



# Suicide

## What is suicide?

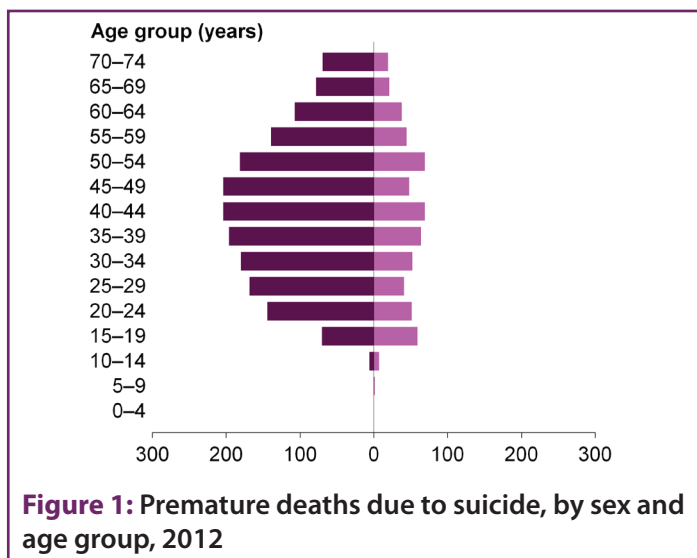
Suicide is the act of deliberately killing oneself (WHO 2015). There is a wide range of biological, psychological and social factors that increase the risk of intentional self-harm and suicide, including experiencing mental health problems, substance abuse and a family history of suicide (headspace 2015).

Suicide deaths in this report are those deaths classified, (after a coroner's determination or based on an Australian Bureau of Statistics review of National Coronial Information System information), as *Intentional self-harm* (X60-X84) in the International Classification of Diseases (WHO 2006). While this classification is common practice, the scope could include deaths due to intentional self-harm where a fatal outcome was not intended (AIHW: Henley & Harrison 2015).

**Premature mortality** refers to deaths that occur at a younger age than a selected cut-off—for this analysis, deaths among people aged under the age of 75 are considered premature. This is consistent with other AIHW reports on premature mortality. Although this fact sheet focuses on deaths under 75, injury and poisoning deaths at any age can be considered premature.

## Who dies prematurely from suicide?

In 2012, there were 2,329 premature deaths due to suicide in Australia. Three-quarters (75%) of these deaths from suicide were among males (1,746 deaths compared with 583 deaths among females) (Figure 1). Among 20–74 year olds, the mortality rate per 100,000 population for males was 3–4 times the rate for females.



## Quick facts

Suicide was the **3rd** leading cause of premature death in Australia in 2010–2012.



**3 in 4** premature deaths due to suicide in 2012 were among males (75%).



The premature death rate due to suicide **fluctuated** over the 3 decades from 1982 to 2012 but decreased by **11%** between these 2 time points.



For males, premature deaths from suicide were most common among those aged 40–44 and 45–49 (each with 204 deaths). For females, premature deaths from suicide were most common among 40–44 and 50–54 year olds (each with 69 deaths).

While suicide is more common among males, females are hospitalised at a much higher rate than males for intentional self-harm, particularly in the teen years (AIHW: Harrison & Henley 2014).

Aboriginal and Torres Strait Islander people and people living in *Remote* and *Very Remote* areas experience higher rates of suicide than the national average (AIHW: Harrison & Henley 2015).

## What population-level approaches target premature deaths due to suicide?

The pathways that lead a person to take their own life are complex (Fleischmann & Bertolote 2003). Prevention approaches are therefore multifaceted.

The *National Suicide Prevention Strategy*, developed in 2000, is Australia's policy platform for suicide prevention through promotion, prevention and early intervention (Department of Health 2014). Objectives of the strategy include building individual resilience and capacity for self-help and providing targeted suicide prevention activities.

The **removal of access to means** used for suicide, for example firearms and certain medications, can contribute to increasing the safety of at-risk individuals (WHO 2014). This can include the construction of physical barriers (for example, barriers at well-known 'jump points') which has been recognised as effective policy at the population level (Department of Health 2012). Firearm possession legislation is another example.



**Addressing risk factors** is an appropriate means of targeted intervention. Alcohol and drugs have been identified as significant risk factors for suicides, especially in Indigenous communities (Senate Community Affairs References Committee 2010). Receiving effective care for mental, physical and substance-abuse disorders may also protect at-risk individuals.

