SUICIDE - A HEALTH PROBLEM OF THE NINETIES

Information Circular No. 13

QUEENSLAND HEALTH

EPIDEMIOLOGY AND HEALTH INFORMATION BRANCH
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SUICIDE - A HEALTH PROBLEM OF THE NINETIES

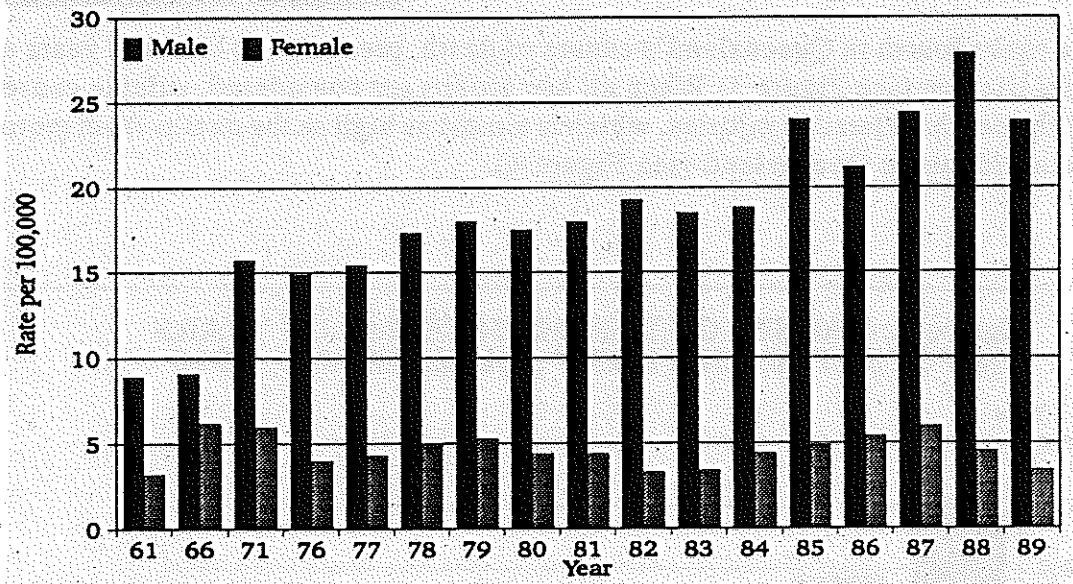
The 1960's and 1970's saw a massive rise in rates of **attempted** suicide. This rise, although extremely burdensome and costly in terms of health care utilisation was fortunately accompanied by relatively unaffected mortality rates. Currently though, there is reawakened concern due to an alarming rise in actual **mortality** from suicide in young people in most corners of the globe.

Young Males - Group of Most Concern

International comparisons of suicide rates rank Australia at the extreme high end for males aged 15-29 years (see Appendix 1).

In Australia the current **rise in suicide mortality** is most apparent in males aged 15 to 29 years. Suicide rates for males aged 15-24 years have risen 150% over the last 3 decades and continue to rise (see figure 1).

Figure 1: SUICIDE RATES, AGE 15-24 YEARS, AUSTRALIA

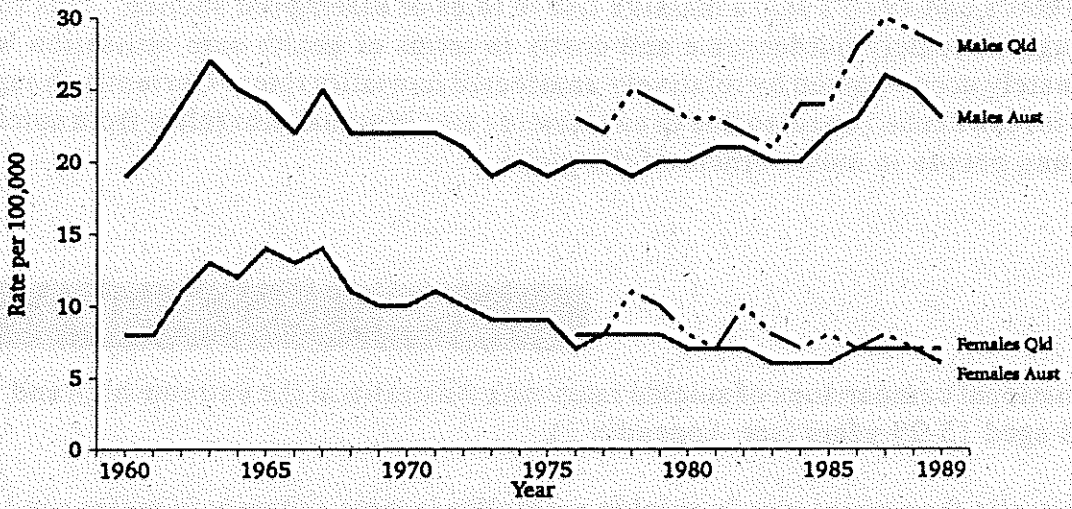


Source: Australian Bureau of Statistics

Age standardised suicide rates for Australia and Queensland are shown in Figure 2. Queensland's suicide rate is higher than the Australian rate for males and females.

