Suicide

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Suicide affects many people across all ages and many cultures. Suicidal behavior is not just the act of a person taking his or her own life. Suicide also includes self-harm, attempting suicide and thinking about suicide.

Risk behavior is closely associated with suicidal behaviour and includes behaviour that places a person's life and health at risk e.g. fast and dangerous driving, regular heavy drug use, unsafe sex with various partners.

Rates

Global situation

Suicide rates across the world have increased by 60% over the past 45 years, with an increase in the numbers of youth suicides. Mental Disorders are associated with more than 90% of all suicides although it is recognised that sociocultural factors are involved and that suicide is more likely to occur in times of crisis.[1]

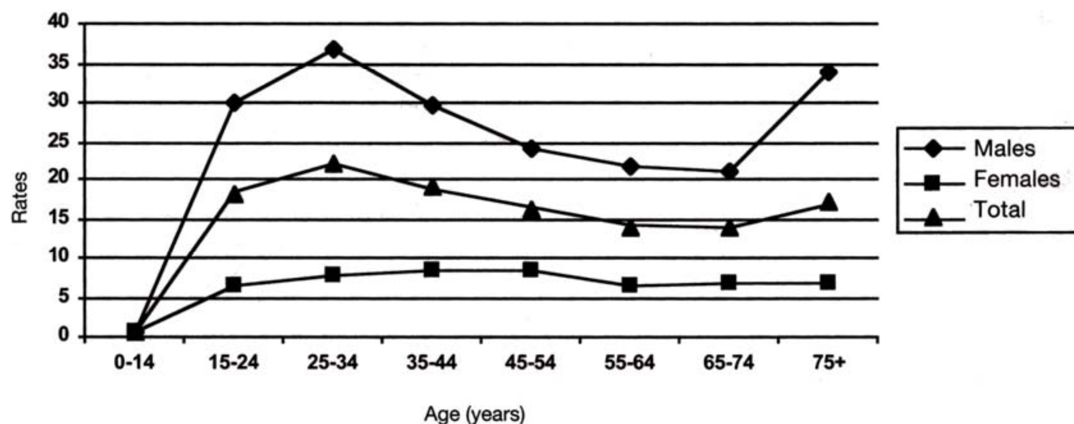
Australia

The pattern of suicide death rates for Australians across all ages has been relatively constant since 1921, with an average annual rate of approximately 21 deaths per 100 000 for males, and 5.5 deaths per 100 000 for females.[2] The age pattern of suicide has changed over this time, however, with less middle-aged people dying from suicide and an increase in the rate of young people and older people dying from suicide. Suicide rates in young men tripled between 1960 and 1990 while the rates for young women doubled.

Gender

Males are five times more likely to die from suicide than females, though more females attempt suicide and are hospitalised following suicide attempts. It is estimated that for one completed suicide there are 50–100 attempts.[3]

Figure 1: Suicide rates (per 100 000) by gender and age, Australia, 1997[2]



Methods

In Australia the most common method of suicide attempt for both males and females is drug overdose. However, more males die by hanging than any other form of suicide, and more females die from drug overdose than other methods of suicide.[4] Hanging is one of the most lethal forms of suicide i.e. it is easy to die from hanging.

For Indigenous people hanging has become the most common method of suicide. The increase in suicide by hanging in Indigenous communities can be related to the struggle of Indigenous peoples at the political, community and individual level:

> . . .the Aboriginal collective experience of two hundred years of incarceration, capital punishment, and outback murders . . . makes all hanging deaths 'custody' deaths in that they relate to a bloody history of incarceration institutionalisation, and eroded freedoms, and reflect relentless and oppressive circumstance . . .[5]

Hunter, Reser, Baird and Reser provide an in-depth discussion about Indigenous suicide.[5] They discuss suicide in terms of cultural meaning and understanding, media representation, symbolic representation and the influence of deaths in custody. Amongst other things, they suggest that increased representation of Indigenous peoples committing suicide by hanging has led to this method becoming common within the Indigenous community.

