# 2

# Understanding Youth Suicide

2.1 To establish the basis for the Committee's focus on the issue of youth suicide and early intervention, this Chapter presents an overview of the statistics on suicide in Australia, and youth suicide in particular. The difficulties associated with collecting accurate and comprehensive suicide data are considered. The Chapter also presents an overview of the factors which affect the likelihood of youth suicide, and identifies groups that are at increased risk of suicide.

## Statistics on Suicide in Australia

2.2 Statistics on suicide in Australia are available from a number of sources. National data on suicide is published in some years by the Australian Bureau of Statistics (ABS). The most recent, published in 2007, contains summary statistics on deaths registered in 2005 where the cause of death was determined to be suicide.[1] Even more recent, though less comprehensive, statistics on suicides in Australia are published annually in the ABS 'causes of death' reports. The 2011 *Causes of Death Report* provides information on suicides based on mortality data from 2009.[2] Coroners, through the National Coroners Information System (NCIS), are another significant source of suicide data. In addition, the Australian Institute of Health and Welfare (AIHW) has also produced a number of publications based on information extracted from the AIHW Mortality Database.[3] These data are supplemented by data collection and research

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1 Australian Bureau of Statistics (ABS), *Suicides, Australia 2005* (2007), cat no 3309.0.

2 ABS, *Causes of Death, Australia 2009* (2011), cat no 3303.0.

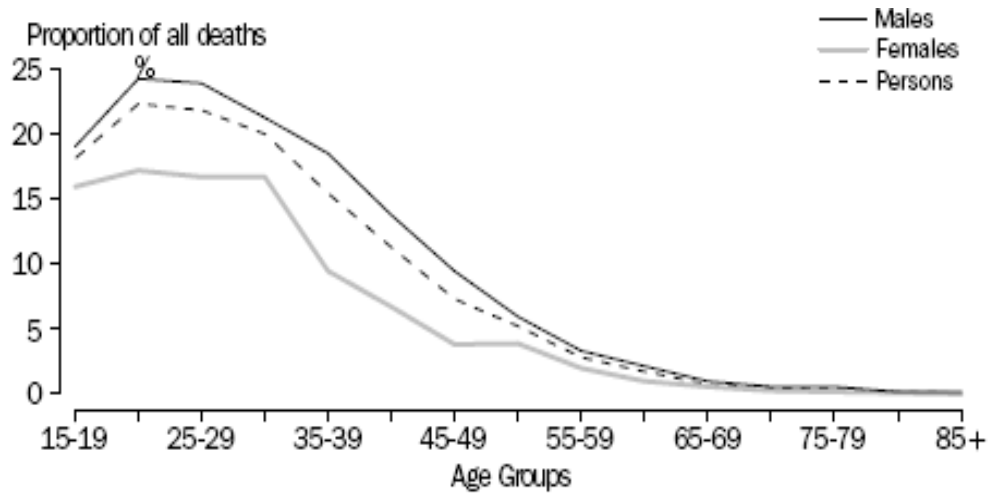
3 Australian Institute of Health Welfare (AIHW) website, http://www.aihw.gov.au/aihw-national-mortality-database/, viewed on 20 May 2011.

conducted by academic institutions and by community based organisations.

2.3 Although not intended to be a comprehensive review of suicide in Australia, the following section provides key information on suicide rates, trends and 'at risk' groups. According to the ABS, in the year 2009 suicide was the registered cause of 2,132 deaths, making it the 14th most common cause of death in the population generally.[4] Across all age-groups suicide is much more common in males than females, with over three-quarters (76.6%) of suicides in 2009 being males. Suicide was the 10th most common cause of death in males that year.[5]

2.4 While suicide accounts for only a relatively small proportion (1.5%) of all deaths in Australia, as shown in Figure 2.1, suicide is a disproportionate cause of death in some age groups. In 2009, 24% of all male deaths aged 15 to 24 years were due to suicide. Similarly for females, suicide deaths comprise a much higher proportion of total deaths in younger age groups.[6]

