Foundation for Alcohol Research & Education

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Ms Bailey Nation-Ingle
State Suicide Prevention and Response Adviser
Mental Health and Wellbeing Division
Department of Health
50 Lonsdale St Melbourne, 3000 Victoria
suicide.prevention@health.vic.gov.au

Dear Ms Nation-Ingle,

Re. Discussion paper for the Victorian suicide prevention and response strategy

Thank you for the opportunity to provide a submission on the Discussion paper for the Victorian suicide prevention response strategy. We welcome the development of a suicide prevention strategy for Victoria.

The Foundation for Alcohol Research and Education (FARE) is the leading not-for-profit organisation working towards an Australia free from alcohol harms. We approach this through developing evidence-informed policy, enabling people-powered advocacy and delivering health promotion programs. FARE has been working with communities across the country to improve the health and wellbeing of Australians for 20 years.

FARE acknowledges the strengths of people living with mental illness and those experiencing psychological distress, their families, carers and supporters, and people working in the mental health and alcohol and other drugs (AOD) sectors. This includes people exposed to and impacted by suicide. Further action is needed to prevent suicide, with data showing there has been no meaningful improvement in Victoria's suicide rate over the 10 years to 2019.[1]

Suicide is complex, with multiple, inter-related contributing risk factors, including the use of alcohol and other substances. Alcohol has a clear association with the risk of suicidality, and the role of alcohol in suicidality interacts with other risk factors.[2] Alcohol is the second leading risk factor among males aged 15 and over for suicide, responsible for 17 per cent of the burden of suicide and self-inflicted injuries among males aged 15 years and over in 2019.[3]

Between 2010 and 2015, more than 26 per cent of suicide deaths in Australia had a blood alcohol concentration (BAC) above 0.05 g/100 mL.[4] Alcohol use is associated with 65 per cent increased risk of suicidality.[5] Research in the United States also found that the risk of death by suicide was increased over 30 times for people with multiple AOD use disorders.[6]

There are also strong associations between risky or dependent alcohol use and mental illnesses, such as depression and anxiety.[7] Stress can lead to the onset and maintenance of risky alcohol use, and alcohol can also be used to attempt to manage anxiety. People are more likely to have increased alcohol use if they had more severe symptoms of depression or anxiety.[8] There is also evidence of associations between depressive and anxiety symptoms and increased alcohol use during the COVID-19 pandemic in Australia[9] and in New Zealand.[10]

Recently released data shows that in 2020-21, only 5.5 per cent of people thought to modify their alcohol use to improve their mental health, compared with over 90 per cent who did activities with

family or friends, or who got support from family and friends.[11] This points to a need for raising awareness in the community about the link between alcohol and mental health.

This submission addresses some of the questions in the consultation paper. Text that is italicised reflects the questions in the consultation paper verbatim.

Question 1 Vision. *The Royal Commission suggested 'towards zero suicides' as a vision for the strategy. Is this appropriate?*

FARE supports this is an appropriate vision. This strongly corresponds to FARE's vision, which is '*An Australia free from alcohol harms'*.

Question 2 Priority Groups. *In the discussion paper we have listed a series of groups that may need a greater focus in the strategy. Is this list appropriate?*

FARE supports the Priority Groups listed, especially people experiencing discrimination and stigma such as Aboriginal and Torres Strait Islander peoples, people with disability, people living with mental illness, risky alcohol use and dependency, and other people experiencing harm from alcohol.

Internationally, alcohol use disorders are the second most common psychiatric disorder in people who die by suicide, after mood disorders.[12] As mentioned above, in Australia, alcohol is the second leading risk factor for suicide and self-inflicted injury among males aged 15 and over. The second leading risk factor for females 15 years and over is intimate family violence, of which alcohol increases the frequency and severity.[13] These priority groups will not always be contactable through formal service delivery pathways, (only half of those who die by suicide in Australia each year have previously accessed mental health services).[14] This means developing informal networks of people with lived experience and supporting community-led initiatives in order to better engage with hard-to-reach people.

Question 3 Priority Areas. *What priority areas should be included in the strategy to create the greatest impact and help us achieve our vision?*

FARE supports the Priority Areas listed in the discussion paper, especially lived experience partnerships. FARE has been working with people with lived experience of alcohol harm, including people impacted by Fetal Alcohol Spectrum Disorder (FASD), Domestic and Family Violence (DFV), and risky AOD use. Genuine co-production involves the self-determination of program design and decision-making, not just advisory oversight.

Question 4 Principles. *What principles should guide the development and implementation of the strategy?*

FARE supports the principles listed in the discussion paper. We would also suggest adding principles focusing on:

- Factors contributing to increased risk of suicide (including alcohol).
- Social and commercial determinants of mental health and wellbeing, that include addressing harm from alcohol use.
- Adopting a preventive health approach to suicide prevention (in addition to a responsive approach).
- Awareness-raising about links between alcohol and suicide and poor mental health.

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Question 5a Initiatives. *In addition to the Royal Commission's recommended initiatives, what other initiatives should be included in the strategy?*

FARE suggests that the strategy include the following:

Reduce Harm from Alcohol. There is extensive evidence linking increased per capita alcohol use with increased suicide.[15,16] Evidence suggests that alcohol harm reduction policies may contribute to suicide prevention, and to a reduction of alcohol involvement among suicide deaths. As part of a comprehensive approach to suicide prevention, alcohol policies (such as regulating price, promotion and availability) should be adopted.[17]

Adequately fund AOD services. Increased investment is needed in AOD treatment and harm reduction services. A 2019 study into unmet demand for AOD services in Australia showed that between 26.8 per cent and 56.4 per cent of those in need of treatment accessed it. This translates to a demand gap of 43.6 to 73.2 per cent, or 180,000 to 553,000 people nationally.[18] Research also demonstrates that for every dollar invested in treatment services, more than $7 is returned to the community through health and social benefits.[19,20] The Victorian government needs to prioritise implementation of the shared government commitments on AOD outlined in the National Agreement on Mental Health and Suicide Prevention, including integrating alcohol and other drug services and mental health and suicide prevention services.[21]

Question 5b Stigma. *What opportunities should be created for the Victorian community to be part of the change to reduce the stigma associated with suicide, increase understanding and awareness, and prevent suicide?*

FARE acknowledges that stigma is a common experience for people experiencing mental ill health and people with AOD use disorders. It is often quite pervasive, creating barriers to accessing support. Stigma and discrimination can occur in social settings, healthcare, welfare, support services, criminal justice and employment. Stigma can be reduced for people seeking support for their alcohol and other drug use by:

- Delivering anti-stigma training and resources to improve awareness in services.
- Portraying people positively in the media as everyday human beings, to promote hope, not fear.
- Engaging with people with lived experience to 'co-produce' policies, programs and services.
- Funding AOD services adequately to provide more equitable access.
- Changing the justice system to treat AOD problems as health problems not justice problems.
- Using non-stigmatising language to acknowledge social and commercial determinants of health.
- Increasing community-led support for families affected by suicide.

Thank you for the opportunity to provide a submission to this review. We would welcome further discussion with you during the next stage of the consultation process.

Yours sincerely,

CATERINA GIORGI

CHIEF EXECUTIVE OFFICER

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