Suicide Facts and Statistics

This section contains a brief overview of facts and statistics about suicide in Australia. Comprehensive and up-dated facts and statistics (as they become available) can be found on the Mindframe website at www.mindframe-media.info. Alternatively you may want to contact the agencies listed on page 79 for further information.

The main source of Australian data on suicides is the Australian Bureau of Statistics (ABS). They release new data on an annual basis. Unless otherwise stated, the statistics provided in this document are from the ABS publication, Causes of Death 2009, Catalogue 3303.0.55

Definition of Terms

Terms that are commonly used when discussing suicide include:

Suicide – death determined by the coroner as a result of self-inflicted harm where the intention was to die.

Attempted suicide – self-inflicted harm where death does not occur but the intention of the person was to die.

Self-harm – any behaviour that involves deliberate injury to oneself. Self-harm may be an attempt at suicide although it is not necessarily so. It is usually a response to distress.

Suicidal behaviour – acts such as suicide and attempted suicide. This also includes suicide related communications such as verbal or nonverbal statements expressing suicidal intent.

Suicidal ideation/thoughts – thoughts about, or plans for, taking one’s own life that may or may not lead to a suicide attempt.

A Note on Interpreting Facts and Statistics

Suicide statistics are usually reported as either the total number of persons who died by suicide or as an age-standardised suicide rate, such as 7 per 100,000 people. This means that for every 100,000 people in a population or sub-group, seven died by suicide in a given time period (usually a year). Suicide statistics may also be reported as a percentage of deaths from all causes, such as 2% of all deaths in a population were due to suicide. This means that for every 100 deaths in a population in a given time period, two were due to suicide.

Caution should be exercised when reporting and interpreting suicide information. The reliability of suicide statistics are affected by a number of factors including under-reporting, differences in reporting methods across states and territories, and the length of time it takes for Coroners to process deaths that are reported as potential suicides.
An Overview of Suicide in Australia

How many people die by suicide in Australia?

- Suicide is a prominent public health concern in Australia. Over the past decade, about 2100 people have died by suicide each year.\(^{54}\)
- There were 2132 deaths from suicide registered in 2009, which is down from the 2282 deaths from suicide recorded in 2008. Note that both 2008 and 2009 figures are subject to revision.
- Deaths from suicide represented 1.4% of all deaths registered in 2009.

Is the problem getting worse?

- Suicide rates for both males and females have generally decreased since the mid-90s, with the overall suicide rate decreasing by 23% between 1999 and 2009.
- Suicide rates for males peaked in 1997 at 23.6 per 100,000 but have steadily decreased since then and stood at 14.9 per 100,000 in 2009.
- Female rates reached a high of 6.2 per 100,000 in 1997. Rates declined after that and were 4.5 per 100,000 in 2009.

Do rates vary between states?

- Combining suicide data over a 5-year period provides a more reliable picture of differences across the states and territories due to the relatively small number of suicides in some states and territories in any one year.
- In recent years (2005-2009) Tasmania and the Northern Territory have had the highest rates of suicide, followed by South Australia. In contrast, New South Wales and Victoria had the lowest rates of suicide and the Australia Capital Territory and Queensland had fluctuating rates.

Are the rates different for males and females?

- Suicide rates for males are higher than those for females and have been higher since at least the 1920’s;\(^{57}\) however, more women than men attempt suicide.\(^{54}\)
- The ratio of male to female suicides rose from 2:1 in the 1960s to over 4:1 in the mid 1990s. In recent years, the suicide rate for males has reduced slightly and it is now 3.3 times that of females in 2009, and is consistent across most age groups.
- Between 2000 and 2009, the suicide rate fell by 22%, with this rate of change different for males (24%) and females (13%).
Do rates vary across age groups?

- From 1990 until 1997, 20 to 24 year old men were consistently the most likely of all age groups to die by suicide, with rates reaching 42.8 per 100,000 in 1997. However, between 1998 and 2005 the highest rates have been observed for males aged in the 25-45 year age groups. In 2009 the highest rate in men was observed in the 85+ year age groups, followed by the 40-44 year age group.
- From 1990 onwards, there has not been any one age group of females that has consistently had a higher rate of suicide than other age groups.

Is there a youth suicide epidemic?

- During the mid 1980s, suicide rates for 15 to 19 year old males rose rapidly and peaked at 21 per 100,000 in 1988. Over the following decade, rates fluctuated from around 17 to 19 per 100,000 for this group and stood at 18.4 per 100,000 in 1997.
- Since 1997, suicide rates among 15 to 19 year old males have decreased fairly consistently and in 2009, the rate was 9.3 per 100,000 – this is the third lowest rate (after 2004 and 2006) seen in this age group for at least 20 years.
- In contrast, for 15 to 19 year old females, the suicide rate has been relatively stable over the past 20 years at around 3 to 5 suicide deaths per 100,000. In 2009, 3.4 per 100,000 15 to 19 year old females had died by suicide.
- Suicide in children under the age of 15 years is a rare event in Australia.

Are the patterns the same for Aboriginal and Torres Strait Islander Australians?55

- Accurate suicide statistics and population estimates are difficult to obtain for Aboriginal and Torres Strait Islander people. Thus data on suicide levels and rates for Aboriginal and Torres Strait Islander people are likely to be, at best, minimum figures and the information must be interpreted cautiously.
- Due to both the relatively small numbers and low coverage in some areas of Australia, the ABS only publishes data on suicide deaths among Aboriginal and Torres Strait Islander people for New South Wales, Queensland, South Australia, Western Australia and the Northern Territory. In 2009, there were 97 deaths by suicide of Aboriginal and Torres Strait Islander people in the five states and territories considered.56
- The percentage of all deaths attributable to suicide is much higher among Aboriginal and Torres Strait Islander people (4.2% in 2007) than Non-Indigenous Australians (1.4%) in the specified states and territories.
- Suicide is more concentrated in the earlier adult years for Aboriginal and Torres Strait Islander Australians than for the general Australian population,51 with available data indicating the highest rates for both males and females being in the 15 to 24 year age group.62
- As for other Australians, Aboriginal and Torres Strait Islander males are more likely to die by suicide than are Aboriginals and Torres Strait Islander females. Using combined data for 1998 to 2002, 6.7% of all males deaths were due to suicide compared with 1.9% of all deaths for females.
Do rates vary among people from culturally and linguistically diverse backgrounds?

