

# In this issue

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## SUICIDE STATISTICS

Deaths coded by the Australian Bureau of Statistics (ABS) as being due to suicide have fallen by about a third since 1997. However, concerns have been raised that suicides may have been under-reported. De Leo and colleagues (page 452) and Bradley and colleagues (page 428) examine possible reasons for under-enumeration of suicides, including problems with data collection and coding methods and lack of consistency in coronial processes for determining intent. The ABS has responded by changing its system for coding coroner-certified deaths registered after 2006. Under the new system, cases assigned a code in the “unspecified” or “undetermined” categories, because of incomplete information at the reporting deadline for deaths registered in a particular year, will be reviewed by the ABS; thus, some cases will probably be re-coded as suicide.

While acknowledging the concerns about suicide data, Large and Nielssen (page 432) have examined changes in the rates of methods of suicide in the states and territories from 1988 to 2007. Comparing the later (1998–2007) with the earlier (1988–1997) decade, they found there were declines in rates for many methods of suicide but an increase in hanging among both men and women.

## CORONERS' CLOSURE

Accurately establishing the manner and cause of death can be a very difficult task, but one that has important implications, particularly for the families of the deceased. In a retrospective analysis of deaths reported to Australian coroners between 1 July 2000 and 31 December 2007, Studdert and Cordner (page 444) found that, in 5.2% of cases, the manner of death or intent classification changed as a result of coronial investigation. Of those cases in which it was initially thought that manner of death would be unlikely to be known, 70.4% were determined to be due to natural or external (eg, unintentional injuries or suicide) causes.

## REDUCING ALCOHOL-RELATED HARM

The National Preventative Health Taskforce recommends the long-term goal of reshaping Australia's drinking culture to produce healthier and safer outcomes, but what reforms to alcohol policy in Australia would best achieve this? Doran and colleagues (page 468) discuss a study by Cobiac and colleagues which found that the most cost-effective measures to reduce alcohol-related harm included volumetric taxation, banning advertising, increasing the minimum legal drinking age (MLDA) to 21, brief intervention by general practitioners, licencing controls, a mass media campaign on drink-driving and random breath testing (RBT).

Hall and colleagues (page 464) propose that raising the MLDA in Australia from 18 to 21 would be as effective as and more cost-effective than RBT and campaigns against drink-driving for reducing alcohol-related road crash deaths among young Australians. Another option that might be more appealing to young Australians would be to extend the zero blood alcohol concentration (BAC) laws until at least age 21 (similar to the current policy of zero BAC until age 22 in Victoria) to all states and territories. Byrnes and colleagues (page 439) use mathematical modelling to answer the question of whether volumetric taxation would be cost-effective in reducing alcohol-related harm in Australia.



## ANOTHER TIME ... ANOTHER PLACE

It seems a law of nature that the race must pay a penalty for development, and while some develop others must degenerate, hence insanity and suicide must increase as civilization and material progress advance.

John Chalmers Da Costa

## MALARIA TRAIL

Although transfusion-transmitted malaria is very rare in Australia, since 2005 to further minimise the low risk, potential blood donors with a risk of infection have been tested with an enzyme immunoassay for *Plasmodium falciparum* and *Plasmodium vivax* antibodies. Seed and colleagues (page 471) present two cases of Australian blood donors who tested negative for malarial antibodies at the time of donation but who were subsequently diagnosed with relapsing *P. vivax* malaria. Both had returned from travel in Papua New Guinea, 5 and 15 months, respectively, before diagnosis. In both cases, detection occurred before the transfusion components were used; nevertheless, the two cases have raised safety concerns about the current malaria blood testing strategy.

## DAILY BREAD MAY NOT BE ENOUGH

Iodine deficiency in pregnancy may have a negative effect on fetal brain development, so adequate intake of iodine during pregnancy is essential. Although mandatory iodine fortification for Australia involving the use of iodised salt in bread came into effect in October 2009, pregnant women may still not be receiving an adequate intake of iodine. Gallego and colleagues (page 461) propose that most women planning a pregnancy, as well as pregnant and lactating women, should be advised to take an iodine supplement. Women with pre-existing thyroid disease require individualised medical advice before taking a supplement. These recommendations are supported in a recent National Health and Medical Research Council (NHMRC) public statement, “Iodine supplementation for pregnant and breastfeeding women ([http://www.nhmrc.gov.au/\\_files\\_nhmrc/file/publications/synopses/new45\\_statement.pdf](http://www.nhmrc.gov.au/_files_nhmrc/file/publications/synopses/new45_statement.pdf)).

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