Mental health and suicide

Although most people with a psychiatric disorder do not suicide, it is reported, '90% of suicides in all age groups are associated with psychiatric or addictive disorders'.[6] Depression is believed to be the most common associated factor linked to suicide.[3,6]

Young people

National Action Plan for Suicide Prevention reports that up to one in ten young people attempt suicide, and up to 50% of young people think about suicide (suicide ideation).[4]

Australia has one of the highest rates of youth suicide in the world. Suicide is one of the leading causes of death for young people. For young men aged 15–24 years it is the leading cause of death.[3]

At any time 1–3% of adolescents suffer from a major depressive disorder.[7] Up to 24% of young people will have suffered at lease one episode of major depression by the time they are 18 years of age. Self-report studies indicate that 77% of young people reporting deliberate self-harm have a mental health problem.[8]

Indigenous Australia

The suicide rate amongst Aboriginal and Torres Strait Islander peoples is approximately 40% greater than the national average.[4]

Suicide rates for young Indigenous people is approximately double that for non-Indigenous young people.[8]

Rural and remote Australia

The rate of suicide in remote areas is almost twice the rate of urban areas.[4] There has been a four-fold increase in male youth suicide in rural areas in the past 25 years. For 15–19-year-old males the rates have increased by up to six-fold.[9]

Northern Territory

Northern Territory has a higher rate of suicide than the national average with 45 per 100 000 compared with a national average of 25 per 100 000 people. The rate of suicide for young females in the NT is over three times the national average.

Figure 2: Total number of youth suicides (<26 years) in Central Australia annually between 1989 and 2001, by gender and cultural background. (Figures up to October 2001.)

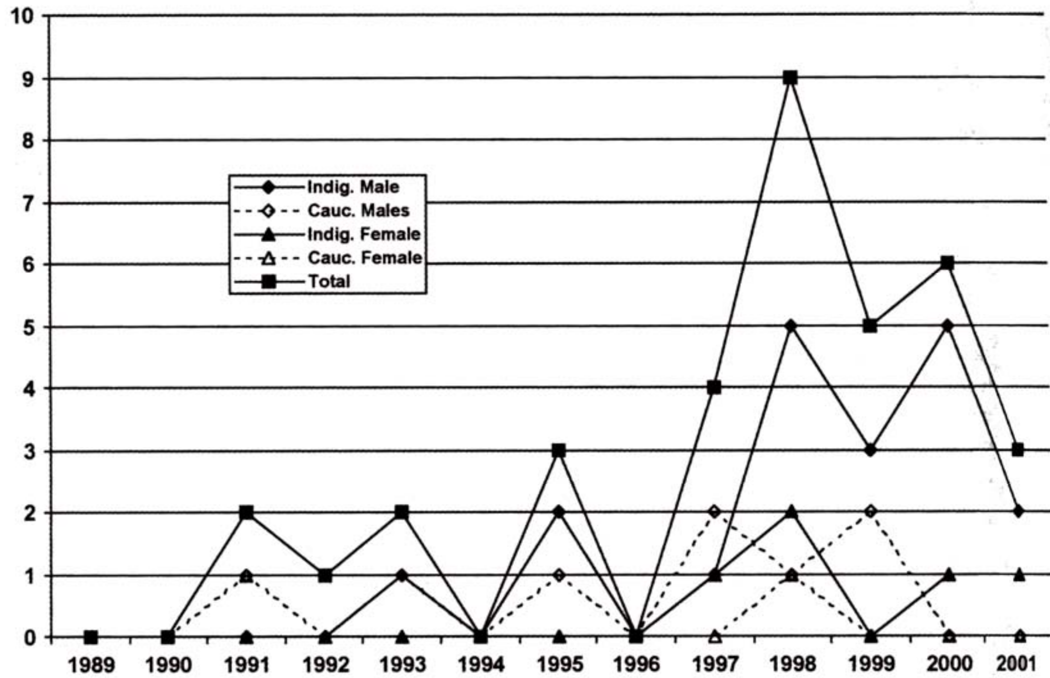


Figure 3: Total number of adult suicides (>25 years) annually between 1989 and 2001, by gender and cultural background. (Figures up to October 2001. One male unknown age or ethnicity died in 1989.)

