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Suicide in Queensland: An Update on Recent Trends and Strategies

In 1996, the Queensland Parliamentary Library published a Research Bulletin which examined the “epidemic in youth suicide”. At that time, male youth suicide rates were alarmingly high in Australia. Rates of youth suicide in Queensland exceeded the national average, and some regions of Queensland were experiencing rates double the national average. Accordingly, suicide prevention strategies were clearly targeted at youth suicide.

Recent statistics, however, demonstrate that the rates of youth suicide in Australia have declined from their peak in 1997. Current concern rests with the worryingly high rates of suicide among males aged 25 to 29 years, followed by those aged 30 to 34 years and 35 to 39 years (and in particular Indigenous males). Further, despite males across all age groups having suicide rates approximately four times those for similarly aged females, females experience higher rates of hospitalisation for self-harm and attempted suicide.

This Research Brief examines the recent statistics in suicide rates, and the suicide prevention programs of the Commonwealth and Queensland Governments.

Renee Giskes

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Research Publications and Resources Section

| | |
|---|----------------|
| Ms Karen Sampford, Director | (07) 3406 7116 |
| Ms Nicolee Dixon, Senior Parliamentary Research Officer | (07) 3406 7409 |
| Ms Renee Giskes, Parliamentary Research Officer | (07) 3406 7241 |

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Inquiries should be addressed to:

Director, Research Publications & Resources

Queensland Parliamentary Library

Parliament House

George Street, Brisbane QLD 4000

Ms Karen Sampford. (Tel: 07 3406 7116)

Email: Karen.Sampford@parliament.qld.gov.au

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EXECUTIVE SUMMARY

In 1996, the Queensland Parliamentary Library published a Research Bulletin entitled “The Epidemic in Youth Suicide”, which considered trends in youth suicide statistics, characteristics of youth suicide, possible explanations for the high rates of youth suicide and Commonwealth and Queensland Government strategies aimed at preventing youth suicide (**pages 2-5**).

At that time, male youth suicide rates were alarmingly high in Australia. Rates of youth suicide in Queensland exceeded the national average, and some regions of Queensland were experiencing rates double the national average. Accordingly, suicide prevention strategies were clearly targeted at youth suicide.

Recent statistics, however, demonstrate declines in the rates of youth suicide, from their peak in 1997. What was referred to as an epidemic in male youth suicide in the mid to late-1990s may now be referred to as an epidemic in suicide among young to middle aged adult males, particularly Indigenous males, and an epidemic in attempted suicides (**pages 6-26**).

These statistics and trends underpin a shift in the focus of the suicide prevention programs of the Commonwealth and Queensland Governments from the late 1990s to cover all age groups (**pages 32-46**).

Recent research has examined the impact on suicide rates of national suicide prevention strategies, mental health and mental health programs, substance abuse and substance abuse policies, antidepressants’ use and unemployment (**pages 26-31**).

A number of support agencies provide valuable assistance to people at risk of suicide, and to their families and friends. Well known services in this respect include Lifeline Australia and Kids Help Line. Two further national services, *beyondblue* (**pages 47-48**) and Reach Out! (**page 48**), are recently established initiatives which are also making a valuable contribution in this area.

1 INTRODUCTION

In 1996, the Queensland Parliamentary Library published a Research Bulletin entitled “The Epidemic in Youth Suicide”¹ (‘1996 Research Bulletin’). The 1996 Research Bulletin considered trends in youth suicide statistics, characteristics of youth suicide, possible explanations for the high rates of youth suicide and Commonwealth and Queensland Government strategies aimed at preventing youth suicide.

The 1996 Research Bulletin was set in the context of increasing, and alarmingly high, rates of suicide among Australian males aged 15 to 24 years. Australia was recording one of the highest rates of youth suicide in the industrialised western world. Rates of youth suicide in Queensland exceeded the national average, and some regions of Queensland were experiencing rates double the national average.

Suicide prevention strategies were implemented by both the Commonwealth and Queensland Governments. At that time, the strategies were clearly aimed at lowering the high rates of youth suicide.

Recent statistics demonstrate declines in the youth suicide rate, from a peak in 1997. Currently, worryingly high rates of suicide exist among males aged 25 to 29 years, followed by those aged 30 to 34 years and 35 to 39 years (and in particular among Indigenous males). Although low when compared to other countries, the high rates of suicide among older males (75 years and over) are also of concern, particularly when compared to the rates for similarly aged females. Further, despite males across all age groups having suicide rates approximately four times those for similarly aged females, females experience higher rates of hospitalisation for self-harm and attempted suicide.

Accordingly, what was referred to as an epidemic in male youth suicide in the mid to late-1990s may now be referred to as an epidemic in suicide among young to middle aged adult males, particularly Indigenous males, and an epidemic in attempted suicides.

Completed and attempted suicides are also only an indication of the levels of well-being in the wider community. For example, there have been reports of concerning rates of depression, with indications that up to 30% of young people are experiencing significant psychological distress or disturbance.² Depression is

¹ Linda Woodrow, *The Epidemic in Youth Suicide*, Queensland Parliamentary Library, Research Bulletin 1/96, <http://www.parliament.qld.gov.au/ConcordDocs/RB0/RB0196LW.PDF>.

² Richard Eckersley, ‘Generation wrecked’, *Sydney Morning Herald*, 19 February 1999, p 10.

projected by the World Health Organisation to be the second highest medical cause of illness and disability worldwide by 2020.³

The recent statistics and trends in suicide underpin a shift in the focus of suicide prevention programs from the late 1990s to cover all age groups. This Research Brief examines the recent statistics in suicide rates, and the suicide prevention programs of the Commonwealth and Queensland Governments.

2 FINDINGS OF THE 1996 RESEARCH BULLETIN

The findings of the 1996 Research Bulletin are summarised below to gain an understanding of the issue of youth suicide in the mid-1990s. The groups that were identified as being at a significantly greater risk of death by suicide are listed, as are various rates and trends in youth suicide, possible explanations for the high rates of youth suicide, and programs that were conducted by the Commonwealth and Queensland Governments to address the issue.

2.1 'AT RISK' GROUPS

The following groups were described as being capable of easy identification of significantly greater risk of death by suicide than the general population:⁴

- young Aboriginal and Torres Strait Islander males;
- young males who had been charged with an offence;
- young people who had been diagnosed with a mental illness; and
- young people who had already attempted suicide.

2.2 RATES AND TRENDS IN YOUTH SUICIDE

The 1996 Research Bulletin found that:

- Australia had one of the highest rates of youth suicide in the industrialised western world. In 1992, there were 25.6 suicide deaths per 100,000 of population for 15 to 24 year old males. For females in the same age group, the rate was 5.0.⁵

³ 'Depression receives focus at last', *Australian*, 18 March 2000, p 20.

⁴ *The Epidemic in Youth Suicide*, p 34.

⁵ *The Epidemic in Youth Suicide*, p 6.

- Since the early 1970s, suicide rates for young males had shown a steep upward rise. Nationally, the rate of suicide among 15 to 24 year olds had almost trebled in the past 40 years, and the rate for young males outnumbered that for young females by 6:1. The proportion of all deaths of young males due to suicide had increased from 18% in 1985 to 27% in 1994.⁶
- It was thought that the rate of attempted suicide was five to six times higher in females than in males.⁷
- In 1994, for the fourth consecutive year, more Australians died by suicide (1,830) than by motor vehicle accidents (1,369). Suicide was the leading cause of death for 15 to 24 year old males in Queensland.⁸
- Queensland's youth suicide rate in 1994 (14.2 per 100,000 of population) was significantly higher than the national average (12.7). In some regions of Queensland, the rate was double the national average.⁹
- The suicide rate from 1990 to 1992 among Queensland's Indigenous male population aged 15 to 29 years was 70.1 per 100,000 persons. This was over double the rate for the general population.¹⁰
- People in custody had a suicide rate 13 times that of the general population. In police custody (particularly police lock-ups), the rate was about 20 times greater.¹¹

Between 1988 and 1992, the leading methods of suicide by Australian males aged 15 to 24 years were hanging, strangulation and suffocation (31.4%); firearms and explosives (30.9%) and poisoning by gases (17.3%). For similarly aged females, the leading causes were poisoning by solid or liquid substances (28.6%); hanging, strangulation and suffocation (24.3%) and poisoning by gases (14.9%).¹²

⁶ *The Epidemic in Youth Suicide*, pp 7, 8, 11.

⁷ *The Epidemic in Youth Suicide*, pp 11-14.

⁸ *The Epidemic in Youth Suicide*, pp 8-9.

⁹ *The Epidemic in Youth Suicide*, pp 9-10, 16-17.

¹⁰ *The Epidemic in Youth Suicide*, pp 26-27.

¹¹ *The Epidemic in Youth Suicide*, p 26.

¹² *The Epidemic in Youth Suicide*, p 12.

2.3 REASONS FOR THE HIGH RATES OF YOUTH SUICIDE

The following possible explanations were raised by the 1996 Research Bulletin for the high rates of youth suicide:¹³

- depression and mental illness;
- geographical isolation;
- the effects of alcohol;
- unemployment, and the characteristics of youth employment (such as low skill and pay levels, insecurity, part-time or casual status, highly competitive in nature and lacking in a career path);
- the decline in rural economies;
- prior attempts at suicide;
- family issues such as divorce, separation or remarriage, abuse, changes in living conditions and custodial arrangements, societal changes and relationship breakdowns; and
- a sense of hopelessness, 'youth culture', engaging in impulsive and risky behaviour, models of masculinity and availability of means.

2.4 GOVERNMENT PROGRAMS

The following programs, conducted by the Commonwealth and Queensland Governments, were discussed in the 1996 Research Bulletin.

2.4.1 Commonwealth

There was proposed funding for youth suicide of \$7.4 million over four years in the 1995/1996 Federal Budget. The funding was to be supplemented by an additional \$6 million from existing allocations for the *National Mental Health Strategy*.

Within the *National Mental Health Strategy*, the Commonwealth also had a program, outlined in *Better Health Outcomes for Australians* with the goal of reducing the rate of suicide among people with mental disorders. The targets included reducing overall suicide rates by 15% within ten years, and reducing the suicide rates in people suffering schizophrenia and other psychoses by 25%.¹⁴

¹³ *The Epidemic in Youth Suicide*, pp 15-16, 19, 22, 25, 27-33.

¹⁴ *The Epidemic in Youth Suicide*, p 41.

2.4.2 Queensland

Appendix B of the 1996 Research Bulletin contained a copy of the Queensland program *Young People at Risk: Access, Prevention and Action*, which was aimed at preventing self-harming and suicidal behaviour among young people.

The target group for the program was all young people between 10 and 24 years of age. Although it was not specifically directed at young people displaying suicidal ideation, the following groups, considered to be at a greater risk of suicidal or self-harming behaviour, were of particular focus:

- young people with a mental illness;
- young males with access to firearms;
- young females;
- young Aboriginal and Torres Strait Islander people; and
- the unemployed.

The program aimed to:

- increase the ability of young people to gain access to early intervention and support services, prior to a crisis developing;
- ensure that local communities responded effectively to young people at risk of suicidal and self-harming behaviour; and
- reduce suicidal and self-harming behaviour amongst young people.

In the first instance, pilot programs were established in the following Queensland Health regions:

- South West, based on Roma, Charleville, St George and Cunnamulla;
- Brisbane South, based primarily on Logan City;
- West Moreton, based on Esk, Laidley, Boonah and Moreton Shires, Ipswich and Goodna; and
- Wide Bay, based on provincial centres including Mundubbera and Nanango.

An additional program was also established at Yarrabah Aboriginal Community.

‘Local Action Reference Groups’, consisting of school guidance officers, teachers, ministers of religion, general practitioners, health staff, police and others, were formed. These groups were trained to identify, and act as a possible first point of contact for, ‘at risk’ young people.

‘Multidisciplinary Action Teams’ were also established within each region. These teams received highly specialised training and, in turn, provided training to local people and support and referral for young people to Queensland Health services.

3 RECENT STATISTICS

Against the background of the 1996 Research Bulletin outlined above, this part of the Research Brief examines more recent statistics and trends in suicide rates.¹⁵ This information assists in understanding a shift in the focus of current suicide prevention programs in Australia from youth suicide to suicide across all age groups.

3.1 OVERALL OBSERVATIONS ON RECENT RATES AND TRENDS

The following observations can be made about the recent trends in suicide rates:

- In 2002 there were 2,320 registered suicides in Australia, compared with 2,720 in 1997. This equated to 11.8 suicides per 100,000 persons in 2002, and 14.7 in 1997.¹⁶ The reduction in the overall rate of suicide is predominantly due to reductions in the rates for young adult males.
- From 1992 to 2002, male suicide rates outnumbered female suicide rates across all age groups by a factor of approximately four.
- Females have higher rates of hospitalisation from self-harm or attempted suicide than males. There are also higher rates in young people than in older people.
- Male youth suicide rates peaked in 1997 at 18.5 deaths per 100,000 persons for 15 to 19 year olds, and 42.8 deaths per 100,000 persons for 20 to 24 year olds. The rates for the corresponding age groups in 2002 were 13.9 deaths and 24.2 deaths respectively. In 2002, the suicide rate for males across these age groups was the lowest since 1984.¹⁷ Almost all countries experienced a substantial increase in male youth suicide during the 1980s and/or 1990s. Since 1997, however, there have been declines in suicide for this group across most regions of the world, with marked declines occurring in Australia.¹⁸

¹⁵ When considering statistics associated with suicide, it is important to recognise that the actual number of deaths from suicide may be higher than the number of registered suicides, due to difficulties in data collection and classification. In particular, there may be difficulties in ascertaining the circumstances of some deaths.

¹⁶ ABS, *Suicides: Recent trends, Australia*, Tables on Suicide, cat 3309.0.55.001, table 2.

¹⁷ Australian Institute of Health and Welfare, *Australia's Health 2004*, Canberra, 2004, p xi, <http://www.aihw.gov.au/publications/aus/ah04/ah04.pdf>.

¹⁸ Australian Institute for Suicide Research and Prevention (Griffith University), Diego De Leo and Russell Evans, *International Suicide Rates – Recent Trends and Implications for Australia*, 2003, p 20, <http://www.parliament.qld.gov.au/ConcordDocs/E04/E040408LP02.PDF>.