There has been a small decline in suicide rates in older age groups so that the overall rate in Australia is no higher than in 1961. There is concern however, not only for the loss of young Australian males in the prime of life, but that the **vulnerability of this cohort** of young people may be carried into later life and result in a rise in overall suicide rates in the years ahead.

Figure 2: TRENDS IN AGE ADJUSTED* SUICIDE RATES, QUEENSLAND (1976-89) AND AUSTRALIA (1960-89)



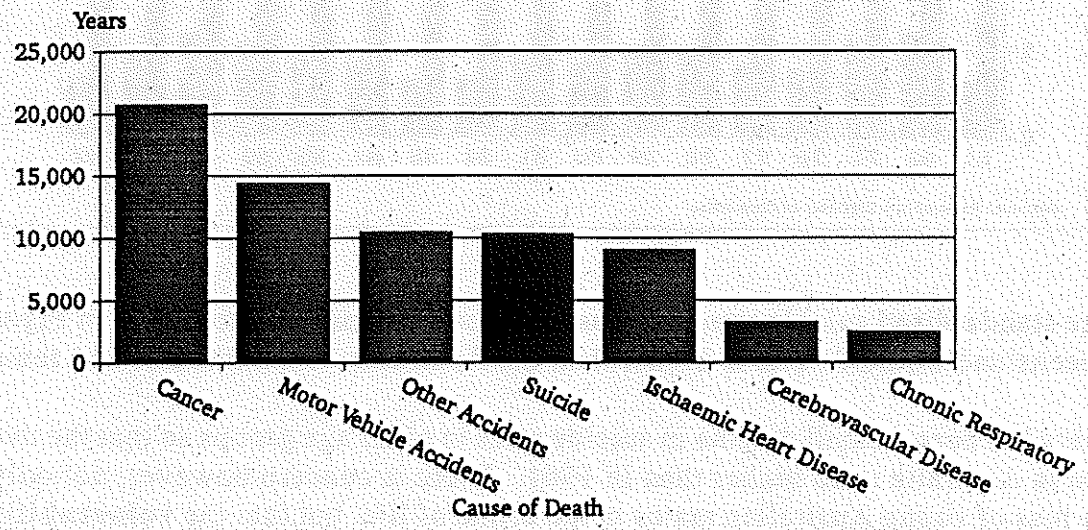
* Standardised to Australia 1986 population

Source: Epidemiology and Health Information Branch, Queensland Health
Suicide Research Prevention Program, Queensland Health

How Big is the Problem?

Suicide ranks fourth in Queensland's causes of death, presented in terms of years of potential life lost (see Figure 3). When all age groups are considered, suicide causes 28% of the deaths related to injuries, which is almost as high as the deaths from motor vehicle accidents in Queensland (see Figure 4).

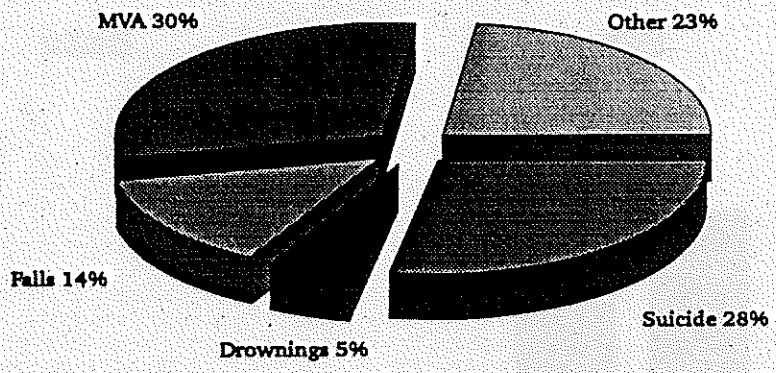
Figure 3: CAUSES OF DEATH, IN TERMS OF YEARS OF POTENTIAL LIFE LOST*, QUEENSLAND, 1989