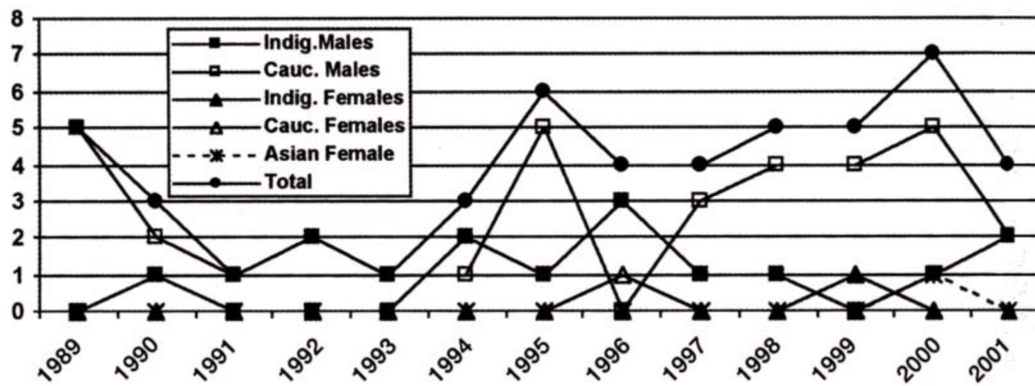


Table 1: Rates of suicide per 100 000 of 15-24 year olds (1998) Australian and the Northern Territory[10]

	Males	Females	Total
Northern Territory	31	14	45
Australia	25	4	29

Table 3: Total number of adult suicides in Central Australia by age and cultural background (figures from 1989-2001)

Years of age	26-29	30-39	40-49	50-59	60-69	70-79	TOTAL
Indigenous males	2	7	1	2	-	-	12
Caucasian males	9	6	12	5	2	1	35
Indigenous females	-	-	1	-	-	-	1
Caucasian females	-	1	-	-	-	-	1
Asian female	-	-	1	-	-	-	1
Total	11	14	15	7	2	1	50

Table 4: Rates of suicide between Alice Springs, Tennant Creek and remote locations

	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	Total
A/S	5	1	1	2	3	2	3	2	7	9	5	8	4	52
Remote	1	1	1	1	0	1	4	2	1	3	3	4	1	23
T/C	0	1	1	0	0	0	2	0	0	2	2	1	1	10
Total	6	3	3	3	3	3	9	4	8	14	10	13	6	85

A/S = Alice Springs Remote = remote community T/C = Tennant Creek

The Central Australian region[11]

Young people

Between 1989 and 2001 there was a steady increase in the number of youth suicides in the Central Australian region. Figures indicate that the pattern of suicide for non-Indigenous young people was relatively constant, with an increase in 1997 and 1999. Over this period, 11 young men and two young women completed suicide. The pattern of suicide for Indigenous young people changed dramatically over this period. Between 1989 and 1992 there were no recorded suicides by young Indigenous people. Between 1993 and 2001, 23 young Indigenous people completed a suicide, 18 of these were male (see figure 2).

While there was a decrease in the number of young people completing suicide in 2001, the increase of youth suicides over the past five years is considered by health professionals in the Central Australian region as an ongoing crisis. In response to this crisis, the Life Promotion Project was implemented in 1998 to coordinate the response to suicide and suicide prevention in the region.[12]

Table 2 indicates that nearly all youth suicide was completed by young people aged between 15 and 25 years. The highest risk group is young Indigenous men aged between 20 and 25 years. Anecdotal reports suggest that children under the age of 10 have attempted suicide in the region.

Table 2: Total number of youth suicides in Central Australia by age and cultural background (figures from 1989–2001)

	10–14 yrs	15–19 yrs	20–25 yrs	TOTAL
Indigenous male	–	5	14	19
Caucasian male	–	4	5	9
Indigenous female	1	2	1	4
Caucasian female	–	2	1	3
Total	1	13	21	35

Adults

In contrast to young people, the pattern of adult suicide indicates a crisis in the non-Indigenous male population. A total of 35 non-Indigenous men completed suicide between 1989 and October 2001, with 25 of these suicides occurring since 1995. The rate of suicide in the remaining adult population remained relatively consistent with some variations occurring in the adult Indigenous male population (see figure 3).