- Males aged 25 to 29 years experienced the highest rate of death from suicide in Australia in 2002 (31.1 deaths per 100,000 persons), followed by males aged 30 to 34 years (30.8 deaths) and males aged 35 to 39 years (30.3 deaths). Males aged 25 to 39 years accounted for 37% of all male suicides in 2002, and 29% of total suicides. New Zealand has experienced a similar upward trend for males across these age groups, as have Italy and Spain. Stable rates have occurred in the United States, England and Canada, whereas recent downward trends have been observed in Scandinavia, Sweden, Denmark, Norway and Finland.¹⁹
- For females, the highest rate of death from suicide in 2002 occurred in the 40 to 44 year age group (9.7 deaths per 100,000 persons), followed equally by the 30 to 34 year and 45 to 49 year age groups (both 7.4 deaths).
- In 2002, almost half of the total number of suicides in Australia occurred by males and females in the 25 to 45 year age group.
- Although low by international standards (particularly when compared to rates for eastern and western European countries and Asia), the rate of suicide among older Australian men remains high, and is high compared to that for similarly aged females.²⁰
- In terms of the methods of suicide employed, a significant decrease in the use of firearms has occurred. There have been significant increases in hanging, strangulation and suffocation, and a decrease in poisoning by drugs.
- The rate of death from suicide exceeds the rate of death from transport accidents for both males and females aged 25 to 34 years and 35 to 44 years.
- The rate of male suicide in Queensland exceeded the national average each year from 1992 to 2002. Female suicide in Queensland exceeded the national average for a majority of the same time.
- Differences in the rates of suicide between urban and regional areas in Queensland are more pronounced for males aged 15 to 24 years and 75 years and over. Regional differences in the rates of suicide throughout Queensland also occur.
- Higher rates of suicide continue to be observed amongst Australia's Indigenous population, with the proportion of deaths from suicide in Queensland's Indigenous population exceeding the national average. The age-specific death rate is highest for Indigenous males aged 25 to 34 years (three times that for the general population of males in the same age group),

¹⁹ *International Suicide Rates – Recent Trends and Implications for Australia*, p 20.

²⁰ *International Suicide Rates – Recent Trends and Implications for Australia*, p 65.

followed by those aged 35 to 44 years. From 45 years onwards, however, Indigenous males record lower or equivalent rates of suicide compared to similarly aged males in the general population. Other than 15 to 24 year old Indigenous females (who have a rate four times higher than that for similarly aged females in the general population), suicide rates for Indigenous females are similar to those for all Australian females.

- Married people are less likely to die from suicide than those who have never married or who are widowed or divorced.
- In 1998, a mental disorder (either substance abuse or a depressive disorder) was reported as an associated or contributory medical condition in the suicide of 15% of males and 18% of females.
- Internationally, Australia continues to experience high rates of suicide among males aged 15 to 24 years and 25 to 34 years. Australia, however, records lower rates of suicide among males and females aged 75 years and over.

3.2 MALE SUICIDE RATES

The suicide rates for Australian males (per 100,000 of the estimated mid-year population for each age group) from 1992 and 2002 were as follows.²¹

| Age group | 1992 | 1993 | 1994 | 1995 | 1996 | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 |
|-----------|------|------|------|------|------|------|------|------|------|------|------|
| 15-19 | 18.4 | 16.7 | 18.6 | 15.1 | 17.4 | 18.5 | 17.6 | 14.6 | 13.1 | 13.8 | 13.9 |
| 20-24 | 34.9 | 32.0 | 34.5 | 34.8 | 33.4 | 42.8 | 36.9 | 32.1 | 26.6 | 27.4 | 24.2 |
| 25-29 | 32.6 | 29.2 | 30.0 | 34.1 | 33.2 | 40.5 | 42.9 | 37.3 | 32.5 | 32.2 | 31.1 |
| 30-34 | 28.2 | 28.2 | 28.4 | 32.7 | 31.8 | 34.6 | 39.4 | 33.5 | 33.9 | 35.8 | 30.8 |
| 35-39 | 26.8 | 22.2 | 25.0 | 30.9 | 32.2 | 29.2 | 36.6 | 29.8 | 31.3 | 32.4 | 30.3 |
| 40-44 | 23.0 | 20.5 | 27.3 | 24.3 | 26.5 | 31.5 | 29.7 | 28.8 | 29.2 | 28.2 | 27.8 |
| 45-49 | 27.8 | 25.9 | 24.3 | 24.2 | 23.1 | 23.5 | 25.5 | 24.9 | 22.8 | 25.3 | 23.2 |
| 50-54 | 23.3 | 20.4 | 25.3 | 23.4 | 22.2 | 25.3 | 24.8 | 23.9 | 21.9 | 21.5 | 22.0 |
| 55-59 | 21.4 | 21.9 | 23.1 | 26.6 | 22.2 | 22.3 | 19.6 | 21.7 | 16.3 | 19.7 | 15.3 |
| 60-64 | 24.8 | 24.0 | 23.1 | 19.5 | 24.9 | 22.1 | 20.2 | 19.2 | 16.5 | 17.9 | 17.3 |
| 65-69 | 25.5 | 22.4 | 22.9 | 18.8 | 20.2 | 22.8 | 25.9 | 18.9 | 16.9 | 18.8 | 18.6 |
| 70-74 | 29.7 | 24.3 | 24.6 | 20.0 | 24.6 | 24.5 | 17.0 | 26.1 | 21.4 | 21.1 | 16.8 |

²¹ ABS, *Suicides: Recent trends, Australia*, Tables on Suicide, cat 3309.0.55.001, table 2.

| | | | | | | | | | | | |
|-----------|------|------|------|------|------|------|------|------|------|------|------|
| 75 + | 30.6 | 30.6 | 31.7 | 29.2 | 32.4 | 36.1 | 25.5 | 30.4 | 27.2 | 24.5 | 22.5 |
| All males | 21.3 | 19.6 | 21.0 | 21.1 | 21.5 | 23.6 | 23.2 | 21.6 | 19.8 | 20.3 | 18.8 |

In 2002, the highest rate of death from suicide in males occurred in the 25 to 29 year age group, followed by the 30 to 34 year and 35 to 39 year age groups.

The data shows a general decrease in rates for all males from 1997 to 2002. More significant decreases were observed in the 20 to 24 year age group (from 42.8 deaths per 100,000 in 1997 to 24.2 in 2002), followed by those aged 15 to 19 years (from 18.5 in 1997 to 13.9 in 2002) and 25 to 29 years (from 40.5 in 1997 to 31.1 in 2002). In contrast, there were less significant declines for other age groups, particularly those aged 30 to 39 years and 45 to 49 years.

3.2.1 Younger to Middle-Aged Male Suicide

Suicide in younger to middle-aged males (25 to 44 years) is currently at worryingly high rates. The number of Australian men in this age group who are taking their lives has increased 44% since 1979.²² The same trend is not evident in similarly aged females.

Concerns have been expressed about a “generational tendency” in these men; that “the same generation of boys that effectively started the youth suicide crisis in the late 1970s are continuing to take their own lives, as they progress to adulthood, and middle age”.²³ There are also concerning reports regarding some of these men taking the lives of other family members, particularly their children, when they suicide.

This age group is typically a period characterised by establishing a career path or stable employment, a life-long partnership and rearing a family. The following have been raised as possible factors contributing to the high rates of suicide among this age group.²⁴

²² Wesley Mission, *Suicide in Australia, a Dying Shame*, Suicide Prevention Week, November 2000, p 2, http://www.parliament.qld.gov.au/ConcordDocs/E01/E010523_09.PDF.

²³ *Suicide in Australia, a Dying Shame*, pp 2, 12.

²⁴ These factors are considered in a number of reports. Refer also to *Suicide in Australia, a Dying Shame*; Michael Cave, ‘Fair-go society under threat’, *Australian Financial Review*, 11 November 2003, p 60; Bettina Arndt, ‘Marginal Men’, *Sydney Morning Herald*, 10 October 1998, p 6.

- aspects of male health (such as lower rates who seek medical advice, impacts of men's socialised behaviour on their health, responses by males to stressful and emotional events, and depression among men);
- marital status (including shifts in partnering patterns in Australia where young, unemployed males are being 'locked out' of permanent relationships) and marriage or relationship breakdown, particularly where children are involved;
- substance abuse (particularly abuse of alcohol);
- unemployment or underemployment; and
- financial concerns.

In a study of 4,000 male suicides, it was found that at least 70% were associated with a relationship breakdown. Men are nine times more likely to take their own lives following such a breakdown than women.²⁵

In 2003, the Family Court of Australia announced that it was investigating the extent to which its decisions were contributing to male suicides.²⁶

3.2.2 Suicide in Older Men

Rates of death from suicide in older Australian males, particularly those 75 years and over, are considerably higher than for similarly aged females. In 2002, the suicide rates (per 100,000 persons) for males aged 70 to 74 years and 75 years and over were 16.8 and 22.5 respectively. Rates for females in the same age groups were 4.5 and 5.5 respectively.²⁷

It has been reported that suicide rates among older men are much higher than the current statistics indicate, due to a failure to report deaths as such where the suicide is mistaken for another cause of death. This, in turn, affects efforts to prevent suicide in older men, by impacting on the resources that are allocated to this group.²⁸

²⁵ *Suicide in Australia, a Dying Shame*, p 15.

²⁶ Julie-Ann Davies, 'Family Court probes suicides', *Sydney Morning Herald*, 16 August 2003.

²⁷ ABS, *Suicides: Recent trends, Australia*, Tables on Suicide, cat 3309.0.55.001, table 2.

²⁸ Luke Petony, 'Suicide rate worse among older men', *Independent Monthly*, June 2004, <http://www.parliament.qld.gov.au/ConcordDocs/A04/A040624LD14.PDF>.

In 1999, a report was commissioned into the high rates of suicide among older men in Queensland.²⁹ The report considered the extent, nature and risk factors for suicide by these men, and suggested possible methods of prevention.

The report found that:

- despite some fluctuation over the years, suicide in older men in Queensland remains high, and is a problem particularly for non-Indigenous males;
- major depression is the key risk factor for suicidal behaviour in older men. Other risk factors include mental and physical illness, life conditions and events (for example, the circumstances culminating in an older male living alone; the frequency and timing of losses, such as the death of a spouse and other family members or friends; and retirement), unresolved grief, functional disability (for example, difficulty walking or showering), loss of autonomy (for example, becoming physically or financially dependent) and changed living circumstances;
- older men use more use more violent means of suicide, and over 70% of such suicides occur at their place of residence. Older men are more likely to have a physical illness, and are less likely to have made a previous attempt at suicide, than younger Queenslanders who suicide. These lower rates of attempted suicide make detection and prevention of suicide ideation in older men especially important;
- excessive alcohol consumption was noted in about 20% of males aged 65 to 74 years, and 10% of males aged 75 years and over, who suicided;
- over 60% of males aged 65 to 74 years, and over 50% aged 75 years and over, were married or in a de facto relationship when they suicided. About 20% and 40% of males in the same age groups were widowed when they suicided;
- in the three months prior to committing suicide, 90% of men aged 65 to 74 years, and 94% of men aged 75 years and over, had visited a doctor; and
- strategies on the prevention of depression in older men are an important protective factor against suicide. Also important is training for general practitioners, nurses and other relevant professionals to allow for identification of depression or other possible mental illness in older men, identification of older men at risk of suicide, and adequate responses to older men who are depressed and at risk of suicide. Reducing the social

²⁹ Australian Institute for Suicide Research and Prevention (Griffith University), *A Hidden Problem – Suicide in Older Men in Queensland*, 2002; http://www.gu.edu.au/school/psy/aisrap/pdf/report_govt.pdf (a synopsis of the report is available at <http://www.parliament.qld.gov.au/ConcordDocs/310/310300MW01A.PDF>). Another useful report is Australian Institute for Suicide Research and Prevention (Griffith University), Diego De Leo, Portia Hickey, Kerry Neulinger, Christopher Cantor, *Ageing and Suicide*, 2001, <http://www.gu.edu.au/school/psy/aisrap/pdf/ageing.pdf>.

isolation of older men, and providing them with opportunities to talk and share their feelings or concerns, is a further important protective factor. Increasing public awareness (particularly among seniors groups) of the prevalence of depression and associated risk of suicide in older people, the availability of mental health support services and the importance of treating mental illnesses is also important.

3.3 FEMALE SUICIDE RATES

The suicide rates for Australian females (per 100,000 of the estimated mid-year population for each age group) from 1992 and 2002 were as follows.³⁰

| Age group | 1992 | 1993 | 1994 | 1995 | 1996 | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 |
|--------------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|
| 15-19 | 4.8 | 3.0 | 2.7 | 4.7 | 4.2 | 5.3 | 5.6 | 4.2 | 6.3 | 3.8 | 4.1 |
| 20-24 | 6.5 | 5.1 | 5.6 | 7.8 | 4.4 | 9.0 | 7.2 | 6.9 | 5.3 | 5.9 | 4.4 |
| 25-29 | 6.1 | 5.6 | 6.3 | 7.1 | 6.9 | 8.1 | 7.6 | 7.5 | 7.8 | 7.8 | 6.8 |
| 30-34 | 8.0 | 5.5 | 5.7 | 6.8 | 6.5 | 7.8 | 7.5 | 8.6 | 6.8 | 7.2 | 7.4 |
| 35-39 | 6.6 | 7.7 | 7.9 | 7.0 | 8.9 | 8.6 | 10.2 | 6.3 | 8.9 | 8.7 | 6.5 |
| 40-44 | 7.8 | 4.2 | 6.7 | 8.1 | 6.6 | 8.4 | 8.3 | 7.8 | 8.9 | 7.1 | 9.7 |
| 45-49 | 6.1 | 7.5 | 6.4 | 7.8 | 7.8 | 7.0 | 5.0 | 8.6 | 5.0 | 7.2 | 7.4 |
| 50-54 | 6.8 | 6.5 | 6.6 | 8.6 | 7.6 | 9.5 | 6.8 | 6.7 | 5.3 | 8.8 | 6.6 |
| 55-59 | 7.6 | 5.1 | 6.0 | 7.8 | 5.2 | 7.6 | 6.9 | 4.4 | 6.1 | 5.6 | 6.5 |
| 60-64 | 6.6 | 5.0 | 6.7 | 5.3 | 5.3 | 6.6 | 6.2 | 5.7 | 5.5 | 4.9 | 5.0 |
| 65-69 | 6.8 | 5.6 | 3.9 | 6.5 | 4.2 | 7.1 | 5.7 | 4.9 | 5.8 | 3.7 | 4.2 |
| 70-74 | 7.2 | 6.3 | 5.7 | 4.3 | 7.0 | 6.7 | 6.3 | 3.6 | 6.3 | 6.0 | 4.5 |
| 75 + | 8.1 | 6.5 | 7.1 | 5.9 | 4.8 | 7.0 | 6.4 | 3.7 | 4.6 | 5.6 | 5.5 |
| All females | 5.4 | 4.5 | 4.8 | 5.5 | 5.1 | 6.2 | 5.6 | 5.1 | 5.2 | 5.3 | 5.0 |

In 2002, the highest rate of death from suicide in females occurred in the 40 to 44 year age group, followed equally by those aged 30 to 34 years and the 45 to 49 years.