* Years of Potential Life Lost were calculated for deaths of persons aged 1 to 65 years, based on average life expectancy of 66 years. Assumes that up to age 66 years, decedent would not have died from other causes

Source: Epidemiology and Health Information Branch, Queensland Health

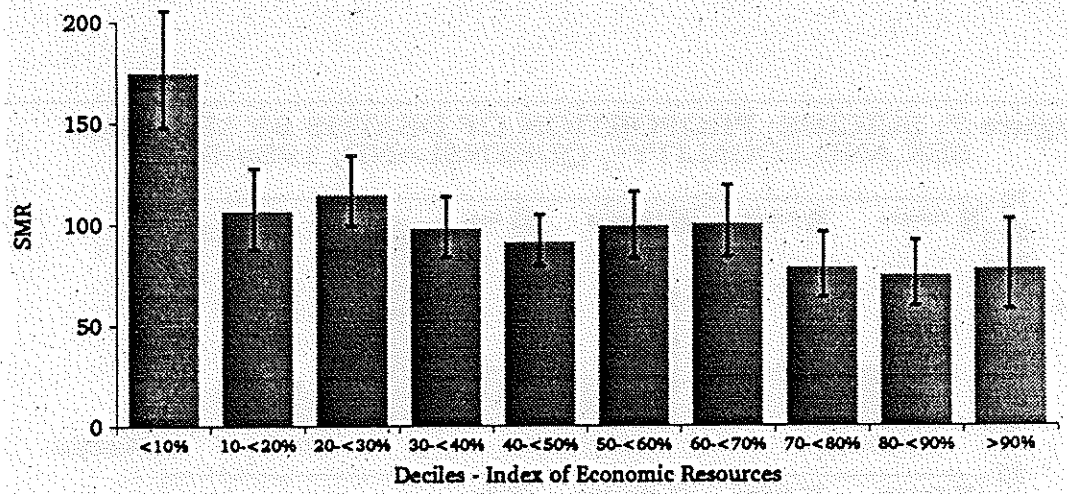
Figure 4: SUICIDE AS A PROPORTION OF DEATHS FROM EXTERNAL CAUSES, QUEENSLAND, 1989



Source: Australian Bureau of Statistics

Figure 5 shows significant excess of suicide mortality for males in the lowest socioeconomic decile. There is evidence that some cases have experienced a downward drift in socio-economic status prior to the event which may reduce this differential.

Figure 5: MALE SUICIDE, STANDARDISED* MORTALITY RATIOS BY SOCIOECONOMIC STATUS, QUEENSLAND, 1984-88

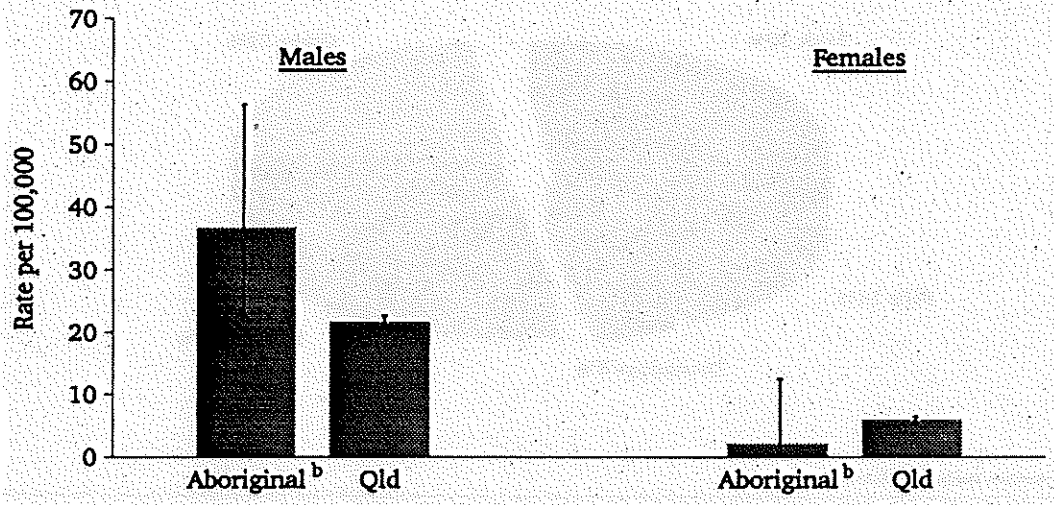


* Standardised to Qld 1986 population, with 95% confidence intervals, ages 0-85+

Source: Epidemiology and Health Information Branch, Queensland Health

Figure 6 shows, from limited analysis, an excess of suicide mortality in males of Aboriginal and Torres Strait Islander descent when compared to Queensland male rates . There is no statistically significant difference for females.