Figure 2.1: Suicides by Selected Age Groups: 2009




*Source: ABS, Causes of Death, Australia 2009 (2011), cat no 3303.0 2009*

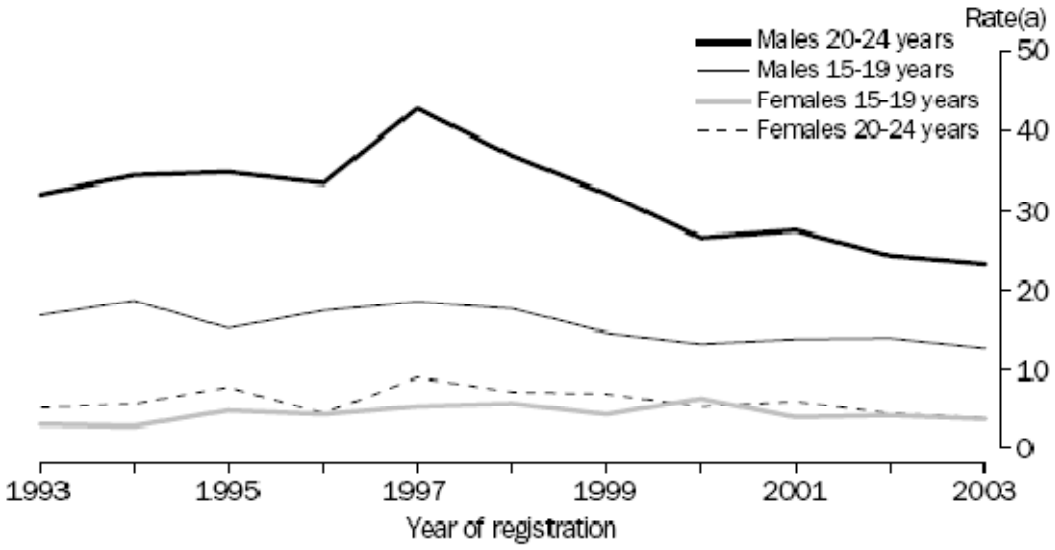
2.5 Further examination of the data reveals a more complex picture of youth suicide.[7] Data from 2008 indicates that men aged 20 to 24 years were

4 ABS, *Causes of Death, Australia 2009* (2011), cat no 3303.0, p 25.
5 ABS, *Causes of Death, Australia 2009* (2011), cat no 3303.0, p 25.
6 ABS, *Causes of Death, Australia 2009* (2011), cat no 3303.0, p 26.
7 ABS, *Suicides, Australia 2005* (2007), cat no 3309.0, p 7.

particularly vulnerable to suicide, with a rate of around 19 suicides per 100,000. This is a higher rate than for young men aged 15 to 19 years with around 9 suicides per 100,000 men in 2008. Data from 2008 for young women, records rates of 3 suicides per 100,000 women aged 15 to 19 years and 5 suicides per 100,000 women aged 20 to 24 years.

2.6 Data from the ABS also shows that youth suicide rates fluctuate over time (Figure 2.2). A general decline in youth suicide rates has been recorded since the late 1990s. In 1997, suicide rates for 15 to 19 year old males peaked at 18.4 per 100,000, decreasing consistently over the next decade, and in 2009 the rate was 9.3 per 100,000 in this age group.[8] A more dramatic decrease in suicide rates over the same period was observed in young men aged 15 to 24 years, decreasing from 42.8 per 100,000 in 1997 to 19 per 100,000 in 2009. In contrast, the suicide rate for females aged 15 to 19 years has remained relatively stable over the same period at around 3-5 per 100,000. In 2009, the suicide rate in females aged 15 to 19 years was 3.4 per 100,000.[9]

Figure 2.2: Age-Specific Suicide Rates: 1993 to 2003




*Source: ABS, Suicides: Recent Trends, Australia 1993-2003 (2004), cat no 3309.0.55.001*

8 ABS, *Suicides, Australia 2005* (2007), cat no 3309.0, p 4; ABS, *Causes of Death, Australian 2009* (2010), cat no 3303.0, p 27.