Overall, the data shows a fairly steady rate in female suicide between 1992 and 2002.

³⁰ ABS, *Suicides: Recent trends, Australia*, Tables on Suicide, cat 3309.0.55.001, table 2.

3.4 METHODS OF SUICIDE

Noticeable changes occurred between 1992 and 2002 in the methods of suicide used by males and females, including:³¹

- a significant decrease in the use of firearms, particularly by males;
- a significant increase in hanging, strangulation and suffocation, by both males and females; and
- a decrease in poisoning by drugs, by both males and females.

Restricting various means of suicide has long been regarded a factor in addressing rates of suicide.

In terms of poisoning by motor vehicle exhaust, the Prime Minister announced in late 2001 that the Government was making a \$2 million commitment to research and development aimed at reducing suicide by this method. The commitment would fund the development and trial of a cabin air monitor, and obtain an Australian design rule for the introduction of the monitor in new Australian motor vehicles. It would also involve development and introduction of tail pipe modification devices for used cars.³²

3.4.1 Males

The methods of suicide employed by Australian males between 1992 and 2002 (as a proportion of total suicides) were as follows.³³

| Method | 1992 | 1993 | 1994 | 1995 | 1996 | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 |
|-------------------------|------|------|------|------|------|------|------|------|------|------|------|
| Poisoning by drugs | 9.5 | 8.0 | 10.3 | 10.4 | 8.4 | 7.5 | 7.3 | 7.9 | 7.7 | 7.8 | 8.6 |
| Poisoning by other (a) | 25.2 | 23.4 | 23.2 | 24.3 | 25.2 | 25.9 | 23.2 | 24.6 | 25.4 | 22.1 | 19.9 |
| Hanging (b) | 27.3 | 30.1 | 29.1 | 31.2 | 34.8 | 37.9 | 48.1 | 43.4 | 43.4 | 44.2 | 46.6 |
| Firearms and explosives | 25.5 | 24.8 | 21.9 | 19.5 | 19.1 | 14.4 | 10.1 | 12.8 | 11.5 | 12.5 | 11.4 |
| Other (c) | 12.6 | 13.8 | 15.6 | 14.6 | 12.5 | 14.3 | 11.2 | 11.3 | 12.0 | 13.4 | 13.5 |

(a) Includes other solids, liquids, gases and vapours (including motor vehicle exhaust).

(b) Includes strangulation and suffocation.

(c) Includes drowning, cutting and piercing instruments, jumping from high places and other unspecified means.

³¹ ABS, *Suicides: Recent trends, Australia*, Tables on Suicide, cat 3309.0.55.001, table 4.

³² Hon J Howard MP, Prime Minister, *Transcript of Speech regarding Suicide Prevention Policy*, Sydney, 3 November 2001, <http://www.pm.gov.au/news/speeches/2001/speech1320.htm>

³³ ABS, *Suicides: Recent trends, Australia*, Tables on Suicide, cat 3309.0.55.001, table 4.

3.4.2 Females

The methods of suicide employed by Australian females between 1992 and 2002 (as a proportion of total suicides) were as follows.³⁴

| Method | 1992 | 1993 | 1994 | 1995 | 1996 | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 |
|-------------------------|------|------|------|------|------|------|------|------|------|------|------|
| Poisoning by drugs | 37.8 | 32.2 | 33.2 | 31.1 | 35.7 | 25.8 | 28.7 | 24.5 | 25.6 | 25.8 | 26.0 |
| Poisoning by other (a) | 14.3 | 17.0 | 16.8 | 20.4 | 20.3 | 20.1 | 16.3 | 21.0 | 20.3 | 16.6 | 15.3 |
| Hanging (b) | 19.6 | 22.3 | 25.0 | 23.0 | 26.0 | 30.3 | 34.1 | 32.7 | 36.2 | 37.6 | 39.6 |
| Firearms and explosives | 5.5 | 4.3 | 4.7 | 4.6 | 3.2 | 3.6 | 3.2 | 2.7 | 2.0 | 3.9 | 2.2 |
| Other (c) | 22.8 | 24.1 | 20.3 | 20.8 | 14.7 | 20.1 | 17.6 | 19.2 | 15.9 | 16.2 | 16.9 |

(a) Includes other solids, liquids, gases and vapours (including motor vehicle exhaust).

(b) Includes strangulation and suffocation.

(c) Includes drowning, cutting and piercing instruments, jumping from high places and other unspecified means.

It is recognised that females typically adopt less 'lethal' methods of suicide than males. This may partly explain the higher rates of hospital separations for self-injury or attempted suicide among females.

3.5 HOSPITAL SEPARATIONS FOR SELF-HARM OR ATTEMPTED SUICIDE

Hospital separation rates for self-inflicted injury or attempted suicide (per 100,000 of population) in 1993-1994 and 2001-2002 for younger and older males and females are shown below.³⁵

| Group | 1993-1994 | 2001-2002 |
|---------------------|-----------|-----------|
| Males 15-24 | 141 | 189 |
| Females 15-24 | 236 | 372 |
| Males 65 and over | 39 | 52 |
| Females 65 and over | 30 | 42 |

These figures demonstrate a higher incidence of self-harm and attempted suicide among younger people, and among females in particular.

³⁴ ABS, *Suicides: Recent trends, Australia*, Tables on Suicide, cat 3309.0.55.001, table 4.

³⁵ *Australia's Health 2004*, p 473. Another useful report is Australian Institute of Health and Welfare, Malinda Steenkamp and James Harrison, *Suicide and Hospitalised Self-harm in Australia*, 2000, http://www.nisu.flinders.edu.au/pubs/reports/2001/suicide_injcat30.pdf.

For both young men and women, poisoning was the most common reason for hospitalisation between 2000 and 2001, accounting for 78% of hospitalisations for self-harm, followed by injury from a sharp object (15%).³⁶

For every completed male suicide, it has been reported that there are five attempts; for every completed female suicide, there are 35 attempts.³⁷

3.6 DEATHS FROM SUICIDE COMPARED TO TRANSPORT ACCIDENTS

The following table compares the rate of death from suicide in 2002 (per 100,000 of the estimated mid-year population for each age group) with the rate of death from transport accidents.³⁸

| Cause | 15-24 | | 25-34 | | 35-44 | |
|---------------------|-------|---------|-------|---------|-------|---------|
| | Males | Females | Males | Females | Males | Females |
| Transport Accidents | 27.0 | 8.8 | 21.4 | 4.2 | 14.4 | 4.4 |
| Suicide | 19.0 | 4.3 | 30.9 | 7.1 | 29.0 | 8.1 |

The overall rate of death from suicide in Queensland in 2002 was 14.6 (per 100,000 of the estimated mid-year population), compared to 10.3 for transport accidents. The rates in 1992 were 14.3 and 16.0 respectively.³⁹

3.7 INTERSTATE COMPARISONS

In terms of national average rates for suicide between 1992 and 2002, Queensland exceeded the national average.⁴⁰

³⁶ Australian Institute of Health and Welfare, *Australia's Young People: Their Health and Wellbeing 2003*, 2003, p 107, <http://www.aihw.gov.au/publications/phe/ayp03/ayp03.pdf>.

³⁷ *Suicide in Australia, a Dying Shame*, p 3.

³⁸ ABS, *Causes of Death*, 2002, cat 3303.0, pp 10-11.

³⁹ ABS, *Causes of Death*, 2002, cat 3303.0, p 24.

⁴⁰ When considering this data, care needs to be taken when interpreting the rates for States and Territories (particularly those with smaller populations) because of the smaller number of suicides that are registered. This can result in incorrect interpretations of large increases or decreases in the associated rates.

- each year, for male suicides. The Northern Territory and Tasmania also experienced rates of male suicide which consistently exceeded the national average. In comparison, male suicides rates in Victoria were below the national average for each of these years;
- for the majority of this time, for female suicides; and
- for almost every year, in terms of overall rates of suicide.

More recently, the nation's highest rates of suicide, for both males and females, have been recorded in the Northern Territory.

The Queensland Government's current suicide prevention strategy⁴¹ notes the higher rates of suicide in Queensland, compared to the national average. Emphasis is placed on the higher rates for:⁴²

- young people (particularly young men);
- Indigenous populations (especially males aged 15 to 24 years);
- older people (particularly older men);
- older people from culturally and linguistically diverse backgrounds;
- people with a mental illness;
- people in custody (particularly in the youth justice system); and
- same-sex attracted people (particularly in relation to suicidal behaviour).

3.7.1 Males

The suicide rates for males in the various States and Territories (per 100,000 of the estimated mid-year population for each age group) from 1992 and 2002 were as follows.⁴³

| State/Territory | 1992 | 1993 | 1994 | 1995 | 1996 | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 |
|-----------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|
| NSW | 20.3 | 19.3 | 21.4 | 19.8 | 21.8 | 23.1 | 22.6 | 22.0 | 18.6 | 19.0 | 16.9 |
| Vic | 20.7 | 18.3 | 18.3 | 19.9 | 17.4 | 23.5 | 19.4 | 19.2 | 16.6 | 17.5 | 16.2 |
| Qld | 22.3 | 20.8 | 23.6 | 24.8 | 27.1 | 25.9 | 26.6 | 23.0 | 24.3 | 22.8 | 23.8 |
| SA | 22.7 | 18.5 | 19.5 | 22.2 | 21.2 | 22.2 | 26.9 | 20.8 | 21.7 | 22.6 | 18.5 |

⁴¹ Queensland. *Reducing Suicide: The Queensland Government Suicide Prevention Strategy 2003-2008*, July 2003, p 3, http://www.health.qld.gov.au/mental_hlth/publications/20769.pdf.

⁴² *Reducing Suicide: The Queensland Government Suicide Prevention Strategy 2003-2008*, pp 13-16.

⁴³ ABS, *Suicides: Recent trends, Australia*, Tables on Suicide, cat 3309.0.55.001, table 6.

| | | | | | | | | | | | |
|-------------------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|
| WA | 20.8 | 21.0 | 22.2 | 20.4 | 19.4 | 23.2 | 25.9 | 21.2 | 21.8 | 22.6 | 19.6 |
| Tas | 32.9 | 29.2 | 28.3 | 21.8 | 24.5 | 18.0 | 21.7 | 30.6 | 18.0 | 23.1 | 24.4 |
| NT | 25.1 | 26.9 | 17.9 | 23.7 | 29.6 | 36.3 | 35.4 | 23.0 | 33.0 | 37.4 | 41.9 |
| ACT | 19.6 | 13.4 | 16.3 | 23.7 | 16.7 | 17.8 | 20.1 | 23.8 | 15.2 | 21.1 | 14.0 |
| National Average | 21.3 | 19.6 | 21.0 | 21.1 | 21.5 | 23.6 | 23.2 | 21.6 | 19.8 | 20.3 | 18.8 |

3.7.2 Females

The suicide rates for females in the various States and Territories (per 100,000 of the estimated mid-year population for each age group) from 1992 and 2002 were as follows.⁴⁴

| State/Territory | 1992 | 1993 | 1994 | 1995 | 1996 | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 |
|-------------------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|
| NSW | 4.9 | 4.5 | 5.0 | 5.6 | 5.0 | 7.1 | 4.9 | 5.5 | 4.3 | 5.1 | 4.1 |
| Vic | 5.0 | 4.1 | 4.9 | 5.6 | 4.8 | 6.1 | 5.6 | 4.6 | 5.3 | 5.3 | 5.7 |
| Qld | 6.5 | 4.1 | 5.8 | 6.3 | 5.4 | 5.9 | 7.2 | 4.9 | 6.7 | 5.1 | 5.7 |
| SA | 6.7 | 4.6 | 4.0 | 5.2 | 4.3 | 4.6 | 5.7 | 6.0 | 5.0 | 4.9 | 3.7 |
| WA | 5.4 | 5.3 | 3.5 | 4.5 | 5.3 | 5.6 | 5.8 | 4.8 | 5.8 | 5.9 | 5.6 |
| Tas | 8.4 | 7.1 | 3.0 | 6.8 | 4.1 | 4.6 | 4.1 | 4.4 | 4.3 | 5.2 | 6.6 |
| NT | 3.5 | 5.7 | 8.2 | 5.9 | 7.8 | 5.1 | 7.0 | 5.0 | 4.8 | 3.8 | 10.6 |
| ACT | 3.6 | 2.8 | 5.6 | 2.1 | 7.1 | 8.0 | 1.9 | 5.7 | 2.3 | 7.0 | 2.6 |
| National Average | 5.4 | 4.5 | 4.8 | 5.5 | 5.1 | 6.2 | 5.6 | 5.1 | 5.2 | 5.3 | 5.0 |

3.8 RURAL AND URBAN COMPARISONS

The distribution of the Australian population in 2001 between 'major cities', 'inner regional' or 'outer regional', and 'remote' or 'very remote' areas is represented below.⁴⁵

⁴⁴ ABS, *Suicides: Recent trends, Australia*, Tables on Suicide, cat 3309.0.55.001, table 6.