Figure 6: SUICIDE; STANDARDISED[a] MORTALITY RATES, QUEENSLAND, 1982-90

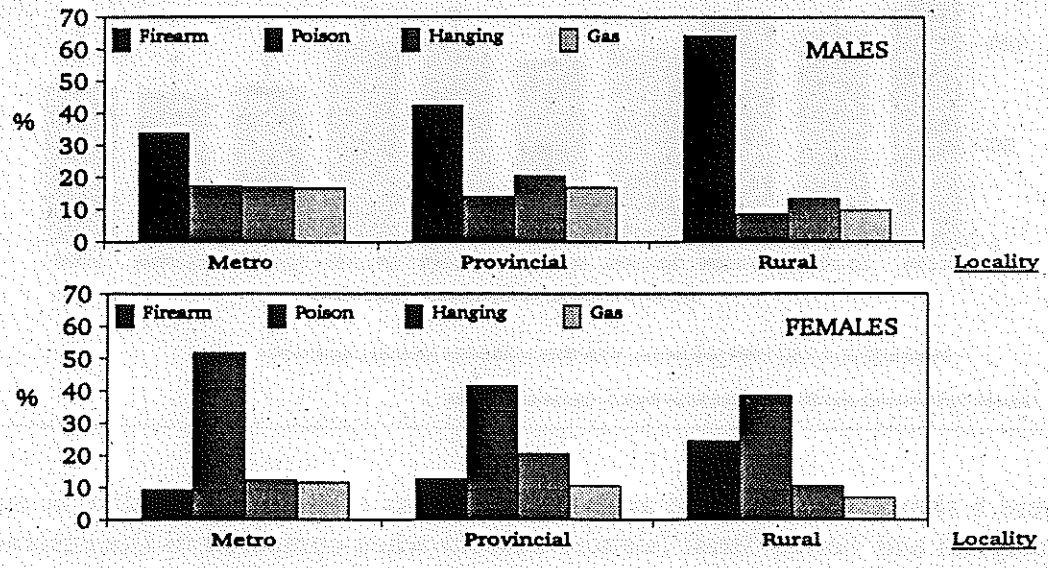


a Standardised Australian population 1986
b Areas of >50% Aboriginal & Torres Strait Islander population

Source: Epidemiology and Health Information Branch, Queensland Health

Suicide by firearms was the major method of male suicide in Queensland in 1984-88 (43.3% of male suicides; 125 deaths per year). For Queensland during 1984-88, there was a significantly higher proportion of male deaths by firearms in rural areas when compared with metropolitan and provincial areas (see Figure 7). Poisoning was the major method of suicide for females (46% of female suicides; 36 deaths per year).

Figure 7: SUICIDE: PROPORTION OF DEATHS BY METHOD, SEX AND LOCALITY*, QUEENSLAND, 1984-88



* Metropolitan - Brisbane Statistical Division
Provincial - Moreton Statistical Division; Cairns, Townsville, Mackay, Rockhampton, Gladstone, Bundaberg Statistical Districts; Maryborough, Hervey Bay, Gympie, Toowoomba Cities
Rural - remainder

Source: Epidemiology and Health Information Branch, Queensland Health

Suicide has significant social impact. For example, a typical 23 year old male suicide case impacts widely in the local community, producing a bereavement reaction in 2 parents, 2 siblings, 1 spouse/partner, 1 child, 2-4 grandparents, several friends and many acquaintances.

Studies have shown that more than 90% of persons who suicide have a mental disorder or serious mental health problem (adult suicide[1-2], adolescent suicide[3-6]). Many cases (some studies[7] suggest as many as 60%) occur whilst in psychiatric care.

Goals and Targets

Queensland Health's targets for the next three years include:

- halting the rising suicide rates for males aged 15-29 years,
- decreasing suicide rates for other groups by 10-20%, and
- decreasing the repetition rate for non fatal suicide attempts by 20%.

Proposed national targets for the year 2000 include reducing deaths from suicide:

- for 15-24 year olds by 10% for males and 5% for females,
- for males and females aged 55 years and over by 5%,
- for males in all age groups by 30%, and
- for females in all age groups by 10%.

Health Service Responses

Experts at the World Health Organisation have called for review of approaches to suicide prevention. In particular they suggest:

1. **Improving clinical services.** This should be broadly based and include not only hospital emergency services for attempted suicides but also inpatient and outpatient psychiatric care and primary care delivery.

