ANZJP

Australian & New Zealand Journal of Psychiatry
1–2
DOI: 10.1177/0004867418774415

Effective suicide prevention: Where is the discussion on alcohol?

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Suicide claims the lives of more than 2800 Australians each year and is the leading cause of death for Australians between 15 and 44 years. Importantly, the risk of suicidal behaviour is particularly elevated in those diagnosed with a substance use disorder. Globally, substance use disorders were responsible for almost one-fifth of suicide-related disability-adjusted life years in 2010, with 13.3% of this burden attributable to alcohol use disorders alone (Ferrari et al., 2014). Alcohol increases suicidal behaviour through multiple mechanisms. First, as a central nervous system depressant, alcohol intoxication can increase impulsiveness and psychological distress, known risk factors for suicidal behaviour, while alcohol dependence is associated with a depressive syndrome that resembles major depression. Alcohol dependence can also impact work and relationships, reducing social connection and support, and can result in frontal executive dysfunction, which, in turn, may inhibit problem-solving ability and future orientation; all further risk factors for suicide. Although research consistently estimates that between one-quarter to one-third of suicide decedents meet diagnostic criteria for alcohol use disorder, there has been little conversation regarding the potential value of policies aimed at reducing alcohol availability as a way of further reducing the suicide rate in Australia.

The *National Suicide Prevention Strategy* (*NSPS*), first introduced in 1999, formalised and coordinated suicide prevention activities, as well as provided for greater funding and investment in suicide prevention research. While Australia observed a decline in the suicide rate following the introduction of the NSPS, this was principally related to efforts to reduce access to highly lethal means, such as firearms (Large and Nielssen, 2010). Complementing the NSPS, most states and territories also outline their own responses. Queensland, the Northern Territory, South Australia, Tasmania, Victoria and Western Australia, for example, all have current suicide prevention strategies that outline a number of initiatives to build capacity within community-based organisations, to improve the timely provision of mental health treatment for those presenting to clinical services and to improve aftercare and follow-up services through greater investment in evidence-based treatments. Yet despite the increased risk of suicidal behaviour in those diagnosed with a substance use disorder, specific suicide prevention strategies focusing on individuals with alcohol or other drug use disorders remain notably absent.

Overlaying both the NSPS and each individual state and territory's suicide prevention strategy are a number of evidence-based clinical practice guidelines that provide recommendations for prevention and intervention activities. The recently updated Royal Australian and New Zealand College of Psychiatrists' *Clinical Practice Guidelines for the Management of Deliberate Self-Harm*, for example, recognises that those who engage in non-fatal self-harm are at increased risk of suicide (Carter et al., 2016). These guidelines therefore recommend greater investment in the treatment and management of persons presenting to clinical services following an episode of self-harm through the provision of psychosocial risk/needs assessments to better identify patients' treatment needs which, in turn, will assist with the development of appropriate evidence-based treatment and management plans that target modifiable risk and/or protective factors to reduce self-harm repetition and suicide. However, specific recommendations on the management of substance use disorders in this population remain absent from these guidelines.

Furthermore, while the relationship between alcohol and other drug use and suicidal behaviour is robust, and alcohol is commonly involved in suicidal presentations, individuals with alcohol and other drug use problems are typically excluded from randomised controlled trials of novel interventions for the prevention of self-harm and/or suicide. For example, while there is strong evidence for the effectiveness of cognitive behavioural therapy in reducing the proportion of patients engaging in a repeat episode of self-harm, around one-third of the trials included in a recent Cochrane review specifically excluded participants intoxicated with alcohol and/or

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drugs and/or diagnosed with substance dependence. The exclusion of these participants from intervention research to date has therefore resulted in a systematic blindness to addressing alcohol use as a core component of suicide prevention efforts.

Individuals with alcohol and other substance use disorders are therefore infrequently identified as an important 'at risk' group, despite the fact that alcohol dependence in particular has been consistently identified as the second most common psychiatric diagnosis behind depression as a precipitating factor for suicide. This is particularly relevant in the context of male suicide, given that men are less likely to seek help for suicidal ideation and/or behaviours until they reach a crisis point. Males with depression, for example, are more likely to report problems with alcohol use, whereas females are more likely to report 'classical' symptoms of depression (Cavanagh et al., 2017). Therefore, when males do seek help, given their focus on alcohol, they are more likely to be referred for alcohol and drug treatment in the first instance. It is therefore important that alcohol and other drug services are adequately skilled to identify individuals at risk of suicide, appropriate prevention and intervention strategies are sufficiently resourced within these settings, and effective partnerships are in place with local mental health providers to provide support and referral pathways.

While the development of clinical resources and interventions has undoubtedly strengthened suicide prevention efforts, the focus of many current strategies remain on those already in contact with mental health services. However, given that only around one-third of suicide decedents were in contact with mental health services in the year preceding their death, other public health initiatives are required to meaningfully reduce suicide rates. At the population level, rates and patterns of alcohol consumption have been consistently associated with suicide rates across a number of countries, particularly for males. Data from a number of eastern European countries suggest increasing per capita alcohol consumption is associated with an increase in overall suicide rates, with the proportion of suicides attributable to alcohol as high as 66.4% in countries that predominately consume spirits and 34.5% in countries that predominately consume non-spirits-based alcoholic beverages (Landberg, 2008). Such findings highlight the need for a more robust public discussion about the relationship between alcohol and suicide in Australia and that, similar to the current community conversations concerning the link between alcohol and cancer, future suicide prevention strategies must advocate for policies that effectively reduce alcohol consumption, such as increasing the price of alcohol through taxation and limiting marketing and promotion.

The limited attention paid to alcohol and other drug use in current suicide prevention strategies probably reflects the challenging political environment related to the implementation of effective public policy responses to reduce alcohol-related harms across the community, as well as the separation of alcohol and drug prevention, research and treatment from the mental health field in Australia over the past 25 years. Stigma, in the form of personal and organisational beliefs that both alcohol and drug use and suicidality are self-inflicted and are therefore less worthy of appropriate treatment and management than physical health complaints, also likely plays a role. In addition, there has been little research seeking to estimate the burden of intentional injury and death related to suicidal behaviour attributable to alcohol. Together, these factors contribute to the apparent discounting of alcohol in suicide policy. As such, if meaningful reductions in Australia's suicide rate remain a national priority, this can only be achieved when initiatives acknowledge the role of alcohol in suicidal behaviour, and all relevant at risk populations are targeted.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship and/or publication of this article.

Research Ethics and Patient Consent

The information presented in this paper was obtained from previously published reports available within the public domain. Specific institutional, ethics approach and informed consent were therefore not required for this paper.

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