⁴⁵ *Australia's Health 2004*, p 209. These area classifications are based on the ABS Australian Standard Geographic Classification (ASGC) Remoteness Areas classification, which allocates

| | Major City | Inner Regional | Outer Regional | Remote | Very Remote |
|--------------------------|------------|----------------|----------------|--------|-------------|
| % of national population | 66 | 21 | 10 | 2 | 1 |

From 1997 to 1999, death rates in inner and outer regional areas were, on average, 1.1 times those in major cities. In very remote areas, rates were 1.5 times higher than those in major cities.⁴⁶

These higher death rates equate to approximately 3,303 more deaths annually outside major cities than if major city death rates apply (comprising 2,757 more deaths than expected in regional areas and 546 more in remote areas).⁴⁷ 184, or 6%, of these 'excess' deaths are attributable to suicide.⁴⁸ Nearly all of these are constituted by males.⁴⁹

3.8.1 Males

The trends in death rates from suicide (per 100,000 persons) for younger and older males in these geographical areas from 1997 to 1999, and 2000 to 2002, are shown below.⁵⁰

| Males 15-24 | 1997-1999 | 2000-2002 | Males 65 years and over | 1997-1999 | 2000-2002 |
|----------------|-----------|-----------|-------------------------|-----------|-----------|
| Major cities | 23 | 16 | Major cities | 26 | 19 |
| Inner regional | 33 | 23 | Inner regional | 26 | 25 |
| Outer regional | 34 | 27 | Outer regional | 32 | 30 |
| Remote | 56 | 49 | Remote | 38 | 27 |
| Very remote | 82 | 87 | Very remote | 24 | 40 |

a category of remoteness to areas based on an average of the road distance to the closest of five classes of service centre.

⁴⁶ *Australia's Health 2004*, p 209.

⁴⁷ *Australia's Health 2004*, p 209.

⁴⁸ *Australia's Health 2004*, p 210.

⁴⁹ *Australia's Health 2004*, p 211.

⁵⁰ *Australia's Health 2004*, p 473.

3.8.2 Females

The trends in death rates from suicide (per 100,000 persons) for younger and older females in these geographical areas from 1997 to 1999, and 2000 to 2002, are shown below.⁵¹

| Females 15-24 | 1997-1999 | 2000-2002 | Females 65 years and over | 1997-1999 | 2000-2002 |
|----------------|-----------|-----------|---------------------------|-----------|-----------|
| Major cities | 6 | 4 | Major cities | 6 | 6 |
| Inner regional | 7 | 6 | Inner regional | 5 | 4 |
| Outer regional | 7 | 7 | Outer regional | 5 | 3 |
| Remote | 7 | 16 | Remote | 4 | 6 |
| Very remote | 10 | 16 | Very remote | 10 | 2 |

3.8.3 Queensland

A report into suicide in Queensland between 1996 and 1998 provides an analysis of the statistics for regional and urban areas.⁵² It concludes that there were no statistically significant differences between the rates of suicide in urban and rural areas for either gender, or for all persons overall.⁵³ However, an analysis by age group shows significant differences in the rates for rural males aged 15 to 24 years, and 75 years and over, compared to their urban counterparts. Differences in rates of suicide were also noted for different regions in Queensland.

Urban and rural rates in Queensland

Shown below are the rates of suicide for males and females (per 100,000 of population) in various age groups in urban and regional areas between 1996 and 1998.⁵⁴

⁵¹ *Australia's Health 2004*, p 473.

⁵² Australian Institute for Suicide Prevention (Griffith University), Diego De Leo and Russell Evans, *Suicide in Queensland 1996-1998: Mortality Rates and Related Data*, 2002, http://www.gu.edu.au/school/psy/aisrap/pdf/suicide_qld.pdf. These figures are also referred to in *Reducing Suicide: The Queensland Government Suicide Prevention Strategy 2003-2008*, p 12.

⁵³ *Suicide in Queensland 1996-1998: Mortality Rates and Related Data*, p 51.

⁵⁴ *Suicide in Queensland 1996-1998: Mortality Rates and Related Data*, p 52.

| Age | Urban | | | Rural | | |
|----------|-------|--------|------|-------|--------|------|
| | Male | Female | All | Male | Female | All |
| 15-24 | 30.5 | 6.7 | 18.7 | 39.7 | 9.5 | 25.3 |
| 25-34 | 45.4 | 8.1 | 26.7 | 35.4 | 6.3 | 21.1 |
| 35-44 | 35.8 | 11.6 | 23.5 | 32.5 | 11.7 | 22.4 |
| 45-54 | 25.9 | 9.5 | 17.7 | 29.3 | - | 17.2 |
| 55-64 | 24.0 | 5.7 | 14.9 | 31.4 | - | 19.2 |
| 65-74 | 21.2 | 7.8 | 14.1 | 26.6 | - | 16.6 |
| 75 + | 27.9 | 8.0 | 15.8 | 51.6 | - | 23.5 |
| All ages | 25.3 | 6.8 | 15.9 | 26.3 | 5.6 | 16.3 |

Regional Queensland

Rates of suicide for males and females (per 100,000 of population) in various age groups throughout different regions in Queensland between 1996 and 1998 are listed below.⁵⁵ A map of Queensland, showing the location of the seven regions, is included in Appendix 1 of this Research Brief.

| | Brisbane City | Outer Brisbane | Coastal | Darling Downs & Wide Bay | Mackay-Fitzroy | Western | North & Far North |
|----------------|---------------|----------------|---------|--------------------------|----------------|---------|-------------------|
| Males | | | | | | | |
| 15-24 | 25.1 | 33.9 | 33.4 | 33.8 | 30.5 | 80.9 | 40.3 |
| 25-34 | 46.8 | 43.7 | 44.8 | 39.6 | 34.3 | - | 40.5 |
| 35-44 | 32.6 | 34.0 | 40.7 | 42.4 | 22.1 | - | 36.0 |
| 45-54 | 22.3 | 28.0 | 24.7 | 37.1 | - | - | 28.5 |
| 55-64 | 21.6 | 26.8 | 16.2 | 38.1 | 27.0 | - | 22.2 |
| 65-74 | 18.2 | 36.2 | 17.7 | 24.4 | - | - | - |
| 75 + | 34.0 | - | 28.1 | 43.6 | - | - | - |
| All ages | 24.8 | 25.1 | 25.3 | 28.2 | 20.8 | 35.2 | 26.4 |
| Females | | | | | | | |
| 15-24 | 8.3 | - | - | - | - | - | 12.2 |

⁵⁵ *Suicide in Queensland 1996-1998: Mortality Rates and Related Data*, pp 59-77.

| | | | | | | | |
|-------------------------|------|------|------|------|------|------|------|
| 25-34 | 9.2 | 7.2 | 9.2 | - | - | - | - |
| 35-44 | 12.0 | 7.4 | 17.9 | 12.2 | - | - | 10.6 |
| 45-54 | 8.0 | 10.7 | 14.1 | - | - | - | - |
| 55-64 | - | - | - | - | - | - | - |
| 65-74 | - | - | - | - | - | - | - |
| 75 + | - | - | - | - | - | - | - |
| All ages | 6.8 | 5.8 | 10.0 | 4.9 | 3.9 | 7.7 | 6.4 |
| Persons all ages | 15.6 | 15.4 | 17.5 | 16.6 | 12.6 | 22.4 | 16.7 |

(Note: - indicates that the rate was not calculated because the number of suicides was less than 10).

3.9 DIFFERENCES BETWEEN INDIGENOUS AND NON-INDIGENOUS POPULATIONS

The distribution of the Indigenous population in 2001 between 'major cities', 'inner regional' or 'outer regional', and 'remote' or 'very remote' is represented below.⁵⁶

| | Major City | Inner Regional | Outer Regional | Remote | Very Remote | Australia |
|--|------------|----------------|----------------|--------|-------------|-----------|
| Indigenous population as a % of total population in the area | 1 | 2 | 5 | 12 | 45 | 2 |
| % of national Indigenous population | 30 | 20 | 23 | 9 | 18 | 100 |

The proportion of total deaths attributable to suicide for both Indigenous and non-Indigenous populations throughout Australia between 1998 and 2002 is listed below.⁵⁷

⁵⁶ *Australia's Health 2004*, p 209. These area classifications are based on the ABS Australian Standard Geographic Classification (ASGC) Remoteness Areas classification, which allocates a category of remoteness to areas based on an average of the road distance to the closest of five classes of service centre.

⁵⁷ ABS, *Causes of Death*, 2002, cat 3303.0, pp 26-29; ABS, *Causes of Death*, 2001, cat 3303.0, pp 26-29; ABS, *Causes of Death*, 2000, cat 3303.0, pp 33-36; ABS, *Causes of Death*, 1999, cat 3303.0, pp 33-35; ABS, *Causes of Death*, 1998, cat 3303.0, pp 33-34.

| Proportion of total deaths (%) | WA | SA | NSW | Vic | Qld | NT | Australia |
|--------------------------------|-----|-----|-----|-----|------------|-----|------------|
| 2002 | | | | | | | |
| Indigenous | 2.4 | 2.8 | 5.0 | 4.7 | 6.8 | 7.1 | 5.4 |
| Non-Indigenous | 2.0 | 1.4 | 1.4 | 1.5 | 2.1 | 5.0 | 1.7 |
| 2001 | | | | | | | |
| Indigenous | 3.0 | 6.4 | 3.7 | 7.5 | 7.4 | 4.2 | 5.1 |
| Non-Indigenous | 2.9 | 1.6 | 1.8 | 1.7 | 2.1 | 5.7 | 1.9 |
| 2000 | | | | | | | |
| Indigenous | 5.7 | 3.5 | 3.2 | 4.6 | 4.5 | 3.1 | 4.0 |
| Non-Indigenous | 2.3 | 1.7 | 1.6 | 1.6 | 2.4 | 6.1 | 1.8 |
| 1999 | | | | | | | |
| Indigenous | 3.4 | 1.7 | 1.6 | 3.1 | 4.5 | 4.0 | NA |
| Non-Indigenous | 2.1 | 1.8 | 1.9 | 1.7 | 2.0 | 3.7 | NA |
| 1998 | | | | | | | |
| Indigenous | 5.3 | 7.1 | NA | NA | 7.4 | 2.7 | NA |
| Non-Indigenous | 2.6 | 2.0 | NA | NA | 2.5 | 6.8 | NA |

The rate of non-fatal hospital separations among Indigenous Australians from 2001 to 2002 (per 1,000 persons), compared to all Australians, is shown below.⁵⁸

| | Non-Indigenous | Not Stated | Indigenous | Total |
|-------------------|----------------|------------|------------|-------|
| Males | 1.2 | 2.2 | 2.5 | 1.2 |
| Females | 1.8 | 1.8 | 3.1 | 1.8 |
| All people | 1.5 | 1.9 | 2.8 | 1.5 |

The data shows that there continues to be a much higher rate of completed and attempted suicide in Indigenous communities compared to the general population. Among Queensland's population, the proportion of deaths due to suicide is recorded at a higher level than the national average for Indigenous populations.

In 2001, the rate of death from suicide for Indigenous Australians was 35.5 (per 100,000 persons), compared to 13.1 for other Australians. Particularly high was

⁵⁸ Commonwealth. Productivity Commission, *Overcoming Indigenous Disadvantage Key Indicators 2003*, November 2003, p 3.43, <http://www.pc.gov.au/gsp/reports/indigenous/keyindicators2003/keyindicators2003.pdf>.

the rate among those aged 25 to 34 years (67.2), followed by the 35 to 44 year age group (35.9).⁵⁹

For the period 1999 to 2001, the suicide rates for Indigenous males aged 15 to 24 years were over four times higher than the corresponding age-specific rates for males in the general population. The rates for Indigenous males aged 25 to 34 years were three times higher. From 45 years and over, however, Indigenous males record lower or equivalent rates compared to the rates for males in the same age group in the general population. Other than for 15 to 24 year old Indigenous females (who have a death rate from suicide four times higher than the corresponding age-specific rate for females in the general population), Indigenous females have similar rates to those for all Australian females.⁶⁰

For Indigenous males, the leading cause of death from external causes between 1999 and 2001 was intentional self-harm (33%), followed by transport accidents (24%) and assault (10%).⁶¹

3.10 LOWER RATES OF SUICIDE AMONG MARRIED PEOPLE

The table below indicates that between 1980 and 1997:⁶²

- married people were less likely to die from suicide than those who had never married or who were widowed or divorced;
- people in marriages demonstrated a more stable rate of suicide than those who had never married or who were widowed or divorced;
- the rate of suicide among people who had never married increased; and
- although there was a decline in the rate of suicide among divorced people, the rate remained considerably high, for both males and females.

⁵⁹ *Overcoming Indigenous Disadvantage Key Indicators 2003*, November 2003, pp 3.39, 3.42.

⁶⁰ ABS, *The Health and Welfare of Australia's Aboriginal and Torres Strait Island Peoples*, 2003, cat 4704.0, p 196.

⁶¹ *The Health and Welfare of Australia's Aboriginal and Torres Strait Island Peoples*, p 195.

