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SUICIDE IN QUEENSLAND: MORTALITY RATES AND RELATED DATA 2011-2013



Fact sheet

Introduction

Since 1990, the Queensland Government has funded the Australian Institute for Suicide Research and Prevention (AISRAP) at Griffith University to manage the Queensland Suicide Register, a comprehensive database of suicide mortality data in relation to all suicides of Queensland residents. AISRAP has released its latest detailed analysis profiling suicide in Queensland between 2011 and 2013.

Why suicide data is important

Building a stronger, more accessible evidence base provides a solid foundation for effective suicide prevention activities across Queensland, and drives continuous improvement in research, policy and practice. The Queensland Mental Health Commission's partnership with AISRAP to maintain the Queensland Suicide Register, contributes to an improved understanding of suicide mortality trends and rates that can better inform suicide prevention and risk management strategies.

The *Queensland Suicide Prevention Action Plan 2015-17*, prepared by the Commission, includes a commitment to develop and implement a Suicide Data and Information Sharing Network to enhance the collection, analysis and reporting of both suicide mortality and attempt data.

The Commission is working with the Queensland Advisory Group on Suicide Data and Information (QAGSID) to develop the Network to ensure that useful suicide data is accessible to policy makers, funders, service providers and researchers working in the suicide prevention field.

About the report

The Australian Institute for Suicide Research and Prevention (AISRAP) publishes the Suicide in Queensland report every three years based on analysis of confirmed data from the Queensland Suicide Register (QSR). A broad range of information about suicide deaths by Queensland residents from 1990 to the present is

collected in the QSR, covering a wide range of demographic, psychosocial, psychiatric and behavioural aspects.

The *Suicide in Queensland: Mortality Rates and Related Data 2011-2013* report is the seventh edition profiling the main characteristics of suicide mortality in Queensland.

Suicide rates in Queensland

Between January 2011 and December 2013 there were 1,914 suicides in Queensland with an age-standardised rate of 14.0 per 100,000 people. The age-standardised suicide rates for males (21.3 per 100,000) were approximately three times the rate for females (6.9 per 100,000).

Suicide rates for all persons were significantly higher in remote areas (26.77 per 100,000) than in regional (14.85 per 100,000) or metropolitan areas (12.94 per 100,000) of Queensland.

The report outlines that suicide rates have fallen about 12 per cent over the 10 year period since the Queensland Government introduced its first whole-of-government suicide prevention strategy in 2003. This decrease provides some encouragement for government intervention, while at the same time indicating the modest extent of the changes to date.

These falls are not uniform across age groups. There has been an increase in the proportion of suicides in people aged 55 years and older, warranting special examination of the circumstances of these suicides to help identify what measures might be introduced to lessen their frequency.

There has also been an increase in the number of children under the age of 15 years dying by suicide, from six in the period 2008-2010 to 21 children during 2011-2013. Of those who died by suicide 14 were males and seven were females. The youngest suicide occurred by a child less than 10 years of age. Four of these deaths were by children of Aboriginal and/or Torres Strait Islander descent, two were 12 and two were 14 years of age.

In the 2011-2013 period there were 389 (20.3 per cent) deaths recorded in the QSR of persons born outside Australia. The majority of these (93.2 per cent) were born in the English speaking countries of Canada, Republic of Ireland, New Zealand, South Africa, and the United Kingdom. The non-English speaking countries of origin most represented were Germany, the Netherlands, China, Papua New Guinea, Japan and India.

Overall crude rates of suicide were lower for people from culturally and linguistically diverse backgrounds than the rates in the Australian-born population.

Aboriginal and Torres Strait Islander peoples

The age-standardised suicide rate for Aboriginal people and Torres Strait Islanders was 1.7 times the rate for other Queenslanders (23.5) with 66 per cent under 35 years of age at the time of death.

The suicide rate of Aboriginal and Torres Strait Islander peoples has increased and the gap is now two-thirds higher than that in non-Indigenous people, due largely to an increase in suicides among younger Aboriginal and Torres Strait Islander males.

Regional breakdown

The Suicide in Queensland report presents data by Hospital and Health Services (HHS) and Primary Health Network (PHN) regions for the first time since the establishment of the networks in 2012 and 2015 respectively. This approach is aimed at providing more accessible and useful information for services and communities to drive local responses to suicide prevention activities.

Overall, the highest age-standardised suicide rate was found in the Greater Western Queensland region (27.25 per 100,000), and the lowest in Metro South HHS (11.75 per 100,000).