Table 3 indicates that most adult suicides were completed by people aged between 25 and 50 years. The highest risk group is non-Indigenous men aged between 40 and 50 years.

Table 4 indicates that the rate of suicides between Alice Springs, Tennant Creek and remote locations occurred at a ratio of 5:2:1, which is relatively consistent with population levels for these three regions.[10]

A framework for prevention

Knowing, risk factors, possible signs and patterns of behaviour for a person provides us with a prevention framework.

Suicidal people are normal people feeling a lot of stress and/or sadness. Many people at some time in their life think about suicidal. Suicidal behaviour is more likely when a person is finding it hard to cope with stressful things in their life.

Risk Factors

Risk factors most commonly associated with suicide

- Presence of a mental illness, particularly depression
- Previous suicide attempt/s
- In Central Australia, anecdotal evidence from clinicians indicates that sexual abuse is a high risk factor, particularly for young women. The monitoring of young people at risk and the coordinated response to completed suicides by the Life Promotion Program indicates that sexual abuse as a high risk factor for young women in Central Australia. As a clinician working with people at risk for six years in Alice Springs, I have found that young women with suicidal behaviour have often experienced sexual abuse.

Risk factors are factors that are commonly associated with suicide. They may increase the likelihood of a person committing suicide, attempting suicide or engaging in destructive behaviours. While many people who commit suicide have experienced common risk factors, there are many people with these risk factors who do not engage in suicidal behaviour. Risk factors may vary according to population.[6]

People who present with suicidal behaviour often experience the following factors[8,6,13–17]:

Mental Health

- Depression and other mood disorders
- Schizophrenia
- Conduct disorder
- Substance abuse disorders
- Low self-esteem

Previous suicidal behaviour

- Lethality: hanging is the one of the most lethal forms of suicide, overdose is less lethal
- Number of attempts; risk increases as the attempts increase
- Suicide by a family member increases suicide risk by five-fold

Trauma and abuse

- Conflict, violence and other abuse; chronic exposure to violence
- Trauma: up to 75% of young people who report a history of sexual abuse also report suicidal behaviour[8]

Loss or Change

- Death by suicide of family or friends
- Death or loss in friends or family
- Chronic illness or disability/physical illness
- Relationship loss
- Job loss

Family and life experiences

- Poor relationship with or between parents, including separation/divorce; violence/abuse, parenting style/neglect, overprotection, and criticism
- Parents being in prison
- Placed in welfare as a child
- Children of Vietnam Veterans

Media

- There is a link between media reporting on suicides and an increase of suicides after the reporting

Development, identity and environment

- Sexuality issues
- Choice of music (related to death)
- (Sense of) failure at work/school

- Legal issues
- Incarceration

Social disadvantage
- Unemployment
- Limited educational opportunity
- Poverty
- Homelessness

Coping skills
- Vulnerability and low resilience
- Self destructive coping skills
- Limited support networks

Behaviours
- Drug use
- Risk behaviours
- Violence

There are community and political issues that affect suicidal behaviour by creating social isolation, disadvantage and patterns of behaviour, which place certain groups in the community at risk of suicide. These include:
- Social isolation due to community intolerance (mental illness, sexuality, cultural background)
- Social isolation due to negative discourse by the community, media and politicians e.g. about young people, Indigenous peoples, refugees
- Patterns of behaviour developed within a community e.g. hanging as a means of suicide for Aboriginal people; hunger strikes by asylum seekers
- Laws and policies that increase the likelihood of social isolation, family difficulties, and that limit social and economic opportunity e.g. mandatory sentencing, removal of bilingual education, stolen generations.

Warning signs
Sometimes it is hard to tell that a person is suicidal. In most cases, however, there are warning signs. Although they are sometimes subtle, people often give clues and signs about their suicidal thoughts and intentions. As with the risk factors, the following does not predict suicide. If we know the person, we should be aware of major changes in behaviour and recent stresses which may make the person more vulnerable.