⁶² ABS, *Suicides, Australia, 1921-1998*, cat 3303.9, p 25. These figures are the rates of death from suicide per 100,000 persons.

| | Never Married | Married | Widowed | Divorced | Total |
|----------------|---------------|---------|---------|----------|-------|
| Males | | | | | |
| 1980-82 | 23.8 | 14.0 | 41.3 | 45.5 | 19.1 |
| 1985-87 | 27.8 | 16.7 | 59.4 | 52.1 | 24.6 |
| 1990-92 | 31.1 | 14.9 | 43.1 | 48.5 | 22.7 |
| 1995-97 | 33.0 | 14.3 | 43.1 | 42.2 | 23.4 |
| Females | | | | | |
| 1980-82 | 6.8 | 4.6 | 10.7 | 19.0 | 6.4 |
| 1985-87 | 8.2 | 4.5 | 11.0 | 17.5 | 6.7 |
| 1990-92 | 7.2 | 3.7 | 9.2 | 14.4 | 5.8 |
| 1995-97 | 8.2 | 3.5 | 6.2 | 14.0 | 5.6 |
| Persons | | | | | |
| 1980-82 | 16.7 | 9.3 | 16.3 | 30.7 | 12.4 |
| 1985-87 | 19.1 | 9.3 | 17.4 | 28.9 | 13.4 |
| 1990-92 | 20.6 | 9.3 | 15.9 | 29.6 | 14.1 |
| 1995-97 | 22.0 | 8.9 | 13.1 | 26.5 | 14.0 |

3.11 ASSOCIATED OR CONTRIBUTORY CAUSES OF SUICIDE

In 1997, the Australian Bureau of Statistics started tabulating all causes and conditions reported on death certificates. In 1998, the following conditions were recorded as associated or contributory causes of suicide.⁶³

| Reported Medical Condition | Males (%) | Females (%) |
|---|-----------|-------------|
| Mental Disorder | 15.1 | 18.2 |
| (Substance use) | (9.0) | (5.4) |
| (Depressive disorder) | (4.1) | (9.0) |
| Diseases of the circulatory system | 3.9 | 4.5 |
| Symptoms and signs of ill-defined conditions | 2.4 | 4.1 |
| Diseases of the nervous system and sense organs | 1.6 | 3.4 |

⁶³ ABS, Australian Social Trends 2000, *Health – Mortality and Morbidity: Suicide*.

| | | |
|---------------------------------------|------|------|
| Neoplasms | 1.3 | 2.1 |
| HIV | 0.4 | 0.0 |
| Total with reported medical condition | 22.9 | 28.7 |

3.12 INTERNATIONAL TRENDS

A comparison of the rates of suicide (per 100,000 people) between males and females of varying age groups in different countries is shown below.⁶⁴

The data indicates that, by international standards, Australia:

- continues to experience high rates of suicide among males aged 15 to 24 years and 25 to 34 years; and
- has lower rates of suicide among males and females aged 75 years and over.

| Country | Latest Year | 15-24 | | 25-34 | | 35-44 | | 75+ | |
|------------------|-------------|-------------|------------|-------------|------------|-------------|------------|-------------|------------|
| | | Males | Females | Males | Females | Males | Females | Males | Females |
| Argentina | 1996 | 8.8 | 3.4 | 9.3 | 2.1 | 10.3 | 3.8 | 42.4 | 7.7 |
| Australia | 1999 | 22.1 | 5.3 | 35.4 | 8.1 | 29.6 | 7.3 | 30.0 | 3.4 |
| Austria | 2001 | 20.6 | 3.8 | 22.9 | 6.7 | 28.0 | 9.0 | 80.6 | 22.7 |
| Belgium | 1996 | 21.6 | 5.7 | 30.4 | 10.1 | 42.0 | 15.2 | 78.0 | 15.6 |
| Bulgaria | 2000 | 8.9 | 3.5 | 17.4 | 6.5 | 30.2 | 6.1 | 96.6 | 35.4 |
| Canada | 1998 | 21.6 | 5.1 | 22.1 | 5.2 | 30.3 | 7.7 | 31.6 | 6.9 |
| China | 1999 | 9.0 | 6.8 | 18.1 | 8.8 | 16.8 | 9.9 | 53.1 | 38.4 |
| Czech Republic | 2000 | 17.4 | 3.3 | 22.2 | 3.5 | 36.7 | 6.9 | 72.9 | 16.6 |
| Denmark | 1998 | 10.4 | 2.8 | 20.3 | 4.0 | 26.9 | 7.2 | 54.2 | 16.0 |
| Finland | 2000 | 31.1 | 8.1 | 46.5 | 12.4 | 50.4 | 13.6 | 42.1 | 7.3 |
| Germany | 1999 | 12.7 | 3.0 | 17.7 | 4.4 | 23.3 | 6.8 | 62.0 | 18.5 |
| Ireland | 1999 | 25.7 | 5.3 | 29.6 | 5.4 | 22.6 | 3.8 | 14.3 | 4.4 |
| Israel | 1997 | 12.6 | 1.6 | 12.6 | 3.2 | 13.5 | 2.9 | 44.1 | 15.4 |
| Italy | 1999 | 6.8 | 1.7 | 10.3 | 2.7 | 10.3 | 3.3 | 34.3 | 6.3 |
| Japan | 1999 | 16.5 | 7.3 | 28.1 | 11.6 | 37.0 | 10.5 | 60.7 | 34.1 |

⁶⁴ This table was compiled from the most recent data available on each of the countries from the World Health Organisation website, http://www.who.int/mental_health/prevention/suicide/country_reports/en/.

| Country | Latest Year | 15-24 | | 25-34 | | 35-44 | | 75+ | |
|-------------|-------------|-------|---------|-------|---------|-------|---------|-------|---------|
| | | Males | Females | Males | Females | Males | Females | Males | Females |
| Netherlands | 1999 | 8.5 | 4.4 | 15.1 | 6.5 | 16.6 | 7.6 | 27.1 | 9.3 |
| Norway | 1999 | 28.3 | 8.9 | 26.1 | 8.0 | 19.2 | 8.9 | 19.5 | 5.9 |
| NZ | 1998 | 38.1 | 13.3 | 39.2 | 8.5 | 28.9 | 9.7 | 28.0 | 5.1 |
| Portugal | 2000 | 3.7 | 1.0 | 4.9 | 1.1 | 8.6 | 1.1 | 44.9 | 7.8 |
| Singapore | 2000 | 6.5 | 7.7 | 12.5 | 5.9 | 18.4 | 6.0 | 48.8 | 23.0 |
| Spain | 1999 | 7.2 | 2.1 | 11.0 | 2.0 | 12.4 | 3.3 | 43.9 | 9.8 |
| Sweden | 1999 | 14.8 | 6.4 | 16.2 | 7.4 | 24.7 | 11.7 | 40.3 | 10.8 |
| Switzerland | 1999 | 20.1 | 5.2 | 24.4 | 6.7 | 26.8 | 9.4 | 76.9 | 22.7 |
| UK | 1999 | 10.6 | 2.5 | 18.1 | 3.9 | 17.3 | 4.7 | 15.5 | 5.1 |
| USA | 1999 | 17.2 | 3.1 | 22.2 | 4.8 | 22.5 | 6.4 | 41.7 | 4.6 |

4 CURRENT REASONING

The National Advisory Council on Suicide Prevention commissioned a report by the Australian Institute for Suicide Research and Prevention, at Griffith University, on recent trends in international suicide rates and implications for Australia. The report was released in November 2003⁶⁵ and considered the following:

- suicide mortality data and their reliability;
- recent trends in age-specific suicide rates around the world, considering adolescence (15 to 24 years), early adulthood (25 to 44 years), middle adulthood (45 to 64 years) and late adulthood (65 years and over);
- national suicide prevention strategies (components of the strategies and their impact on suicide rates);
- mental health and mental health programs (mental conditions as a risk factor for suicide, international responses to mental illness and mental health policies, and the impact of mental health policies on suicide rates);
- substance abuse and substance abuse policies (substance abuse as a risk factor for suicide, a comparison of alcohol consumption and suicide, and substance abuse policies and their impact on suicide trends);
- the impact of antidepressants use;

⁶⁵ Australian Institute for Suicide Research and Prevention (Griffith University), Diego De Leo and Russel Evans, *International Suicide Rates – Recent Trends and Implications for Australia*, November 2003, <http://www.parliament.qld.gov.au/ConcordDocs/E04/E040408LP02.PDF>. The report was funded by the Australian Government Department of Health and Ageing.

- unemployment and suicide; and
- the influence of period and cohort effects on suicide rates.

4.1 EFFECTIVENESS OF NATIONAL STRATEGIES FOR SUICIDE PREVENTION

The report discusses the comprehensive ‘national strategies’⁶⁶ for suicide prevention developed in Australia,⁶⁷ Finland, New Zealand, Norway and Sweden.

The report concludes that declines in suicide in the countries with national prevention strategies cannot be validly attributed to the introduction of those strategies. Even if the strategies have contributed to recent reductions, the contribution they make cannot currently be identified. There is also little evidence to support the efficacy of any particular approaches or strategies.⁶⁸

Limiting access to means is said to be an approach to suicide prevention that has the strongest evidence for efficacy in prevention, and is a key factor in all national strategies (for example, limiting firearm ownership, detoxifying domestic and exhaust gases, limiting the quantity of medications per pack, reducing prescriptions of lethal medications, erecting barriers on bridges).⁶⁹

It was also noted that improved detection and treatment of depression, which was another potentially efficacious approach to suicide prevention, was a major component of all strategies.⁷⁰

⁶⁶ A ‘national strategy’ was defined “by a set of integrated activities that were multifaceted”, as distinct from ‘prevention programs’ which “consisted of one or more targeted activities with no planned coordination between activities” (*International Suicide Rates – Recent Trends and Implications for Australia*, p 78). It was noted that, more recently, national strategies had been developed in England, the United States, Denmark and Germany.

⁶⁷ The Australian strategies that were considered were the *National Youth Suicide Prevention Strategy* (which targeted youth suicide) and the *National Suicide Prevention Strategy* (which covers all age groups). These strategies are discussed in more detail in part 5.1 of this Research Brief.

⁶⁸ *International Suicide Rates – Recent Trends and Implications for Australia*, p 87.

⁶⁹ *International Suicide Rates – Recent Trends and Implications for Australia*, p 88.

⁷⁰ *International Suicide Rates – Recent Trends and Implications for Australia*, p 88.

4.2 MENTAL HEALTH AND MENTAL HEALTH PROGRAMS

The report stated that suicide occurs most often in circumstances where a person is suffering a pre-existing psychiatric (and/or comorbid) condition, and that approximately 90% of people who complete suicide have at least one diagnosable psychiatric condition at the time of death.⁷¹

Some mood disorders (such as depression) are recognised as being important contributing factors to suicide, as are psychotic disorders (such as schizophrenia), anxiety disorders (such as obsessive compulsive disorder, panic disorder and post traumatic stress disorder) and personality disorders.⁷²

Australia implemented a national mental health program in 1993.⁷³ In relation to the efficacy of national mental health strategies in preventing suicide, the report states that:⁷⁴

The failure of mental health programmes, policies and legislation to have a desired impact on suicide rates necessitates examination of the utility of such programmes in suicide prevention. While some mental health problems are a core risk factor for suicide, suicide prevention requires an integrated approach. This approach is one which acknowledges the interrelatedness of all risk and protective factors for suicide, and which targets both individual and populations levels. An approach to suicide prevention must acknowledge the importance of other related initiatives and their impact on suicide rates. The main problem, however, is that the linkages between mental health and other related strategies (for example, drug and alcohol, crime prevention, suicide prevention, media strategies, and national injury programmes etc) is not always clearly understood.

More consideration must therefore be given to clarifying the linkage between mental health problems and suicide in understanding the impact of mental health strategies on suicide rates.

...

[M]ental health problems are not the only factor associated with suicide risk, ... other risk factors ... may interrelate either in the absence or presence of mental health problems, to result in suicide. These findings strongly support the need to increase understanding of the relations between mental health and suicide, and the impact of mental health and other related strategies (regarding other risk factors for suicide) on reducing suicide rate.

⁷¹ *International Suicide Rates – Recent Trends and Implications for Australia*, p 90.

⁷² *International Suicide Rates – Recent Trends and Implications for Australia*, pp 90-92.

⁷³ *National Mental Health Strategy*. This strategy is discussed in more detail in part 5.1.3 of this Research Brief.

⁷⁴ *International Suicide Rates – Recent Trends and Implications for Australia*, pp 99-100.

4.3 SUBSTANCE ABUSE AND SUBSTANCE ABUSE POLICIES

The report states that substance abuse or dependence heightens a person's risk of suicide, particularly if the individual has another mental illness. In some instances, suicide may be linked directly to the harmful effects of a substance, such as an intentional drug overdose. In other cases, the substance abuse may increase risk of suicide by inducing other psychiatric symptoms (for example, depression) or stressful life events (for example, interpersonal losses), decreasing inhibitions or increasing impulsive behaviour.⁷⁵

Opiates, cannabis and alcohol have been associated with an elevated risk of suicide, whereas the risk among cocaine and amphetamine users has not been systematically determined.⁷⁶ The greatest impact on suicide trends is most likely due to alcohol abuse, as it is used by a large portion of the population.

Australia has implemented a substance abuse strategy.⁷⁷

The report states, however, that substance abuse policies have showed no consistent impact on suicide mortality.⁷⁸

4.4 IMPACT OF ANTIDEPRESSANTS' USE

The report indicates that depressive disorders may be present in 60% of the people who suicide, and it is widely recognised that improved diagnosis and treatment of depression is critical to suicide prevention. It was noted that most people were not receiving treatment for a psychological disorder when they suicided.⁷⁹

The importance of general practitioners in suicide prevention was reinforced by the fact that they are generally considered the 'first line' of treatment for most physical and psychological illness (including depression), and that roughly half of all individuals who complete suicide see a health care professional in the month prior to their death.⁸⁰

⁷⁵ *International Suicide Rates – Recent Trends and Implications for Australia*, p 101.

⁷⁶ *International Suicide Rates – Recent Trends and Implications for Australia*, p 101.

⁷⁷ *National Drug Strategy*. This strategy is discussed in more detail in part 5.1.3 of this Research Brief.

⁷⁸ *International Suicide Rates – Recent Trends and Implications for Australia*, p 113.

⁷⁹ *International Suicide Rates – Recent Trends and Implications for Australia*, p 118.

⁸⁰ *International Suicide Rates – Recent Trends and Implications for Australia*, p 119.

The report states that general practitioners commonly used drugs as the primary treatment for depression, above other methods which address the range of psychosocial factors that are related to suicide and depression. Concerns were also raised regarding patients being prescribed doses below the therapeutic doses for depression.⁸¹

The use of antidepressants has rapidly increased since the late 1980s. Despite this, the report suggests that while antidepressants may be effective in the treatment of depressive disorders, there is strong evidence that they have no effect in reducing the risk of attempts or completions of suicide.⁸² There are also concerns of increased suicide rates among users of 'SSRIs' (selective serotonin reuptake inhibitors), a particular class of antidepressants which became available in the late 1980s.⁸³

It has been stated that in 2003, antidepressant drugs were prescribed to 250,000 Australian children and adolescents, an increase of 30,000 from the previous year. More than 10 million scripts for antidepressants, totalling \$270 million, were issued to Australians in 2003, up by 60% from 1998. As an indication of the increase in antidepressants use since the release of SSRIs in the late 1980s, one in 30 people used antidepressants in 1997, compared with one in 80 in 1980.⁸⁴

4.5 UNEMPLOYMENT

The report discusses the association between trends in unemployment and risk of suicide, which is stronger in younger people and in males.

