Eating Disorders Victoria

The Victorian Suicide Prevention and Response Strategy

Support services

Adults Lifeline 13 11 14 | Suicide Call Back Service 1300 659 467 | Beyond Blue 1300 224 636

Youth Kids Helpline | Headspace | ReachOut

Eating Disorders Victoria Hub helpline (Treatment navigation and resources, not a crisis service) 1300 550 236

Our Submission

Eating disorders specifically are a priority area for targeted and comprehensive suicide prevention action, as the overall mortality rate for the population with an eating disorder is twice as high as the general population and amongst the highest of any psychiatric condition [1]. This rate increases to 5.86 times higher for individuals with Anorexia Nervosa. Mortality from all eating disorders is estimated to account for 1,829 deaths in 2012 in Australia [1], of which approximately 50% are due to suicide. This is a priority area of concern as it is estimated that 332,400+ Victorians currently have an eating disorder.

Suicide is the second leading cause of death for individuals with Anorexia Nervosa [2]. An important statistic found in the literature is that between 20-43% of individuals with Anorexia Nervosa express suicidal ideation [2]. In regard to other subtypes of eating disorders, Bulimia Nervosa and Binge Eating Disorder carry an elevated risk for suicide and suicidal ideation when compared to the general population [2].

Anorexia Nervosa: Completed suicide rate for individuals is 18 times more likely compared to the general population [2].

Bulimia Nervosa: Completed suicide rate is reported to be 7 times more likely than in the general population [2].

Binge-eating disorder: The most common eating disorder (47% of all eating disorders) [1]. Rates of suicidal ideation are 4.5 to 8.6 times higher than the general population and

suicide attempts occur at a rate of 7.7 to 12.7 times more than in the general population [4].

Suicide prevention is paramount for this population as severe anxiety and severe depression are common across all eating disorder diagnoses, with elevated levels of feelings of loneliness and the co-occurrence (current and lifetime) of a severe mental health condition in approximately 79% of the population reported to have an eating disorder in Australia [3].

Recommendations:

1. Scoping of the association between EDs and suicidality/attempts and looking at early warning signs (e.g., AN-BP and BN rates seem particularly high and purging behaviour should be a key warning sign) [5].
2. In general, assertive early intervention in eating disorders would be helpful for preventative action against the length of illness, multiple hospitalisations, and medical complications, factors that have been shown to impact on suicidal ideation and attempts in this population (5).
3. Special attention/screening in health care provider settings for the presence of purging behaviours [5] and co-occurring mental health disorders, such as depression, anxiety disorders, obsessive compulsive disorder, a history of self-harm, and suicidal ideation and suicide attempts is required [4].
4. Given only 25% of all people with eating disorders in the community access treatment, more comprehensive outreach services and referrals should be considered in primary health care and social support services [3].
5. Work 'towards zero suicides' requires targeted and comprehensive action for all eating disorders.
6. Thank you for taking the time to read this submission. We look forward to hearing from you and would like to express our interest in engaging in further discussions in the development of the strategy.

References

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