Look out for the following
- Recent event (or build up) that may make it difficult for the person to cope, such as recent (or anniversary of) loss/death, relationship breakdown
- Recent patterns of thoughts, feelings and behaviour (not just one off)
- The person is not behaving the way they usually do

To identify warning signs be aware of what people are saying, how they are behaving and how they appear to be coping. Warning signs for suicidal behaviour are similar to signs of depression. Be aware of the following.

Things people say and think
- Unhappy with self, life or preoccupied with death
- No sense of future, not able to cope, want it all to end

Changes in personality and behaviour

- Sudden lift in spirits
- Irritability, restlessness
- Anger
- Sleeping and eating patterns change
- Withdrawal
- School or work performance deteriorates
- Crying and moodiness
- Alcohol or other drugs
- Numerous accidents
- Dangerous risky behaviour

Preparations for death
- Goodbyes
- Making will
- Statements that might imply not seeing that person again
- Giving things away
- Writing or drawing things about death or suicide

Signs of depression
- Feeling worthless, guilty
- Tired, not being able to concentrate or make decisions
- Not caring about self, not interested in things and not wanting to do anything
- Problems with sleep; too much or too little
- Withdrawn, restless, irritable

Working with someone at risk of suicide

Many people are scared about suicide, and don't know what to do when someone talks about suicide or is showing suicidal behaviour. It is common for people to respond with panic, anger, or ignore the behaviour claiming that it is 'attention seeking'.

People who attempt or talk about suicide should not be dismissed as attention seeking. All talk of suicide should be taken seriously. It is hard to tell how serious a situation is until you sit down and talk to the person and make an assessment of their needs.

There is no evidence that talking about suicide encourages it to happen. Many people who have thoughts of suicide are scared of these thoughts and are scared of dying. The step of suicide is often a desperate step when people cannot see a way out of their situation. If you can talk about it without judgement and with care it can help reduce the risk of it happening. Always remember to refer to someone else if you don't feel confident. Knowing when you need help, as a clinician, is very important when dealing with people who are suicidal or have mental illness.

Assessment

Assessment for suicide begins with a standard mental status examination.[18] Assessment then turns to presentation of risk factors, with particular focus on previous suicide attempts, signs of depression, current life stress, and suicide intent (thoughts and plans). Current stress commonly associated with suicidal behaviour includes recent loss, relationship breakdown and sexual abuse. Table 5 provides a guideline for assessing risk of suicide.

When responding to someone who is suicidal you need to address their immediate needs and their longer term needs. In the short term you need to assure the person's immediate safety. This may require supervision and monitoring or referral to a mental health facility. It also involves access and referral to counseling and treatment. Treatment may include both medical and psychiatric assessment.

If you are dealing with a person in the longer term, the following provides some steps you can follow:

- Define problem/s
- Define alternatives approaches
- Develop plans to deal with problems
- Establish a commitment, on both sides
- Set goals: steps that are achievable and can be celebrated
- Evaluate how the person is going
- Make plans for coping with future crisis
- Build support networks
- Monitor risk

Guidelines in approach

How you work with people who are suicidal is very important. The following are guidelines which come from my own experience as a practitioner as well as the workbooks, manuals and papers that are referenced during this paper.

Remember the barriers

- To deal with suicide a person must cross many barriers. Some of these are:
  - Shame
  - Reluctance to talk about suicide
  - Keeping things private
  - Fears of confidentiality and everyone in the community knowing their business
  - Not knowing where to go

Communication

- Dealing with suicide is a matter of trust. It is important that you are interested, and respect the person's situation
- Listen to what the young person has to say
- Don't tell them what to do: explore with them their thoughts and feelings and options
- Only promise what you can deliver
- Take the person seriously
- Give them power over their situation: focus on their strengths and support them to make decisions
- Stand in their shoes
- Validate and value them: hear what they are not saying

Confidentiality

Duty of care means that you must do whatever you can to ensure that a person who is suicidal is safe. This means you can never promise to keep a secret about suicide, and you can never promise to keep everything confidential. It is best that the person knows this from the beginning. Explain to the person that it is about their wellbeing and safety. Where possible, make sure the person knows whom you are telling, when and why. If you can get the approval of the person who is suicidal, this can be very powerful.