⁸¹ *International Suicide Rates – Recent Trends and Implications for Australia*, p 119.

⁸² *International Suicide Rates – Recent Trends and Implications for Australia*, pp 120-121.

⁸³ *International Suicide Rates – Recent Trends and Implications for Australia*, pp 121-122.

⁸⁴ For a discussion of the concerns in newspaper reports regarding an increase in the risk of suicide among users of SSRIs see, for example, Richard Yallop, 'Suicide warning for Prozac', *Australian*, 25 March 2004, p 7; Patrick O'Neil, 'Medicines linked to teenage suicides', *Courier Mail*, 27 February 2004, p 15; Leanne Edmestone, 'Medical jury still out on teen depression medications', *Courier Mail*, 4 June 2004, p 12; 'Drugs, doctors and the age of anxiety', *Age*, 23 April 2004, p 1; Richard Guilliat, 'A bitter pill', *Good Weekend*, 19 June 2004; Jessica Lawrence, 'How happy pills are running our lives', *Courier Mail*, 30 May 2004, p 18; Michael Bradley, 'More taking antidepressants, but not for long enough', *Sydney Morning Herald*, 5 July 2004; Belinda Hickman, 'Taking depression out of the shadows', *Australian*, 6 December 1999; Carol Nader, 'Antidepressants: first 9 days a risk', *Age*, 22 July 2004.

Unemployment may also be related to job insecurity, relationship stresses, bankruptcy and poverty, pre-existing mental health or personality disorders. These further problems may also contribute to an increased risk of suicide, in addition to the risk posed simply by the unemployment. Alternatively, some of these factors may also cause, or contribute to, the circumstance of a person's unemployment.⁸⁵

4.6 CONCLUSIONS

The report makes the following conclusions:⁸⁶

- Substance abuse is a particularly important risk factor in suicide, with alcohol having the greatest impact on suicide trends due to its use by a large majority of the population. Greater impacts are likely in countries where binge drinking and alcohol dependence is common. It is recommended that the importance of substance abuse as a risk factor be investigated in Australia, particularly in relation to alcohol use. Depending on the outcome of such an investigation, consideration should be given to addressing the issue within the *National Suicide Prevention Strategy*.
- The reliance of general practitioners on antidepressants in treating individuals prone to suicide may be unsound, and greater consideration needs to be given to psychosocial factors (for example, financial, unemployment, interpersonal difficulties and marital separation). The combined use of antidepressants and psychosocial interventions may have a better outcome, and could be achieved through greater coordination between general practitioners and allied health professionals in the treatment of suicide.
- Unemployment, particularly among the young, needs to be given greater emphasis in national strategies, especially during times of economic recession.
- Investment in scientifically valid investigations to assess the efficacy of specific suicide prevention activities, or packages of activities, is imperative.

⁸⁵ *International Suicide Rates – Recent Trends and Implications for Australia*, p 127.

⁸⁶ *International Suicide Rates – Recent Trends and Implications for Australia*, pp 140-141.

5 GOVERNMENT STRATEGIES

From the late 1990s, there has been a shift in the focus of the suicide prevention strategies of both the Commonwealth and Queensland Governments from youth suicide to suicide across all age groups.

This shift seems to be underpinned by the recent trends in the rates of suicide which are evident from the statistics outlined in part 3 of this Research Brief.

5.1 COMMONWEALTH

Moves for a suicide prevention program at a national level commenced in 1992 when the National Health and Medical Research Council appointed a working group to investigate options for suicide prevention. In 1994, the Commonwealth Government identified suicide prevention as one of its targets in *Better Health Outcomes for Australians – National goals, targets and strategies for better health outcomes into the next century*.

In the 1995/1996 Federal Budget, \$13 million was allocated over four years to the *Here for Life: A National Plan for Youth in Distress* program. In the following budget, a further \$18 million was allocated to expand the program to the *National Youth Suicide Prevention Strategy*, with a total of \$31 million from July 1995 to June 1999.

In 1999, the focus of suicide prevention was extended to Australians across all age groups under the *National Suicide Prevention Strategy*.

In both instances, the strategies have had a broader public health focus, rather than concentrating solely on the needs of high-risk individuals.

5.1.1 National Youth Suicide Prevention Strategy

In 1995, the Department of Health and Ageing published the *National Youth Suicide Prevention Strategy* ('Youth Strategy').⁸⁷

The Youth Strategy primarily addressed the needs of young Australians, and placed great emphasis on early intervention programs to target risk factors associated with suicide.

⁸⁷ Information on the Youth Strategy is available at <http://www.mentalhealth.gov.au/sp/nysps/about.htm>.

Youth Strategy

‘Youth Suicide in Australia: the national youth suicide prevention strategy’⁸⁸ was published in 1997 and outlined Commonwealth plans and activities to June 1999 to tackle youth suicide.

Out of the \$31 million program in total, \$18 million which was allocated under the 1996/97 Federal Budget was used as follows:

- \$6 million for supporting rural youth counselling services;
- \$6 million for enhancing telephone counselling services;
- \$3 million for parent programs;
- \$2 million for the education and training of professionals; and
- \$1 million for research activities.

The four goals of the Youth Strategy were:

- prevention of premature death from suicide among young people;
- reduction in rates of injury and self-harm arising from suicidal behaviour among young people;
- reduction in the incidence and prevalence of suicidal ideation and behaviour among young people; and
- enhancement of the resilience, resourcefulness, respect and interconnectedness of young people, their families and communities.

The Youth Strategy focused on:

- Information gathering activities, to ensure that youth suicide prevention programs and policies were consistent with the highest need, based on the best available evidence, and acceptable and appropriate to the primary target groups. Input from, and consultation with, young people was a feature of the Youth Strategy. \$1 million was also allocated for research into youth suicide.
- Policy and planning activities, to consolidate information regarding best practice into a consistent, clear, accountable, intersectoral and regularly reviewed policy framework. A Youth Suicide Prevention Advisory Group was formed.
- Program development activities, which aimed to influence individual suicide prevention programs and service providers to adopt work practices which were identified as the most effective (for example, in improving education and training in youth suicide prevention, the development of a

⁸⁸ Commonwealth. Department of Health and Family Services, *Youth Suicide in Australia: the national youth suicide prevention strategy*, 1997, <http://www.mentalhealth.gov.au/resources/nysps/pdf/mhb31.pdf>.

Resource Guide on Education and Training, pre-employment training at universities and TAFEs, on-the-job training, conferences and intersectoral networking).

- Injury prevention activities, which aimed to reduce the availability of the more lethal methods of suicide and self-harm.
- Primary prevention and cultural change activities, which targeted young people in general (for example, the \$3 million parenting programs, liaison activities with the media regarding the responsible portrayal of suicide, an initiative to encourage mental health promotion and suicide prevention in schools and a \$1 million allocation to the prevention of suicide in indigenous communities).
- Crisis intervention and primary care programs, which provided direct access to young people at high risk of suicide and which were aimed at averting or ameliorating a suicide crisis (for example, improved access to telephone counselling services following a \$3 million allocation to each of Lifeline and Kids Help Line, and assistance to general practitioners in developing their skills to prevent and respond to suicide).
- Ongoing specialist interventions for young people at sustained risk of suicide, and postvention activities for families and friends affected by the suicide of a young person (for example, rural youth counselling services and offering appropriate services within existing health, welfare, community or youth service systems within local communities, support groups, debriefing and grief work).
- Community development and support approaches, to harness the strength of the entire community in preventing and responding to youth suicide (for example, peer education and support activities, community advocacy groups and volunteer programs).
- Specialised and diverse approaches, which provided programs for young people with special needs and supported equity of access to services (for example, indigenous youth, young men in rural communities, youth from different cultural backgrounds, youth in the criminal justice system and youth with sexuality and drug use problems).

Background Monograph

The 'Youth Suicide in Australia: a background monograph'⁸⁹ was issued as a companion document to the Youth Strategy and considered:

⁸⁹ Commonwealth. Department of Health and Family Services, *Youth Suicide in Australia: a background monograph*, 1997,

- how serious the problem of youth suicide was in Australia;
- how Australia's rates of youth suicide compared internationally;
- the causes and risk factors for suicide among young people; and
- the prevention of youth suicide (including possible options for activities by the Government, community or particular organisations within the framework of an overall approach to suicide prevention).

The possible options for the prevention of youth suicide that were raised included:

- primary prevention strategies aimed at the whole community, or particular population groups;
- strategies for the depiction of suicide in the media;
- reducing access to methods of suicide;
- school based suicide prevention programs;
- targeted interventions for high risk groups and individuals;
- training for caregivers and professionals in health, education and emergency services;
- a mental health approach; and
- an 'intersectoral' approach, involving families, communities and health and welfare professionals.

Achievements

Major achievements of the Youth Strategy included:⁹⁰

- parenting skills programs, which were implemented nationally using proven primary prevention and early intervention approaches, and preparation and delivery of brochures promoting skills for parenting children and adolescents;
- training programs for over 2,500 general practitioners and community health workers, rural, Aboriginal and Torres Strait Islander communities and other community members and tertiary students in medicine, nursing, teaching, journalism, youth work and juvenile justice;
- suicide prevention internet sites (such as 'ReachOut!')⁹¹ and research and information publications for a range of audiences;

<http://www.mentalhealth.gov.au/resources/nysps/pdf/mhb32.pdf>. The monograph was reprinted in 1996 and 1997. The copy that is attached here is the second edition (1997).

⁹⁰ These achievements are listed at <http://www.mentalhealth.gov.au/sp/nysps/about.htm>.

⁹¹ [insert web link]. The ReachOut! Website is discussed in part 6.2 of this Research Brief.

- ‘LIFE’,⁹² a national framework for suicide prevention for the whole community;
- appointment of a National Advisory Council on Youth Suicide Prevention, that brought together Commonwealth, State and Territory governments, community representatives and technical expertise to ensure a national and coordinated approach to suicide prevention;
- initiation of suicide prevention strategies in all States and Territories (previously only Western Australian had a strategy);
- identification of effective models for intervention and prevention of suicide in emergency, mental health, youth and community services;
- publication of two national stocktakes of over 1,000 suicide prevention programs;
- grants to States and Territories for boosting rural and regional youth counselling services; and
- funding to telephone counselling services (such as Lifeline and Kids Help Line).

Assessment of Youth Strategy

The Australian Institute of Family Studies (AIFS) was commissioned to:

- assess the information and communication needs of those involved in youth suicide prevention (this included the two national stocktakes of youth suicide prevention activities and programs mentioned above);⁹³ and
- evaluate the Youth Strategy.

The AIFS also provided information resources for people who were working in, studying or concerned about suicide prevention.⁹⁴

In summary, the evaluation of the Youth Strategy in 2000⁹⁵ found that it:

- enhanced the capacity of services to prevent youth suicide; and

⁹² See <http://www.mentalhealth.gov.au/resources/life/framework.htm>. The LIFE national framework is discussed in part 5.1.2 of this Research Brief.

⁹³ See <http://www.aifs.gov.au/ysp/stocktakemenu.html> (for a description of the stocktakes) and <http://www.aifs.gov.au/ysp/stanalysismenu.html> (for the first stocktake).

⁹⁴ The Youth Suicide Prevention Bulletins may be viewed at <http://www.aifs.gov.au/ysp/pubsmenu.html#bulletins>.

⁹⁵ For the main report (‘Valuing young lives: Evaluation of the National Youth Suicide Prevention Strategy’) and four supplementary technical reports, see <http://www.aifs.gov.au/ysp/yspevaluation/evalmenu.html>.

- developed the evidence base to guide future suicide prevention strategies in Australia.

The evaluation also made a series of 36 recommendations to inform future efforts in suicide prevention.

5.1.2 National Suicide Prevention Strategy

In 1999, the focus of suicide prevention was expanded to cover all age groups within the Australian population under a \$48 million strategy for four years to June 2004 ('National Strategy').

National Framework - LIFE

LIFE ('Living Is For Everyone')⁹⁶ is a four year framework for the prevention of suicide and self-harm across all age groups. It was established in 2000 by the Department of Health and Aged Care, and was developed by the National Advisory Council on Youth Suicide Prevention.

The framework is guided by, and continues to expand on, initiatives commenced under the Youth Strategy.⁹⁷ A new National Advisory Council for Suicide Prevention was formed in August 2000 from the National Advisory Council on Youth Suicide Prevention.

Despite a broadened focus to all age groups, the National Strategy has retained a particular emphasis on young people. It seeks to encourage strategic partnerships, and to position suicide prevention efforts, across all levels of government and the community. The National Strategy offers a framework for planners and workers across a range of sectors to inform them of national priorities and directions in suicide prevention.

Under the National Strategy, emphasis has been placed on the involvement and cooperation of all Australians in building resilience, resourcefulness, tolerance and capacity in the community, and promoting positive options to those at risk of suicide.

⁹⁶ See <http://www.mentalhealth.gov.au/resources/life/framework.htm>.

⁹⁷ The initiatives commenced under the Youth Strategy and continued under the National Strategy included a media and schools initiative (the Mindframe National Media Strategy – see <http://www.mentalhealth.gov.au/mhinfo/ems/media.htm>), building workforce capacity for reducing suicide (see <http://www.mentalhealth.gov.au/mhinfo/ems/nucp.htm>) and developing and promoting best practice (see <http://www.mentalhealth.gov.au/mhinfo/ppei/eiprojects.htm>).

The four broad goals of the National Strategy include:

- reducing deaths from suicide across all age groups and reducing suicidal thinking, behaviour and the injury or self-harm that results;
- enhancing resilience and resourcefulness, respect, interconnectedness and mental health in young people, families and communities, and reducing the prevalence of risk factors for suicide;
- increasing support to individuals, families and communities affected by suicide or suicidal behaviours;
- providing a ‘whole of community’ approach to suicide prevention and extending and improving public understanding of suicide and its causes.

