, which is often all it takes to cause further delays in future help-seeking.³² Improving the way paramedics, general practitioners, and emergency department staff treat people who present with co-occurring addiction and mental health conditions is essential to promote help-seeking and drive down suicide attempts and deaths. More training is needed across the board to ensure healthcare professionals who are frequently in contact with

²⁴ Joanne Simon-Davies, 'International Men's Health Week', *Parliament of Australia* (Blog Post, 14 June 2019) <https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/FlagPost/2019/June/Mens_health>.

²⁵ Nyssa Ferguson et al, "'I Was Worried if I Don't Have a Broken Leg They Might Not Take It Seriously'": Experiences of Men Accessing Ambulance Services For Mental Health and/or Alcohol and Other Drug Problems' (2019) 22(3) *Health Expectations* 565, 565.

²⁶ Anna Cavanagh et al, 'Differences in the Expression of Symptoms in Men Versus Women with Depression: A Systematic Review and Meta-Analysis' (2017) 25(1) *Harvard Review of Psychiatry* 29, 33.

²⁷ Witt and Lubman (n 1) 508.

²⁸ Terence McCann et al, 'Recognition of, and Attitudes Towards, People With Depression and Psychosis With/Without Alcohol and Other Drug Problems: Results From a National Survey of Australian Paramedics' (2018) 8(12) *BMJ Open* 1, 5.

²⁹ Ferguson et al (n 25) 569.

³⁰ McCann et al (n 28).

³¹ Laura Frey, Jason Hans and Julie Cerel, 'Perceptions of Suicide Stigma: How Do Social Networks and Treatment Providers Compare?' (2015) 37(2) *Crisis* 95, 98.

³² Monash University, 'Living Labs: New Research Findings Show Stigma Around Alcohol and Other Drugs Harms a Major Barrier For Patients in Their Care Journey Towards Ageing Well' *Medicine, Nursing and Health Sciences* (News Post, 29 May 2022) <<https://www.monash.edu/medicine/news/latest/2022-articles/Living-Labs-New-research-findings-show-stigma-around-alcohol-and-other-drugs-harms-a-major-barrier-for-patients-in-their-care-journey-towards-ageing-well>>.

people experiencing alcohol, other drug, or gambling harms or addiction and suicidality can identify these conditions and provide high quality, non-judgemental, and potentially life-saving care.

A model of care for addiction-related helpline calls will help prevent suicide

Turning Point has been delivering AOD and gambling helpline services for almost two decades, responding to more than 100,000 helpline calls each year, with around one-third of callers at risk of suicidal behaviour. Its 24/7 helplines include two national online counselling services, Counselling Online and Gambling Help Online, as well as state-based helplines in six jurisdictions. The helplines receive calls from across Australia, including regional and remote areas, with most calls received outside of business hours, when suicide risk is higher. Most callers are also new to treatment and have few other existing supports or care options, meaning they are at increased risk of suicide.

Helplines are ideally placed to provide 24/7 support and care to Australians who present in crisis and with increased suicidal risk related to substance use or gambling, with the added benefit of being able to overcome stigma and geography as barriers to help seeking. Despite this, there is currently no evidence-base or established model of care in Australia to inform best practice responses and address suicidal behaviour in people contacting AOD and gambling helplines. This means that while AOD and gambling helpline counsellors are skilled in delivering addiction care, their ability to provide best practice suicide prevention in helpline settings is limited, resulting in missed opportunities to effectively intervene.

Likewise, crisis support helplines who often engage with suicidal clients do not undergo specialised training in responding to substance use or gambling, and financial counselling helpline staff are not always trained to ask about suicide. As a result, many callers experiencing AOD or gambling harms who are also suicidal are bounced between helplines. This is an issue when people are struggling with both addiction and poor mental health, as constant referrals for separate issues which are closely related can cause people to fall into a cycle of ongoing disjointed care and disengagement from help-seeking altogether.³³

There is a need to develop and implement a best practice suicide prevention model of care for AOD and gambling helplines in collaboration with service users, providers, and experts. We must also upskill the helpline workforce through development of national, online skills-based training. Taken together, these measures will increase the capacity of helplines to prevent and respond to suicidal behaviour related to alcohol, other drug or gambling harms, or addiction.

³³ *Gambling and Suicide Prevention* (n 20) 8.

4. Tackling stigma is essential

Under-resourced addiction services are not the only reason Australians aren't accessing treatment. Stigma remains an enormous barrier to help-seeking, with many waiting years, even decades, before seeking help for their struggles with alcohol, other drugs, or gambling. The median time to first treatment for alcohol dependence, for example, is an astonishing 18 years.³⁴ Stigma and shame associated with addiction are also detrimental to mental health and this contributes to suicidal ideation.

Addiction is only one part of someone's story. Scaling successful anti-stigma campaigns, such as those led by Beyond Blue for depression and anxiety, and the current Rethink Addiction campaign for alcohol, other drug, and gambling harms, can tell the real stories of addiction and break down stigma, and change negative public attitudes of addiction that limit help-seeking. By tackling stigma and treating addiction like any other chronic health condition, we can promote help-seeking and treatment adherence, thereby reducing the risk of suicide. We also know that when people seek help earlier, they are easier and more cost effective to treat.

5. Addiction-related suicides are grossly underestimated

Drug-related suicides are likely significantly underestimated because the coding systems used to provide these official statistics, like the International Classification of Diseases, can only classify deaths as intentional if there is strong evidence of suicidal intent. However, many overdoses and fatal overdoses fall into a grey area where a clear intent to die is either absent or uncertain, or the person using drugs is simply indifferent about whether they live or die. The coding system has no way to quantify this ambivalence and the death is consequently coded as unintentional.³⁵

As fatal overdoses that are coded as unintentional are not considered by state or national suicide prevention strategies, there is no clear plan or resourcing to prevent these deaths. We need to research and develop a suite of interventions that address the underlying drivers of overdose, regardless of intent. Preventing fatal overdoses should have the same aspirational target of zero deaths that we currently see for suicide.

Gambling-related suicides are likewise underestimated. Most investigations by police conducted on behalf of the coroner gather information from family and friends to determine possible factors

³⁴ Chapman et al, 'Delay to First Treatment Contact for Alcohol Use Disorder' (2015) 147 (February) *Drug and Alcohol Dependence* 116, 118.

³⁵ Lubman, Nielsen and Scott (n 7).

influencing a person's death. However, families are often unaware of the deceased's gambling because many hide their addiction, so police might never uncover this information.³⁶ Coronial investigations often examine health records to identify substance use as a contributing factor to suicide, and it would be similarly informative to examine bank or gambling records to determine if a person's spending was indicative of gambling harms that could be related to their suicide.³⁷

6. The path forward

The Strategy should include “people experiencing alcohol, other drug, or gambling harms or addiction” as a priority group and outline concrete actions that will be taken to address addiction-related suicide. Such actions should include investment in research on suicide prevention responses targeted to this priority group, increased investment in addiction treatment services, and public education initiatives that tackle stigma such as the Rethink Addiction campaign. We must also review and improve processes to better gather and assess data to determine the true extent of addiction-related suicide, and to guide suicide prevention strategies and clinical responses related to addiction.³⁸

³⁶ *Gambling and Suicide Prevention* (n 20) 11.

³⁷ *Ibid* 27.

³⁸ Lubman, Nielsen and Scott (n 7).