- Australia is home to people from a wide diversity of cultures. Suicide rates, and risk factors associated with suicide, differ between cultures.

- One quarter of suicides in Australia occur among people who have migrated to Australia, with 60% of these being people who have come from non-English speaking countries. However, rates vary according to country of origin, gender and age.\(^{63}\)

- Rates are generally higher among people born in English-speaking countries, and those from western, northern and eastern Europe, and lower among people from southern Europe, the Middle East and Asia.\(^{64}\)

- Overall, males born outside of Australia have a lower suicide rate than Australian-born males, while the rate is higher for females born overseas than for Australian-born females. The rate is also higher for people of both genders aged over 65.\(^{65}\)

Are rates higher in rural and remote Australia?

- There is some evidence that suicide rates in rural and remote areas are significantly greater than in urban populations. This may be especially true among young men in remote regions.\(^{66}\)

- Possible factors contributing to higher rates in these areas include isolation, rural poverty, increased risk-taking behaviour and access to lethal means (eg firearms). It has also been suggested that a culture of self-reliance, that does not encourage help-seeking behaviour, may be one of the most important contributing factors to youth suicide in rural areas.\(^{67}\)

Are rates higher in people who have mental illness?

- Many people who die by suicide or make a suicide attempt have a history of mental illness or are experiencing symptoms of mental illness.

- Up to 12% of people affected by mental illness take their own lives (compared with an average of 1.4% for the whole population),\(^{68}\) and suicide is the main cause of premature death among people with mental illness.\(^{69}\)

- Early detection and treatment of mental illness is important in preventing suicide, although many people do not seek help until symptoms become severe. This may be partly due to misconceptions and stigma surrounding mental illness.\(^{70}\)
Risk and Protective Factors for Suicide

What are some risk factors for suicide?

There is no single cause for suicidal behaviour and each person’s situation is unique. Suicide is a complex phenomenon and rarely occurs as the result of a single event. However, research has revealed a number of common risk factors, which may increase the likelihood of someone taking their own life:

- **Individual factors** - such as being male, experiencing physical health problems and stressful life events such as bereavement or relationship breakdown. Young gay, lesbian or transgender people may also have an increased risk of suicide;

- **Mental illness** - such as anorexia, depression, substance abuse, psychotic disorders and a history of previous suicide attempts;

- **Family-related factors** - such as family breakdown, family conflict, child custody issues, abuse or family history of suicide;

- **Social factors** - such as socio-economic disadvantage, unemployment, being Aboriginal or Torres Strait Islander, school disengagement, incarceration, and social and geographical isolation (especially remote communities);

- **Environmental factors** - such as access to methods of suicide and exposure to suicide methods via the media or peers. Suicide sometimes occurs in ‘clusters’ within a local area, when people identify with the distress of someone who has taken their own life.

Are there protective factors for suicide?

Similar to risk factors, there are no clear universal protective factors that may decrease the likelihood of a person taking their life. Some known factors include:

- being connected or belonging to a family, school or other community, such as a sporting or recreation group;

- having at least one significant person to relate to and bond with (whether that is a family member, a friend or other person);

- having personal coping skills and resilience to deal with difficult situations;

- a sense of meaning, spiritual faith or belief that suicide is wrong;

- economic security, particularly in older people;

- good physical as well as mental health;

- early detection and treatment for mental illness and emotional problems;

- restricted access to means, such as firearms, prescription medications and certain geographical locations.
Myth Busting

There are many myths and misconceptions about suicide in the community. Below are suggestions for challenging some of these misconceptions using accurate information about suicide that has been drawn from research and clinical practice.

Myth: Most ‘normal’ people don’t think about taking their own life

Measuring suicidal thoughts is difficult, but research suggests that thoughts about suicide are not that uncommon at some point in a person’s life, although most people do not act on them.21

Myth: Most suicides occur without warning

Although there may be some cases where suicide occurs without warning, many people that attempt or complete suicide give verbal or non-verbal clues before the incident. Often there has been a history of personal problems, warning signs, mental health issues, suicide threats or prior attempts. Many people thinking about suicide will tell someone, loved ones and/or strangers, and some will seek professional help.

Myth: If someone reveals their suicide plan, you should not break their confidentiality

Any information suggesting a person is contemplating suicide should be acted upon. A serious threat of suicide is one of the few situations where confidentiality must be breached in the interest of saving a life.

Myth: People who talk about killing themselves or attempting suicide are not serious – talking about it is just an attention-seeking behaviour and should be ignored

Any suggestion of suicidal thoughts or threats of suicide should always be taken seriously. A person who threatens or attempts suicide is in need of support, whether or not they may be serious about ending their life at that particular time.

Myth: Talking about suicide with someone who is at risk may give them the idea and increase the chances of an attempted suicide

Many troubled people may be relieved if the issue is raised in a caring and non-judgemental way, allowing them to talk one-on-one about their feelings and to seek help.

Myth: People who attempt suicide are just selfish or weak

People who attempt suicide are often experiencing strong negative feelings, and may believe there is no other solution. People in this situation need professional and personal support, not judgement.