The National Strategy considers suicide prevention strategies at a local level and supports community organisations and the development of community models of suicide prevention.

Various community projects and initiatives funded under the National Strategy are located in Queensland.⁹⁸

The three companion documents which are part of the National Strategy are discussed below.

LIFE – Areas for Action

‘LIFE - A framework for prevention of suicide and self-harm in Australia – Areas for action’⁹⁹ outlines the framework and major goals, principles and strategic performance indicators for the National Strategy. It also discusses the strategies, outcomes and performance indicators across six action areas.

Suicide prevention activities across the different age groups are also outlined.¹⁰⁰

The six strategic performance indicators are to:¹⁰¹

- reduce the rate of suicide death in the Australian population;

⁹⁸ For information on these projects and initiatives see <http://www.community-life.org.au/nsps.php#list>.

⁹⁹ Commonwealth. Department of Health and Aged Care, *LIFE - A Framework for Prevention of Suicide and Self-harm in Australia – Areas for Action*, 2000, <http://www.mentalhealth.gov.au/resources/life/pdf/action.pdf>.

¹⁰⁰ *LIFE - A Framework for Prevention of Suicide and Self-harm in Australia – Areas for Action*, pp 76-87.

¹⁰¹ *LIFE - A Framework for Prevention of Suicide and Self-harm in Australia – Areas for Action*, pp 18-20.

- reduce the incidence of non-fatal suicide behaviours;
- reduce probable and potentially modifiable risk factors for suicidal behaviour;
- enhance probable and potentially modifiable protective factors for suicidal behaviour;
- enhance community capacity; and
- increase investment in development, research and evaluation of suicide prevention strategies that support a national strategic direction.

The six areas for action are:¹⁰²

- promoting well-being, resilience and community capacity across Australia;
- enhancing protective factors and reducing risk factors for suicide and self-harm across the Australian community;
- services and support within the community for groups at increased risk;
- services for individuals at high risk;
- partnerships with Aboriginal and Torres Strait Islander peoples; and
- progressing the evidence base for suicide prevention and good practice.

LIFE – Learnings about Suicide

‘LIFE – A Framework for Prevention of Suicide and Self-harm in Australia - Learnings about Suicide’¹⁰³ sets the context for suicide prevention activity. It provides a profile of the incidence of suicide and outlines current knowledge regarding risk and protective factors across different age, population and identified ‘at risk’ groups.

Life – Building Partnerships

‘Life – A Framework for Prevention of Suicide and Self-harm in Australia - Building Partnerships’¹⁰⁴ describes the programs, organisations and governments with an interest in, or potential overlap with, suicide prevention activities.

¹⁰² *LIFE - A Framework for Prevention of Suicide and Self-harm in Australia – Areas for Action*, p 21. The action areas are discussed in detail at pages 28 to 73.

¹⁰³ Commonwealth. Department of Health and Aged Care, *LIFE – A Framework for Prevention of Suicide and Self-harm in Australia - Learnings about Suicide*, 2000, <http://www.mentalhealth.gov.au/resources/life/pdf/learning.pdf>.

¹⁰⁴ Commonwealth. Department of Health and Aged Care, *Life – A Framework for Prevention of Suicide and Self-harm in Australia - Building Partnerships*, 2000, <http://www.mentalhealth.gov.au/resources/life/pdf/building.pdf>.

5.1.3 Other Strategies Relevant to Suicide Prevention

Mental Health Strategy

The *National Mental Health Strategy*¹⁰⁵ was adopted by all Australian Health Ministers, and was first funded, in 1992. It aims to reduce stigma and improve the quality of life for Australians with a mental illness. A part of the Strategy targets depression and suicide.

More recently, the National Mental Health Plan 2003-2008¹⁰⁶ was endorsed. It continues the work that has already occurred under the First and Second National Mental Health Plans.¹⁰⁷

The Second National Mental Health Plan (1998-2003) had a reduction in the number of suicides listed as an outcome, together with a reduction in the incidence and prevalence of depression and associated disability. The following documents were released in 2000 under that Plan:

- ‘National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000’¹⁰⁸ (together with its companion document, ‘Promotion, Prevention and Early Intervention for Mental Health: A Monograph 2000’);¹⁰⁹ and
- ‘National Action Plan for Depression’.¹¹⁰

An outcome under the National Mental Health Plan 2003-2008 is a reduction in suicidal behaviours and risk factors in suicidal behaviours, together with

¹⁰⁵ See <http://www.mentalhealth.gov.au/mhinfo/nmhs/index.htm>.

¹⁰⁶ Australian Health Ministers, *National Mental Health Plan 2003-2008*, July 2003, <http://www.mentalhealth.gov.au/mhinfo/nmhs/pdf/mhplan.pdf>.

¹⁰⁷ Australian Health Ministers, *Second National Mental Health Plan*, July 1998, <http://www.mentalhealth.gov.au/mhinfo/nmhs/pdf/plan2.pdf>.

¹⁰⁸ Commonwealth. Department of Health and Aged Care, *National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000*, 2000, <http://www.mentalhealth.gov.au/mhinfo/ppei/pdf/actionplan.pdf>.

¹⁰⁹ Commonwealth. Department of Health and Aged Care, *Promotion, Prevention and Early Intervention for Mental Health: A Monograph 2000*, 2000, <http://www.mentalhealth.gov.au/mhinfo/ppei/pdf/monograph.pdf>.

¹¹⁰ Commonwealth. Department of Health and Aged Care, *National Action Plan for Depression*, November 2000, <http://www.mentalhealth.gov.au/resources/pdf/depression.pdf>.

enhancement of protective factors for suicidal behaviours. The key directions listed for this outcome are:¹¹¹

- recognising and enhancing the synergy between national and State/Territory-based strategies aimed at reducing suicide and enhancing mental health; and
- promoting activities aimed at reducing risk factors and enhancing protective factors for suicidal behaviours for the general community, and for groups at heightened risk such as Aboriginal and Torres Strait Islander people.

Also recently released as part of the *National Mental Health Strategy* is a discussion paper which considers the mental health needs of young Australians aged 16 to 25 years.¹¹²

National Drug Strategy

The *National Drug Strategy* is a cooperative venture between the Commonwealth, State and Territory Governments, and non-government groups, which was endorsed by the Ministerial Council on Drug Strategy in November 1998.¹¹³

National substance-specific strategies include the *National Alcohol Strategy*.¹¹⁴ A *National Indigenous Drug Strategy* has also been developed for 2003 to 2006.¹¹⁵

The framework for 2004 to 2009 has recently been finalised.¹¹⁶

¹¹¹ *National Mental Health Plan 2003-2008*, p 19.

¹¹² Commonwealth. Department of Health and Ageing, *Responding to the Mental Health Needs of Young People in Australia - Discussion Paper: Principles and Strategies*, February 2004, <http://www.mentalhealth.gov.au/resources/pdf/youngpeople.pdf>.

¹¹³ See the National Drug Strategy website, <http://www.nationaldrugstrategy.gov.au/>.

¹¹⁴ Commonwealth. Department of Health and Ageing, *National Alcohol Strategy: A Plan for Action 2001-03/04*, 2001, http://www.nationaldrugstrategy.gov.au/pdf/alcohol_strategy.htm.

¹¹⁵ Commonwealth. Department of Health and Ageing, *National Drug Strategy Aboriginal and Torres Strait Islander Peoples' Complimentary Action Plan 2003-2006*, 2003, <http://www.nationaldrugstrategy.gov.au/pdf/indigenous.htm>.

¹¹⁶ Commonwealth. Department of Health and Ageing, *National Drug Strategy: Australia's Integrated Framework 2004-2009*, 2004, <http://www.nationaldrugstrategy.gov.au/pdf/framework0409.pdf>.

5.2 QUEENSLAND

5.2.1 Queensland Government Youth Suicide Prevention Strategy

The *Queensland Government Youth Suicide Prevention Strategy* was endorsed in November 1997 ('Queensland Youth Strategy').

Key components of the Queensland Youth Strategy included:

- establishing 100 local community networks, to ensure local coordination of activities to address youth suicide and other self-harming behaviour and respond to the needs of youth, families and communities at a local level;
- employment of 19 part-time community network support workers in District Health Services to facilitate the establishment of district networks;
- a grants program to provide funds to community organisations for specific local initiatives;
- guidelines for the successful participation of young people in community networks;
- establishing the Queensland Youth Future Focus network and piloting model youth suicide prevention networks in five locations;
- training strategies for generic and specialised staff in key access and service delivery positions;
- specific projects targeting Aboriginal and Torres Strait Islander people, to assist and support indigenous communities develop culturally appropriate youth suicide prevention strategies, and a 24 hour service providing culturally sensitive support to indigenous youth in the greater Brisbane area;
- establishing a project team responsible for program development, coordination and evaluation activities associated with statewide implementation of the strategy; and
- evaluation of the strategy.

Other Queensland Government programs targeted at the general population and of relevance to suicide prevention included:

- the 'Young People at Risk' program, to improve the mental health and well-being of young people;¹¹⁷
- life promotion programs in indigenous communities (Yarrabah, Palm Island, Hopevale, Wujul Wujul, Mornington Island); and

¹¹⁷ For a description of the program see Australian Institute of Family Studies, Gary Boddy, *Youth Suicide Prevention Bulletin No. 3*, <http://www.aifs.org.au/ysp/pubs/bull3boddy.pdf>.

- dissemination of newsletters and professional guidelines.

Broader Queensland Government strategies to address the needs of young people have included the Queensland Crime Prevention Strategy – Building Safer Communities, Community Renewal Program, the Employment Taskforce and drug and alcohol strategies.

5.2.2 Queensland Government Suicide Prevention Strategy 2003-2008

*Reducing Suicide: The Queensland Government Suicide Prevention Strategy 2003-2008*¹¹⁸ ('Queensland Strategy') builds on the Queensland Youth Strategy. It was developed as a 'whole of population' collaborative effort which is coordinated by Queensland Health, with input from other Queensland Government agencies and peak non-government organisations concerned with suicide prevention.

The Queensland Strategy is consistent with the National Strategy,¹¹⁹ and provides complementary strategies. It recognises the importance of partnerships between government, communities, families, agencies, individuals and key stakeholders.¹²⁰

Although the Queensland Strategy covers all age groups, it also has the following specific targets:¹²¹

- young people (especially young males);
- Indigenous people (especially males aged 15 to 24 years);
- older people (especially older men and those aged over 75 years);
- people in custody, including those in the youth justice system and Indigenous people;
- older people from culturally and linguistically diverse backgrounds;
- current inpatients and people recently discharged from a mental health inpatient facility; and

¹¹⁸ Queensland. *Reducing Suicide: The Queensland Government Suicide Prevention Strategy 2003-2008*, July 2003, p 3, http://www.health.qld.gov.au/mental_hlth/publications/20769.pdf.

¹¹⁹ *Reducing Suicide: The Queensland Government Suicide Prevention Strategy 2003-2008*, p 6.

¹²⁰ *Reducing Suicide: The Queensland Government Suicide Prevention Strategy 2003-2008*, p 22.

¹²¹ *Reducing Suicide: The Queensland Government Suicide Prevention Strategy 2003-2008*, pp 13-16.

- homosexual and bisexual people, and young women (in relation to suicidal behaviour).

Themes under the Queensland Strategy include:¹²²

- promotion of social and emotional well-being;
- prevention (both universally across the population and across selective groups);
- early intervention;
- treatment and support;
- continuing care; and
- postvention.

The targets of the Queensland Strategy are designed, as a minimum, to reduce the rate of suicide and attempted suicide in Queensland to at or lower than the national average, and to remove the suicide rate inequalities between Indigenous and non-Indigenous populations by 2008. The targets also include:¹²³

- improved professional and community knowledge and awareness of risk factors and system responses to suicide prevention and management; and
- improved links between research and knowledge management to inform policy and program development.

In relation to Aboriginal and Torres Strait Islander peoples, the Queensland Strategy aims to present further context about the specific issues facing Indigenous communities and provide direction to Government Departments in developing targeted strategies to reduce the rate of suicide in Indigenous populations.¹²⁴

Some of the key actions under the Queensland Strategy include:¹²⁵

¹²² *Reducing Suicide: The Queensland Government Suicide Prevention Strategy 2003-2008*, pp 16-21.

¹²³ *Reducing Suicide: The Queensland Government Suicide Prevention Strategy 2003-2008*, p 7.

¹²⁴ *Reducing Suicide: The Queensland Government Suicide Prevention Strategy 2003-2008*, pp 27-30.

¹²⁵ Hon P Beattie MP, Premier and Minister for Trade, 'Beattie Govt launches five-year suicide prevention strategy', *Media Statement*, 10 September 2003. A copy of the media statement is attached as Appendix B to this Research Brief. Also included in Appendix B is Hon W Edmond MP, Minister for Health and Minister Assisting the Premier on Women's Policy, 'Early intervention services for people with a "dual diagnosis"', *Media Statement*, 30 October 2003 and Hon L Clark MP, Minister for Aboriginal and Torres Strait Islander Policy, 'Queensland Government tackles suicide prevention', *Media Statement*, 24 May 2004.

- Employment of 19 ‘early intervention officers’ in Queensland Health across 24 Health Service Districts, to work with hospital emergency departments, general practitioners, school-based youth health nurses, youth services, police and emergency services and rural networks to identify and respond to early warning signs of mental health problems and suicidal behaviour.
- The development of ‘district suicide prevention plans’ to reflect regional and local area priorities for suicide prevention.
- Delivery of programs by the Department of Education and Department of Employment and Training to develop resilience and good health in young people and reduce vulnerability to suicide through improved training incentives.
- Employment of ‘indigenous program support officers’ in youth detention centres and the conduct of cultural programs for Indigenous young people by their community elders. The development of infrastructure will also be funded in Townsville, Mt Isa and Cairns to provide safer places for Indigenous people who are homeless.
- Training of farm financial counsellors by the Department of Primary Industries, to allow them to identify suicide risk as part of Farm Financial Counselling Services.
- Training by the Department of Corrective Services, Queensland Police and the Department of Emergency aimed at recognition of suicidal behaviour and protection of people in custody and groups at high risk of suicide.