9 ABS, *Suicides, Australia 2005* (2007), cat no 3309.0, p 4; ABS, *Causes of Death, Australia 2009* (2010), cat no 3303.0, p 27.

2.7 Suicide in children under the age of 15 years is rare. Over the period 1995 to 2005, the reported suicide rate in children under 15 years averaged 0.25 per 100,000.[10]

2.8 A significant body of research also indicates that youth suicide differs greatly across Australia and between social groups. Data indicates that Indigenous young people aged 12 to 24 years had suicide rates up to four times higher than non-Indigenous Australians in the same age group. Between 2001-03 suicide rates for Indigenous young people were 37 per 100,000 compared to 8 per 100,000 for non-Indigenous young people.[11]

2.9 Data also suggests that suicide rates for young people aged 15 to 24 years were elevated for those living in rural and remote locations, with a suicide rate three times that of their counterparts living in major cities.[12] This appears to be particularly the case for young men.[13] The AIHW also reports higher suicide rates for young people living in the most socioeconomically disadvantaged areas of Australia, with rates of 13 per 100,000 compared to 9 per 100,000 in 2003-05.[14]

2.10 Although there is a paucity of data on suicide in culturally and linguistically diverse (CALD) populations, available research suggests that there may be significant variation in patterns of suicide across cultures. For example, while noting that the research referred to is not particularly recent, the Diversity Health Institute notes that amongst people with a non-English speaking background, suicide attempts are higher amongst females than males. This represents a marked difference from the general population.[15]

2.11 Although data is not routinely collected, research has also identified other groups of young people who may be at increased risk of suicide. These include (in no particular order):

- victims of bullying, including cyber-bullying, harassment and discrimination[16];

10 ABS, *Suicides, Australia 2005* (2007), cat no 3309.0, p 17.

11 ABS & AIHW, *Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples* (2008), cat no 4704.0, p 169. See also: AIHW, *Injury among young Australians*, Bulletin 60 (2008), cat no AUS 102, p 29.

12 AIHW, *Injury among young Australians*, Bulletin 60 (2008), cat no AUS 102, p 30.

13 AIHW, *Rural, regional and remote health: a study on mortality*, 2nd Edition (2007), cat no PHE 95, pp 201-202.

14 AIHW, *Injury among young Australians*, Bulletin 60 (2008), cat no AUS 102, p 30.

15 Diversity Health Institute, Submission No 12, p 1.

16 BoysTown, Submission No 10, p 15; Diversity Health Institute, Submission No 10, p 7; Women's Health Victoria, Submission No 18, p 2-3.

- gay, lesbian, bisexual, transgender and intersex individuals[17];
- those who are socially isolated or homeless[18];
- individuals with mental illnesses (especially depression and anxiety)[19];
- those in the juvenile justice system;
- those using drugs and alcohol[20];
- individuals who engage in self harm[21] or who have previously attempted suicide; and
- individuals who have experienced trauma (particularly where unresolved), grief, loss, and family breakdown.[22]

## Collecting and Reporting Suicide Statistics

2.12 Issues relating to the quality of suicide data were a common theme raised in evidence.[23] As indicated above, there is a range of data currently collected around Australia relating to suicide, with the main source of data being the ABS. However, it is also clear that there are difficulties associated with collecting data on suicide. As a consequence suicide data is acknowledged to be incomplete and of varying quality.

2.13 ABS and AIHW reports on suicide and mortality include frequent references to technical notes which emphasise that suicide statistics must be interpreted cautiously. A significant concern is that official statistics of suicide rates may be an underestimate. As the ABS notes:

> ... for a death to be determined a suicide, it must be established by coronial enquiry that the death resulted from a ***deliberate act*** [emphasis added] of the deceased with the intention of ending his or her own life (intentional self-harm).[24]

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17 Australian Psychological Society (APS), Submission No 21, p 4.