In males, the highest mortality was in the Greater Western Queensland region (35.76 per 100,000), and the lowest in Metro South HHS (17.76 per 100,000). In females, suicide rates ranged from 17.60 in Greater Western Queensland to 3.20 per 100,000 in Darling Downs HHS.

Suicides that occurred in remote areas of Queensland in 2011-2013 show a different profile to those in

metropolitan and regional areas. While remote regions comprised only 3.0 per cent of the total Queensland population, it accounted for 5.6 per cent (106 people) of total suicides. Of all suicides in remote areas of Queensland, 48.01 per cent occurred in the age group 34 years and younger, a percentage much higher than in metropolitan (28.8 per cent) and regional (32.7 per cent) areas.

Relationship with health problems

An association between suicide and psychiatric illness was again found, with almost half the number (47 per cent) having a recorded psychiatric illness. The prevalence was significantly greater in females than in males (61.6 per cent vs 42.4 per cent).

The most prevalent psychiatric illness was unipolar depression (36.3 per cent), followed by anxiety disorders (9.8 per cent), substance use disorders (7.8 per cent), psychotic disorders (5.8 per cent), bipolar depression (5.6 per cent) and personality disorders (2.7 per cent).

However, about the same proportion had a physical illness (48 per cent), indicating that increased vigilance is warranted not just for those with psychiatric illness. The most frequent health problems were general or unspecified illness (19 per cent), followed by circulatory system disorders (16.7 per cent) and metabolism or nutritional disorders (10.1 per cent).

Life events

Recording of life events relating to suicide relies on the accuracy of accounts provided to police at the time of death and the coronial investigation. As a result it is likely that some important triggers for suicide are underestimated in the recording of life events in the QSR.

In people who died by suicide in 2011-2013, relationship separation was the most frequently recorded life event (27 per cent), followed by relationship conflict (15.5 per cent), financial problems (14.9 per cent), bereavement (13.9 per cent) and familial conflict (10.3 per cent).

The report identifies that life events related to socio-economic problems are considered of particular importance¹ as they can contribute to harmful substance misuse, financial, relationship or family problems which could lead to psychiatric disorders and suicidal behaviour.

¹ World Health Organization (2014). Preventing suicide: A global imperative. Geneva: World Health Organization.

Suicide methods

The most frequently used suicide methods in Queensland were hanging (49 per cent), drug or medicine overdose (18 per cent), carbon monoxide toxicity (7.1 per cent), and firearms (6.7 per cent).

Other means accounted for 20.1 per cent of all suicides, comprising methods such as jumping from height (4.4 per cent), suffocation by plastic bag (2.6 per cent), cutting by sharp objects (2.5 per cent), and drowning (2 per cent).

Suicide methods have changed substantially over the past two decades. There was a considerable drop in suicide by firearms in the period 1996-1998 coinciding with uniform action on firearms control in Australia. The use of firearms as a method of suicide has continued to decrease, with the lowest recording of deaths by suicide in the period 2011-2013.

Carbon monoxide poisoning as a method has continued to decrease in frequency as it has over the past two triennial reports. The decrease in carbon monoxide poisoning is likely due to increased environmental regulations in Australia, resulting in reduced carbon monoxide emissions from motor vehicles.

Suicide attempts

Approximately 30 per cent of those who died by suicide had a previous suicide attempt (females 38 per cent and males 28 per cent). This outcome suggests that more assertive follow-up of suicide attempts is needed. The Commission is reviewing available models and approaches to deliver a follow-up care pilot project as a priority action under the *Queensland Suicide Prevention Action Plan 2015-17*.

Conclusion

The *Suicide in Queensland: Mortality Rates and Related Data 2011-2013* report is available from the Australian Institute for Suicide Research and Prevention website at www.griffith.edu.au/health/australian-institute-suicide-research-prevention/research.

The report was prepared by Boyd Potts, Kairi Kolves, John O’Gorman, Diego De Leo.

The *Queensland Suicide Prevention Action Plan 2015-17* is available from Commission’s website at www.qmhc.qld.gov.au

SEEK HELP

If you need assistance, these services are available to help you now:

National 24/7 Crisis Services

- Lifeline 13 11 14
- Suicide Call Back Service 1300 659 467
- MensLine Australia 1300 78 99 78

National Support Services

General support

- beyondblue support service 1300 22 4636 or email or chat at www.beyondblue.org.au
- Lifeline www.lifeline.org.au/Get-Help/
- Suicide Call Back Service www.suicidecallbackservice.org.au
- SANE Australia Helpline 1800 18 SANE (7263) www.sane.org

Further information

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