   Examples might include:

   - Providing ready access, including by phone, to a 24 hour Mental Health Service to give advice regarding assessment to the general public and referring practitioners
   - Providing a walk-in emergency service - many suicidal emergencies cannot wait for scheduled appointments

- Reviewing psychological assessment procedures for attempted suicides (e.g. consideration of the Suicide Intent Scale). Identifying the proportion not seeing mental health staff

- Reviewing the histories of all patients suiciding while in care

- Ensuring responsibility for high risk cases rests with suitably qualified staff

- Reviewing aftercare services for suicide attempts; e.g. identifying non-attendance rates, providing home visits

- Drawing up a community response plan for traumatic suicide cases; eg where a boy shoots himself at school

- Conducting regular quality assurance exercises.

2. **Upgrading education and training,** not only to clinicians but also to others in the front line; e.g. teachers, police, youth workers, social services, funeral directors, priests, families etc.

   Examples may include:

   - Upgrading education of hospital staff and general practitioners in areas such as risk assessment and crisis counselling

   - Training police, who need to work in collaboration with other professionals (e.g. family doctor) and relatives in the situation of suicide or attempted suicide.

   Guidelines for the referral of suicidal students by teachers and guidance officers are currently being developed in conjunction with the Education Department in Queensland.

3. **The provision of special services to high risk groups** such as prisoners, Aborigines, the isolated elderly, young men, etc.

   Examples may include:

   - Reviewing cases of suicide occurring in other institutional settings, e.g. jails, nursing homes etc., to assist future suicide prevention efforts

   - Providing outreach services to victims of violence/trauma

   - Developing guidelines for managing depression in the elderly, in circumstances such as recent spouse bereavement, by regional geriatric services.

   - A professionally conducted support group for persons bereaved by suicide has been established as a model for other programs. For details of the "Bereaved by Suicide Support Group", contact The Queensland Association for Mental Health, ph. (07) 358 4988

4. **Improving the research base from which interventions might be developed.**

This could include:

- Designating an appropriately experienced mental health professional to plan and oversee a regional suicide prevention strategy
- Evaluating preventative interventions
- Reviewing data systems for recording suicide attempts (many cases are currently coded as accidents).

Suicide Research and Prevention Program

The Suicide Research and Prevention Program (SRPP) can provide information and advice on the above issues. It can provide detailed assessment of regional suicide profiles. The SRPP also has an extensive statewide network of contacts in suicide prevention.

Contact Persons for the SRPP are:

Dr Chris Cantor

or

Ms Meg Driver

at

GPO Box 48
BRISBANE Q 4001

Material for this circular was provided by the Suicide Research and Prevention Program.

Appendix 1

MALE SUICIDE RATES*, BY COUNTRY AND AGE, 1970 AND 1985/86

		1970			1985/6		
Country		15-29	30-59	60+	15-29	30-59	60+
1	Hungary	33.2	70.6	131.3	33.5	98.3	156.9
2	**Australia**	**15.3**	**29.1**	**33.2**	**26.1**	**22.3**	**28.6**
3	Canada	17.1	27.1	23.9	25.6	26.2	28.2
4	Denmark	15.3	44.7	50.0	24.3	47.1	72.5
5	Belgium	8.8	27.0	76.0	22.7	38.6	85.8
6	France	11.3	32.2	68.5	22.7	41.5	93.7
7	USA	16.2	25.4	39.3	22.6	23.6	43.4
8	West Germany	22.8	39.5	67.7	19.7	32.3	59.2
9	New Zealand	11.1	21.2	26.8	19.6	18.5	33.1
10	Japan	16.5	20.8	70.2	18.4	40.3	64.7
11	Czechoslovakia	32.5	52.3	87.9	18.1	43.4	79.7
12	Ireland	2.8	5.0	4.2	15.9	15.9	16.1
13	Scotland	6.7	14.9	20.8	15.8	23.4	21.1
14	Bulgaria	9.8	16.2	82.5	14.0	22.8	102.5
15	Singapore	10.4	20.3	98.4	12.7	18.1	99.4
16	Venezuela	14.6	17.4	19.1	10.9	13.4	23.4
17	England & Wales	6.7	13.0	21.4	10.5	16.7	19.9
18	Netherlands	6.0	14.1	35.1	10.0	17.7	37.7
19	Mexico	3.1	3.4	5.8	4.3	4.1	9.6

* Rate per 100,000

Source: Diekstra F.W. "Suicide and the Attempted Suicide - An International Perspective", Acta Psychiatrica Scandinavica 1989; 80 (supp 354): 1-24

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