Reducing Suicide: Action Plan 2003

The 'Reducing Suicide: Action Plan 2003'¹²⁶ represents the action plans developed by relevant Queensland Government agencies to implement the Queensland Strategy.

Outcomes from the Action Plan will form the basis of an annual report to Cabinet and will include the impact of the proposed outcomes of the action, proposed future actions, emerging issues in suicide prevention and possible policy responses and the extent of delivery against the Strategy.

5.2.3 Other Strategies Relevant to Suicide Prevention

Other Queensland programs relevant to suicide prevention include:¹²⁷

- *Smart State: Health 2020 – a vision for the future* (2002);
- *The Ten Year Mental Health Strategy for Queensland* (1996);
- *Beyond a Quick Fix – Queensland Drug Strategic Framework* (1999);
- *Putting Families First – Policy Statement* (2000);
- *Queensland Families: Future Directions* (2002);
- *2010 – A Future Strategy, Education Queensland*;
- *Our Shared Future: Queensland's Framework for Ageing 2000-2004* (2000);
- *Towards a Queensland Government and Aboriginal and Torres Strait Islander 10 Year Partnership* (2001);
- *Aboriginal and Torres Strait Islander People: Queensland Mental Health Policy Statement* (1996);
- *Non-English Speaking Background Mental Health Policy Statement* (1995);
and
- *Future Directions for Child and Youth Mental Health Services* (1996).

¹²⁶ Queensland. *Reducing Suicide: Action Plan 2003*, July 2003, http://www.health.qld.gov.au/mental_hlth/publications/20768.pdf.

¹²⁷ *Reducing Suicide: The Queensland Government Suicide Prevention Strategy 2003-2008*, p 32.

6 SUPPORT AGENCIES

A number of support agencies provide valuable assistance to people at risk of suicide, and to their families and friends. Well known services in this respect include Lifeline Australia¹²⁸ and Kids Help Line.¹²⁹

This section discusses two further national services, *beyondblue* and Reach Out!.

6.1 BEYONDBLUE

'*beyondblue*',¹³⁰ the five-year national depression initiative, was established in 2000 by the Commonwealth and Victorian Governments to address issues relating to depression, anxiety and substance misuse disorders in Australia. It was established in the context of projections by the World Health Organisation of an increasing global burden caused by depression.¹³¹

The initiative is now supported by other State and Territory governments, the private sector and community organisations. Its current funding structure is as follows:

- Commonwealth Government - \$17.5 million from October 2000 to October 2005;
- Victorian Government - \$17.5 million from October 2000 to October 2005;
- South Australian Government – \$1.4 million over five years (from June 2001);
- Australian Capital Territory - \$350,000 over five years (from February 2001);
- Northern Territory - \$106,395 over three years (from June 2002);
- Tasmanian Government - \$138,102 over two years (from June 2002); and
- No formal funding agreement, but a total financial contribution of \$300,000 has been made.

¹²⁸ Lifeline Australia receives approximately 24,000 suicide-related calls each year, constituting 4-9% of the 300,000 calls in total received by the organisation ('Lifeline answers the call', *Sunday Mail*, 7 July 2002). The telephone number for Lifeline is 131 114.

¹²⁹ The service received 252 calls from young Queenslanders in 2001 regarding suicide (Louise Crossen, 'Honesty best policy to fight suicide', *Courier Mail*, 11 January 2003, p 8). The telephone number for Kids Helpline is 1800 55 1800.

¹³⁰ <http://www.beyondblue.org.au/index.aspx>.

¹³¹ Depression is currently the highest medical cause of disability worldwide, and is predicted to be the second highest medical cause of illness and disability worldwide by 2020 (behind heart disease) ('Depression receives focus at last', *Australian*, 18 March 2000, p 20).

- Non-government sources of funding.

The major operational and expenditure priorities of *beyond blue* are: preventative and research programs (50%), community awareness and literacy (30%) and training and workforce support (20%).

The five priorities guiding the activities of *beyondblue* are:

- increasing community awareness of depression, anxiety and related substance misuse disorders and addressing the stigma associated with these health problems;
- helping people living with depression to understand that information, support and effective treatments are available as well as promoting their needs and experiences of depression with policy makers in the healthcare system;
- developing prevention and early intervention programs around depression;
- improving training and support for general practitioners and health care professionals around depression; and
- initiating and supporting depression-related research.

The board of directors of *beyond blue* include the Honourable Jeff Kennett, the Honourable Caroline Hogg and Mr Garry McDonald AO.¹³²

6.2 REACH OUT!

Reach Out!¹³³ is a web-based initiative of the Inspire Foundation¹³⁴ that seeks to improve the mental health and well being of young people by providing ‘first step’ support information and referrals in a format that appeals to this group.

Since its launch in 1998 as a specific youth suicide prevention initiative, over 1.3 million people have accessed the site, with an average of 39,000 visits of 12 to 15 minutes duration each month. The initiative also tours rural and regional areas.

Reach Out! is supported by corporate, government, pro bono and community partners.

Although it does not currently provide online counselling, this may occur in the future. Currently, it directs users to either Lifeline or Kids Help Line.

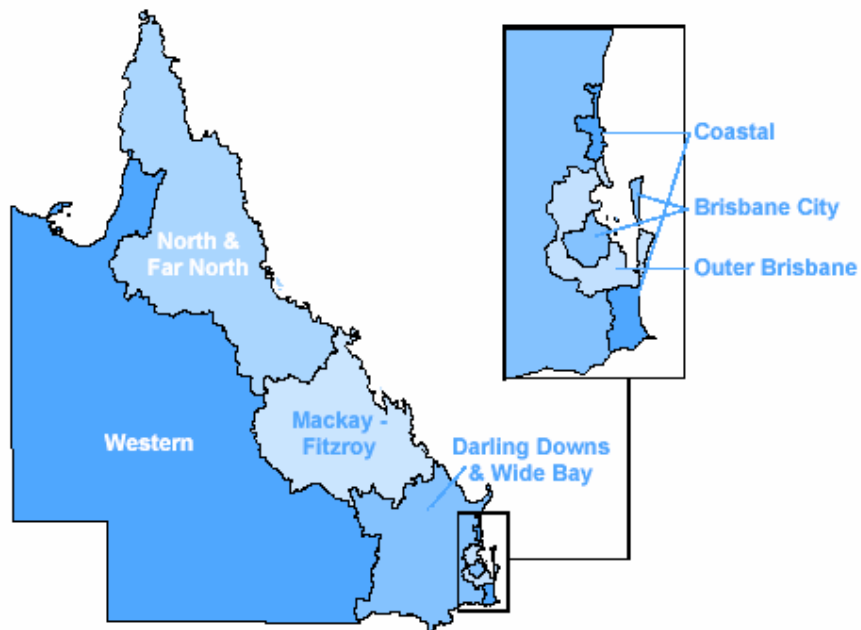
¹³² For information on other members of the board, see http://www.beyondblue.org.au/index.aspx?link_id=2.21.

¹³³ <http://www.reachout.com.au/home.asp>.

¹³⁴ <http://www.inspire.org.au/>. The Inspire Foundation’s board of patrons includes Ms Cathy Freeman OAM.

APPENDIX A ¹³⁵

Source: http://www.gu.edu.au/school/psy/aisrap/pdf/suicide_qld.pdf



The seven regions referred to in Part 3.8.3 of this Research Brief.

¹³⁵ Australian Institute for Suicide Prevention (Griffith University), Diego De Leo and Russell Evans, *Suicide in Queensland 1996-1998: Mortality Rates and Related Data*, 2002, p55 (figure 32).

APPENDIX B – MINISTERIAL MEDIA STATEMENTS

Hon. Liddy Clark MP, Minister for Aboriginal & Torres Strait Islander Policy

24 May 2004

Queensland Government tackles suicide prevention

The first steps have been taken in a whole-of-government strategy to tackle one of the most distressing issues affecting Aboriginal and Torres Strait Islander communities - suicide.

Minister for Aboriginal and Torres Strait Islander Policy Liddy Clark said suicide rates amongst Aboriginal males were six times higher than the rest of Queensland.

"Suicide is a sensitive and emotive subject, but we have to start talking about it more if we are to better understand the causes and develop strategies to reduce the risk in the future," Ms Clark said.

The Queensland Government Suicide Prevention Strategy (QGSPS) is a whole-of-government commitment involving several government departments.

Ms Clark said initially, the strategy would focus on four key areas - training, capacity building, risk management and intervention.

"A government steering committee has been established which will report directly to Cabinet," Ms Clark said.

"A range of additional reference groups, including both community and Indigenous representatives, have been established to provide advice to the steering committee. DATSIP has appointed a Senior Project Officer whose role includes establishing an Indigenous Reference Group.

"The project officer will work closely with the Indigenous Reference Group to advise the Government's Suicide Prevention Steering Committee on all the relevant issues," she said.

"The project officer will also liaise with staff from various government departments who actually deliver services to Indigenous communities."

Ms Clark said further down the track, Aboriginal and Torres Strait Islander communities would be actively encouraged to participate in the planning, development, monitoring and review of the Suicide Prevention Strategy.

"There will be a strong focus on developing effective partnerships and open and honest communication between government and communities," Ms Clark said.

"There is no point trying to develop and implement a strategy that does not meet the needs and expectations of Aboriginal and Torres Strait Islander communities.

"This project is further proof that the Beattie Government is serious about addressing the problems communities are facing," she said.

The Queensland Government Suicide Prevention Strategy is part of a broad range of related projects the government has been implementing over the past 10 years to address Indigenous suicide.

These projects include the implementation of better safety procedures for Indigenous people in watch houses, correction centres, youth detention centres and diversionary centres.

The Department of Aboriginal and Torres Strait Islander Policy has also led government initiatives under the Queensland Aboriginal and Torres Strait Islander Justice Agreement, which aims for significant reductions in incarceration rates for Aboriginal and Torres Strait Islander people.

Those initiatives are linked to the Queensland Government's broad objective to reduce the incidence of Indigenous suicide in custody, by reducing the number of Indigenous people incarcerated.

"The Queensland Government Suicide Prevention Strategy and all of the related programs aim to deliver appropriate solutions which will make a significant difference to the incidence of Indigenous suicide," Ms Clark said.

Media Contact: Marie Low 3222 2350

**Hon. Wendy Edmond MP, Minister for Health & assisting the Premier
on Women's Policy**

30 October 2003

Early intervention services for people with a "dual diagnosis"

Queensland Health will employ nine new Early Intervention Officers under a \$1.6 million program to improve services for "dual diagnosis" patients who had both mental health and substance misuse problems, the Health Minister Wendy Edmond said today.

Under the two year program, the new staff will be based on the Sunshine Coast (2 positions), Cairns (1), Cape York (1), Logan (1), the Gold Coast (2) and Brisbane metropolitan health service districts (2).

Ms Edmond said that dual diagnosis had been identified nationally and internationally as a priority for special attention.

"The nine positions are part of a strategic approach to addressing these complex problems with a shift towards early intervention. Under this approach, Queensland Health is currently implementing two other major programs, directed to Suicide Prevention and service reorientation," Ms Edmond said.

"The 19 Early Intervention Suicide Prevention Officers and 10 Service Reorientation Officers will work closely with the Dual Diagnosis Officers to improve the service provided to this group of consumers."

She said effective early intervention strategies could stop these "high risk" mental health patients from developing more complex problems.

"Whilst more research is required in this area, it is already evident that people with a dual diagnosis require special attention to help them with a range of health and social issues," Ms Edmond said.

"We know, for example, these people have a greater propensity for suicidal and self-harming behaviour and they tend to have frequent contact with the criminal justice system."

Media contact: Steve Rous 3234 1185

Hon. Peter Beattie MP, Premier and Minister for Trade

10 September 2003

Beattie Govt launches five-year suicide prevention strategy

The State Government has launched a new five-year strategy and action plan aimed at reducing suicide rates across Queensland.

Premier Peter Beattie and Health Minister Wendy Edmond today released the Reducing Suicide: Queensland Government Suicide Prevention Strategy 2003 - 2008, which is designed to target risk factors, as well as foster community and individual resilience and capacity, to address the underlying causes of suicide.

"Our commitment for the next five years builds on the achievements and experience gained from the Queensland Government Youth Suicide Prevention Strategy, whilst responding to emerging evidence that says we need an effective whole-of-life approach to suicide prevention," Mr Beattie said.

For the first time, nine Queensland Government agencies have entered into a formal joint partnership to address suicide prevention issues through a comprehensive and integrated cross-Government approach.

The nine agencies are Queensland Health, Education Queensland, the Queensland Police Service and the departments of Families, Emergency Services, Corrections, Aboriginal and Torres Strait Islander Policy Development, Primary Industries and Employment and Training.

This whole-of-government approach will include the following actions:

- Queensland Health will employ 19 Early Intervention Officer positions across 24 Health Service Districts throughout the State, with recruitment currently underway. These officers will work with hospital Emergency Departments, GPs, School Based Youth Health Nurses, Youth Services, Police and rural networks to identify and respond to early warning signs of mental health problems and suicidal behaviour.
- The Department of Education will continue to deliver programs aimed at developing resilience and good health in young people. The Department of Employment and Training will provide special programs aimed at reducing vulnerability to suicide through improved training initiatives.
- The Department of Families will employ Indigenous Program Support Officers in youth detention centres and conduct cultural programs for Indigenous young people run by their community elders. The Department of Aboriginal and Torres Strait Islander Policy will fund the development of infrastructure in Townsville, Mt Isa and Cairns to provide safer places for Indigenous homeless people.

- The Department of Primary Industries will extend training to Farm Financial Counsellors to identify suicide risk, as part of its Farm Financial Counselling Service.
- The Department of Corrective Services, the Queensland Police Service and the Department of Emergency Services will provide training aimed at recognition of suicidal behaviour and protection for people in custody and groups at high risk of suicide.

"The strategy recognises suicide as a priority issue and acknowledges that genuine partnership between all level of government and the community is required in order to make some real difference, " the Premier said.

Mr Beattie said the Reducing Suicide strategy was developed after extensive consultation with community and government agencies and the Government acknowledged the valuable contributions from concerned Queenslanders as well as service providers and community workers.

Media contact: Steve Rous 3234 1185

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