Expression

Support the person to express their feelings and thoughts; make sure that the environment is safe (i.e. private, few distractions) and that you feel confident to deal with whatever may come up. There are people who want to die but don't want to take their own life, and there are others who want to die and intend to act on these thoughts.

Consequential questioning and understanding permanence

Often people who are suicidal are self-focused, desperate and concentrated on specific issues. They often lose sight of how their behaviour may impact on others and what other options are available to them. By asking questions about a person's life, why they want to suicide and whether they understand the impact of suicide, a clinician can shift the way the person is seeing the world. Suicide is usually an option when a person can no longer cope with their feelings, or can see no way out of a difficult situation. Once a person can see the difference between wanting to die and wanting their feelings or situation to change, you can start problem solving.

Table 5: Risk assessment for suicide15

Risk factors	Low risk	Moderate risk	High risk
1. Personal difficulties •Long-term stress •Short-term stress	Little	Loss and experiences resulting in moderate stress response	Substantial with acute current stress
2. Responses and resources •Coping strategies Suicidal thoughts Expression of feelings Other •Lifestyle and behaviour(Stability) •Networks Family, friends, work, clubs, support services, other	Occasional thoughts Can express thoughts and Stable relationships, and activities Networks available and willing to support	Daily or more often thoughts Some expression Some activities interrupted Little change in daily life Some support network, but not as much as person needs	Constant thoughts Indirect expressing feelings Losing touch with reality Functioning disturbed Instability in some areas High risk behaviours Resists help, no support or not available Difficulty with peers, unstable relationships etc.
3. Previous suicide attempt •Lethality •Number of attempts	None or one of low lethality	Multiple low lethality One medium lethality Repeated threats	One of high or medium lethality Several recent attempts
4. Suicide plan •Details •Availability •Time frame •Lethality •Chance of intervention	Vague Not available immediately None Low (slash wrists, pills) Others present mostly	Specifics Closely available Hours Drugs/alcohol, car Other may be called on	Planned Means ready now Immediate Hanging, gun, carbon monoxide No-one around
5. Emotional state (chronic/acute) •Depression •hopelessness/despair	Feels low/down	Irritable, lonely, sad, decrease in energy and interest	Extreme sense of worthlessness, anger, mood changes, despair

Resources and referral

Resource Contact

Life Promotion Program
Central Australia-- (08) 8952 3311
Top End---(08) 8999 4938

Mental Health Services
Central AustraliA---(08) 8951 7710
Top End---(08) 8999 4988

Danila Dilba, Darwin ---(08) 8936 1717

Congress Social and Emotional Well Being Centre, Alice Springs -----(08) 8951 4444

Wurli Wurlinjang, Katherine --(08) 8971 0044

Anyingini Congress, Tennant Creek ----------------------------------(08) 8962 2385

Gove Hospital --(08) 8987 0211

Darwin Hospital (will refer to Mental Health Services, Darwin)------(08) 8922 8888

Alice Springs Hospital (will refer to Mental Health Services, Alice Springs)
(08)8951 7777

Katherine Hospital ---(08) 8973 9211

Tennant Creek Hospital (will refer to Mental Health Services – Tennant Creek)
(08)8952 4399

Alice Springs Youth Accommodation and Support Services, Alice Springs (08)89534200

Anglicare, Top End--(08) 8985 0000

Look at strengths and times of coping

Ask about times when the person did not want to die. These are times of coping and strength and provide an evidence of a person's ability. Also ask if there have been times when they have wanted to suicide but didn't. This is also a time of coping. Investigate what resources and strategies they used.

Deal with the problem/s

- Make the problems manageable
- Break down all of the pressures that the person is feeling/under
- Separate them: write them down, put them in boxes etc.
- Address each one, starting with the ones that are most easily resolved
- Create a new picture — step by step — with the person
- Work on the strengths that you can identify in the persons life, internal and external.

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