Suicide in Australia

Mortality, Deficits in Current Suicide Prevention Initiatives, Prioritising Target Groups for Prevention

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Root Cause/Correlate Analysis of Suicide Mortality © AIMHS 2017

Isolation
- Being elderly
- Relationship breakdown
- Loss of employment
- Bereavement
- Sexual identity issues
- Change in health status
- Change in marital status
- Accommodation location
- Social expectations of males

Situational Distress
- Unemployment
- Separation
- Loss of access to children
- Bereavement
- Health crisis
- Homelessness
- Financial difficulties
- Job related stress

History of Self-Harm, or Mental Health Difficulty
- Unintended lethal self-harm
- Poorly treated or untreated high intensity mental health difficulty
- Alcohol or substance abuse
- Incomplete suicide attempt
- Inappropriate prescribing of medication for depression

Completed Suicide
3,027 deaths as at 2015 (latest ABS figures)

Rural or Remote Location
- Diminishing size of communities
- Little or no access to support services
- Access to means of suicide
- Changing nature of agriculture
- Succession crises
- Unemployment
- Diminishing female population
- Fluctuating cycles of agricultural economies
- Climate variability
- Community dynamics

Circumstantial Distress
- Collapse of industry
- Natural disaster
- Communities in poverty
- Suicides in community
- Economic downturn
- Health and mental health services engage poorly with predominant at-risk groups
- Labour market policies and practices

Inadequate Early Detection or Support
- Prevention activity - late level intervention is frequently prioritised over early detection and intervention
- Conflation of suicide with mental illness
- Poor engagement of at-risk groups
- Inefffectual community education

For supporting data see accompanying references pages
Root Cause/Factor Analysis of Deficits in Current Suicide Prevention Initiatives

Conflation of Mental Illness with Suicide
- Situational and circumstantial issues are often overlooked or unnecessarily pathologised and medicated, because of a mental illness focus
- Suicide prevention is presumed to belong within the compass of the mental health system; community capacity is limited
- Prevention initiatives are not adequately informed or targeted
- Mental health promotion and suicide prevention messaging lacks impact
- The most at-risk groups are poorly engaged
- Suicide is conflated with self-harm and limits the remediation of both

Poor Service Engagement with Predominant At-Risk Groups
- The services of health, mental health, and human service providers are often not sufficiently tailored or responsive to the psychosocial culture of the most at risk groups
- Some of the most at-risk groups and communities are poorly serviced by health and mental health services

Prevention Activity: Early Detection and Intervention Confused with Late Level Intervention
- Late interventions with people who are suicidal, who have attempted suicide, or with families affected by completed suicide, are frequently prioritised over early detection and early intervention
- At least 75% of suicides are male and many (perhaps most) will die on their first attempt. Clearly, appropriate early detection and prevention should have greater priority

Poor Utilisation of Community Capacity
- Significant community capacity and willingness to be involved in prevention activity is under utilised or used unproductively
- Community powerlessness about suicide is exacerbated

Too Little Focus on Contextual & Social Determinants
- Key risk factors such as unemployment, industry failure, drought, labour market policies and practices, often fall outside the compass of current prevention efforts

Suicide Prevention - Systemic Deficits
42% increase in suicide in the last decade

For supporting data see accompanying references pages
Prioritising Target Groups for Prevention Initiatives (based on gross national suicide data)
Male Suicide Deaths by Age  

ABS 2005 – 2015

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Suicide Deaths</th>
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<tr>
<td>Under 20</td>
<td>5%</td>
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<tr>
<td>20s</td>
<td>17%</td>
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<td>70s or Over</td>
<td>6%</td>
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<td>80+</td>
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Male and Female Suicide Deaths by State  

ABS 2015

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<th>Males</th>
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</table>
Prioritising **Target** Groups for Prevention Initiatives  © AIMHS 2017

*(based on gross national suicide data)*

**Suicides by:**

**Gender = Males**

**Age = 30-50 yr olds**

**State = NSW, Vic + Qld**

**Increase:** Over a ten year period (2005-2015)  
*2,118 to 3,027 a 42.9 % increase*

**Gender:** At least **75% Male** and approximately 25% female

**Method:** Hanging and poisoning are the most common method

**Age:** 40-55 most at risk

**State:** 27% NSW, 25% Qld, 22% Vic, 13% WA
Prioritising Key Risk Factors for Prevention Initiatives

- Unemployment
- Family Breakdown
- Financial Difficulties
- Isolation/location
- Situational Distress
- Poor Engagement by Mental Health/Human Service Agencies & Professionals

*Weighting of risk factors needs to be part of the next step: Scoping, Action Plan & Budget

Program/initiatives design needs to take account of:
- Analysis of Deficits in Current Suicide Prevention Initiatives
- Ethnic differences
- Local conditions and culture
- Geographic location
- Weighting of risk factors


Beautrais, A. (2001). Suicides and serious suicide attempts: two populations or one?. Psychological Medicine, 31(05). http://dx.doi.org/10.1017/s0033291701003889