18 BoysTown, Submission No 10, p 15; Diversity Health Institute, Submission No 10, p 7.

19 Inspire Foundation, Submission No 4, p 8.

20 Inspire Foundation, Submission No 4, p 8; Australian Suicide Prevention Foundation, Submission No 9, p 9.

21 Prof G Martin, Submission No 1, p 13; Inspire Foundation, Submission No 4, p 6.

22 Name Withheld, Submission No 8, p 1; BoysTown, Submission No 10, p 15.

23 See for example: Suicide Prevention Australia, Submission No 11, p 9; Mr C Gostelow, WA Department of Education, Transcript of Evidence, 31 January 2011, p 25.

24 ABS, *Causes of Death, Australia 2009* (2011), cat no 3303.0, p 25.

2.14 There is an inherent difficulty for coroners in determining the 'intent' of a deceased person, notwithstanding the fact that many people who suicide leave a record of their intentions. As a result, there may be some deaths which are suicides *as a matter of fact*, but insufficient evidence before the coroner precludes the finding of suicide *as a matter of law*.

2.15 ABS figures show that there are many deaths that occur as a result of 'mechanisms'[25] that are common in suicide, but where the element of intent differed or is unclear. For example, in 2009, 5,322 deaths were categorised as 'accidental', all of which were caused by 'mechanisms' common in suicide. Of these there were almost 1000 deaths registered as 'undetermined intent'.[26]

2.16 In addition, an ongoing issue for the ABS has been that the quality of the suicide data can be affected by the length of time required for the coronial process to be finalised and the coronial case to be closed. In the absence of a coronial finding, other conclusive evidence of intent (e.g. a suicide note), is required for a suicide to be recorded in the statistics. According to Suicide Prevention Australia, the accuracy of suicide data is questionable, and some experts suggest that the general rate of suicide may in fact be up to 16% higher than official figures.[27]

2.17 Other issues affecting the quality of data may be a reluctance to record a suicide due to the stigma attached to suicide, as well as recording/reporting variations between jurisdictions, including different standards of proof of intent and different coronial processes and a lack of systemic resourcing and training.[28] As pointed out during a roundtable hearing, with regard to coronial outcomes there are different approaches taken by different coroners which reflect competing but equally valid priorities, such as providing concrete findings to bereaved families, or leaving open findings in the absence of sufficient evidence.[29] However, it is abundantly clear that a complete picture of youth suicide in Australia (and suicide generally) will be hampered by systemically embedded under-reporting and by data collection differences across jurisdictions.

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25 Mechanisms common in suicide include hanging, strangulation or suffocation; poisoning by drugs or other methods including alcohol or carbon monoxide fumes; use of firearms; drowning; jumping from a high place.

26 ABS, *Causes of Death, Australia 2009* (2011), cat no 3303.0, p 29.

27 Suicide Prevention Australia (SPA), Submission No 11, p 9.

28 See for example: The Royal Australian & New Zealand College of Psychiatrists (RANZCP), Submission No 3, p 11; *headspace*, Submission No 14, p 4.

29 Mr S Phillips, Telethon Institute for Child Health Research, Transcript of Evidence, 15 February 2010, p 29.

2.18 Another important consideration raised frequently in evidence relates to the scope of data routinely collected and reported on. To develop a more complete understanding of the complex picture of youth suicide (and suicide generally), including identifying risk factors and emerging trends, and appropriately targeting services, contributors to the inquiry called for the routine collection of suicide data to include information on ethnicity, culture, geography and socio-economic status.[30] Presentation of aggregated data also limits the capacity for organisations to gain an understanding of the more complex picture of youth suicide.[31]

## Committee Comment

2.19 It is clear that there is a range of information on suicide being collected by different organisations, with different collection and reporting standards. The Committee understands that the lack of a nationwide systematic approach limits the usefulness of suicide information. However, it is also evident that the issues associated with data collection and reporting of suicide, including youth suicide, are well recognised.[32] In relation to this, the Committee acknowledges that the ABS has already made significant efforts to implement reforms to improve the accuracy and quality of suicide data, and that these processes are ongoing.[33]

2.20 To address these issues, the *National Committee for the Standardised Reporting of Suicide* (NCSRS) was created by Suicide Prevention Australia with the support of the Australian Government Department of Health and Ageing (DoHA). The NCSRS aims include to 'achieve cross-jurisdictional and multi-party agreement on adequate, standard and operationalised criteria and reporting formats for suicide and related data.'[34] The NCSRS includes representative coroners offices, the NCIS, the ABS, the AIHW, DoHA, State and Territory Health Departments, police and crisis support services.

2.21 The Committee is also aware that the 2010 Senate report on suicide in Australia dealt extensively with the issue of suicide data collection and

30 See for example: RANZCP, Submission No 3, p 4; Diversity Health Institute, Submission No 12, p 6; Women's Health Victoria, Submission No 18, p 3.

31 See for example: Diversity Health Institute, Submission No 12, p 5; Women's Health Victoria, Submission No 18, p 3.

32 AIHW, Harrison JE, Pointer S and Elnour AA, *A review of suicide statistics in Australia. Injury research and statistics series no. 49* (2009).

33 Mrs A Schmider, ABS, Transcript of Evidence, 11 February 2011, p 4.

34 Suicide Prevention Australia's website, http://suicidepreventionaust.org/CurrentProjects.aspx, viewed on 13 April 2011.

reporting. The Senate report makes eight recommendations on these issues, including recommendations for governments, in consultation with the NCSRS, to improve the accuracy of suicide data and reporting.[35] The Committee supports the Senate report's recommendations in this regard, and is pleased to note the Government's positive response.

2.22 In addition to improved accuracy, the Committee considers that consideration should also be given to the scope of information collected, particularly social and demographic data which would assist with developing a better understanding of the complex picture of youth suicide, and suicide more broadly. The Committee also supports provision of more suicide data in disaggregated form.

### Recommendation 1

2.23 **The Committee recommends that the National Committee for the Standardised Reporting of Suicide consider options for, and the feasibility of, extending the scope of social and demographic suicide data routinely collected and reported on, to include information on:**

- **ethnicity;**
- **culture;**
- **geography;**
- **educational attainment;**
- **employment status; and**
- **socio-economic status.**

### Recommendation 2

2.24 **The Committee recommends that the National Committee for the Standardised Reporting of Suicide consider options for providing increased access to disaggregated suicide data.**

35 Parliament of Australia, Senate Community Affairs References Committee, *The Hidden Toll: Suicide in Australia* (June 2010). (See Recommendations 2-7, 21 & 28).

2.25 Of particular relevance to the issue of youth suicide, the Committee notes Recommendation 28 of the Senate report which calls for the ABS (and other relevant public agencies) to record and track suicides and attempted suicides in children aged under 15 years. As noted earlier in this Chapter, registered suicides in this group are relatively uncommon, though for a range of reasons it is likely that the reported figures are an underestimate. While acutely aware of the difficulties of establishing suicidal intent in this age group, and the extreme sensitivity for the families concerned, the Committee is keen to support initiatives which ensure that suicide in this demographic is not 'hidden'. The Committee believes that appropriate recognition of suicide in the under 15 year age group is needed to ensure that prevention initiatives do not neglect these children. The Committee notes that the Senate recommendation has been referred to the ABS.

## Factors Affecting the Likelihood of Suicide

2.26 Understanding the factors that influence the likelihood of suicide will assist in developing strategies to reduce suicide rates. A significant body of research already exists which indicates that many factors contribute to the likelihood that someone will consider or attempt suicide.[36]

2.27 These factors generally act to either increase the likelihood of suicide (risk factors) or decrease this likelihood (protective factors). Risk and protective factors are also categorised according to the level at which they are present; that is *individual* factors, *social* and broad *contextual* factors. Figure 2.3 lists commonly cited risk and protective factors within each of the three categories.

36 See for example: Beautrais A, *Risk factors for suicide and attempted suicide among young people*, Australian and New Zealand Journal of Psychiatry, (2000), Vol 34, pp 420-36; Australian Government Department of Health and Ageing, *LIFE: Research and Evidence in Suicide Prevention* (2007), pp 12-23.

Figure 2.3 Examples of Suicide Risk and Protective Factors

| | Risk factors for suicide | Protective factors for suicide |
|---|---|---|
| **Individual** | • gender (male)<br>• mental illness or disorder<br>• chronic pain or illness<br>• immobility<br>• alcohol and other drug problems<br>• low self-esteem<br>• little sense of control over the circumstances<br>• lack of meaning and purpose in life<br>• poor coping skills<br>• hopelessness<br>• guilt and shame | • gender (female)<br>• mental health and wellbeing<br>• good physical health<br>• physical ability to move about freely<br>• no alcohol or other drug problems<br>• positive sense of self<br>• sense of control over life's circumstances<br>• sense of meaning and purpose in life<br>• good coping skills<br>• positive outlook and attitude to life<br>• absence of guilt and shame |
| **Social** | • abuse and violence<br>• family dispute, conflict and dysfunction<br>• separation and loss<br>• peer rejection<br>• social isolation<br>• imprisonment<br>• poor communication skills<br>• family history of suicide or mental illness | • physical and emotional security<br>• family harmony<br>• supportive and caring parents/family<br>• supportive social relationships<br>• sense of social connection<br>• sense of self-determination<br>• good communication skills<br>• no family history of suicide or mental illness |
| **Contextual** | • neighbourhood violence and crime<br>• poverty<br>• unemployment, economic insecurity<br>• homelessness<br>• school failure<br>• social or cultural discrimination<br>• exposure to environmental stressors<br>• lack of support services | • safe and secure living environment<br>• financial security<br>• employment<br>• safe and affordable housing<br>• positive educational experience<br>• fair and tolerant community<br>• little exposure to environmental stressors<br>• access to support services |

*Source:* *Australian Government Department of Health and Ageing, LIFE: Research and Evidence in Suicide Prevention (2007), p 14*

2.28 Risk and protective factors do not explain everything about suicide. Importantly, risk and protective factors operate differently in each individual, particularly as similar events in life will affect people in different ways. Although suicide is more frequent in individuals who exhibit multiple risk factors and few protective factors, the majority of people in this higher risk group do not attempt to take their own lives. In contrast, people with few or none of the risk factors might suicide. [37]

2.29 Risk and protective factors are also known to have greater or lesser influence in specific social and demographic groups. Among young

37 Australian Government Department of Health and Ageing, *LIFE: Research and Evidence in Suicide Prevention* (2007), p 14.

people some factors might be more influential. As noted by the SPA, transitions from childhood to adolescence and young adulthood are characterised by self-exploration, and acceptance (particularly by peers) is crucial to a robust sense of self worth.[38] Therefore factors that may increase the likelihood of young people feeling marginalised or socially isolated may be particularly important. Issues associated with sexual orientation, body image, bullying (including via social media) and learning difficulties may be particularly relevant to this group.[39] As noted by Lifeline Australia, another characteristic that may be more significant is that suicide among young people can sometimes be an impulsive act, which is not always thought through or planned.[40]

2.30 Importantly, as some factors are modifiable (such as drug use and alcohol abuse) they can be directly targeted by programs, and are fruitful areas for intervention. Other factors are non-modifiable (such as age or sex), but programs can nevertheless try to reduce the impact of these factors on an individual's likelihood of suicide.

## Committee Comment

2.31 The Committee understands that there is a complex array of factors associated with suicide, and cautions against an overly simplistic view of youth suicide and its causes. Access to accurate and comprehensive data and an improved understanding of the influence of risk and protective factors on young people are needed to support an improved understanding. The Committee recognises however, that while this will assist the identification of populations or groups at increased risk of suicide, it will still not be possible to precisely identify individuals at risk, hence the need for early intervention strategies.

2.32 The Committee understands that the main value of this information is to provide a good evidence base to inform the development and appropriate implementation of strategies for reducing rates of youth suicide, and to enable effective evaluation of the impact of interventions. Current approaches to suicide prevention in Australia are considered in Chapter 3, including recently announced additional funding targeting suicide prevention.

38 SPA, Submission No 11, pp 10-11.

39 SPA, Submission No 11, pp 10-11.

40 Lifeline Australia, Submission No 2, p 10.