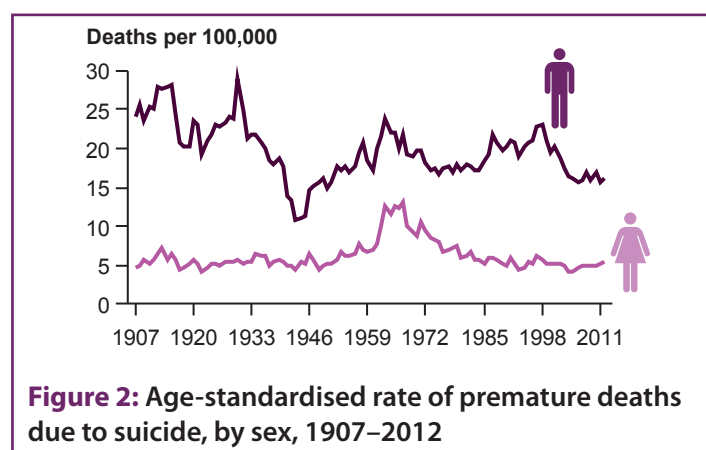
Like addressing risk factors, **protective factors such as social support and employment** may provide avenues for intervention (Melvin et al. 2015). Social support has been linked to increased resiliency to suicide (Kleiman & Liu 2013).

Support can be provided through, for example, **public awareness campaigns** that address stigma, provide information about crisis and support services and encourage help-seeking and social connectedness.

**Organisations** that serve as a resource to the community through the provision of information and crisis support are important in suicide prevention. Examples include Lifeline (2015) and beyondblue (2015).

Premature deaths due to suicide are classified as 'potentially avoidable in the context of the present health system' according to nationally agreed definitions (AIHW 2015). The definition includes deaths from conditions that are potentially preventable through individualised care and/or treatable through existing primary or hospital care.

## How have premature death rates due to suicide changed over time?



**Figure 2: Age-standardised rate of premature deaths due to suicide, by sex, 1907–2012**

Age-standardised premature death rates due to suicide fluctuated considerably between 1907 and 2012, particularly among males (Figure 2). Following a slight peak in the overall premature death rate in 1998 (14 deaths per 100,000 population) there was a relatively steady decline to 11 deaths per 100,000 in 2012—a 25% decrease.

Trends in injury and poisoning deaths, particularly those due to intentional self-harm and suicide, should be interpreted with caution due to changes in data sources and coding practices, and revision status of data. For more information, see AIHW: Harrison & Henley 2015.

Male suicide rates fluctuated at around 20 suicide deaths per 100,000 population, per year. Female rates were close to 5 suicide deaths per 100,000 population, per year, except for a peak in the mid-1960s. AIHW: Harrison & Henley 2014 provides further information on this.

## What has influenced trends in premature deaths due to suicide?

The complex drivers behind suicide make it difficult to define what may impact mortality trends.

The 'mechanism' or 'means' for suicide differ greatly between subgroups and have changed considerably over time. Some trends can be explained by changes in the availability of a certain mechanism. For example, the 1960s saw a peak in suicide deaths from poisoning by drugs attributable to the availability of barbiturate sedatives (AIHW: Harrison & Henley 2014).

The *National Firearms Agreement*, introduced in 1996, is a nation-wide restriction on firearm possession. The agreement resulted in restrictions to legal possession and importation, and committed all states and territories to a firearms registration scheme and to licensing of owners (AIC 2012). Restrictions to firearm access have been linked to a reduction in suicide (Sarchiapone et al. 2011).

## Where can I find out more?

**Premature mortality in Australia (including references):**  
<<http://www.aihw.gov.au/deaths/premature-mortality/>>.

**AIHW GRIM books:**  
<<http://www.aihw.gov.au/deaths/grim-books/>>.

**AIHW web pages and publications:**  
<<http://www.aihw.gov.au/injury/>>  
<<http://www.aihw.gov.au/mental-health/>>.

**Research Centre for Injury Studies website:**  
<<http://www.nisu.flinders.edu.au/>>.

## For assistance or support, please contact:

**Lifeline 13 11 14**, or <[www.lifeline.org.au](http://www.lifeline.org.au)> for online chat service

**Suicide Call Back Service 1300 659 467**, or  
<<https://www.suicidecallbackservice.org.au/>> for online counselling

© Australian Institute of Health and Welfare 2015

This product, excluding the AIHW logo, Commonwealth Coat of Arms and any material owned by a third party or protected by a trademark, has been released under a Creative Commons BY 3.0 (CC BY 3.0) licence (<<http://creativecommons.org/licenses/by/3.0/au/>>). You may distribute, remix and build upon this work. However, you must attribute the AIHW as the copyright holder of the work in compliance with our attribution policy available at <[www.aihw.gov.au/copyright/](http://www.aihw.gov.au/copyright/)>. The full terms and conditions of this licence are available at <<http://creativecommons.org/licenses/by/3.0/au/>>.

## Suggested citation

Australian Institute of Health and Welfare 2015. Leading cause of premature mortality in Australia fact sheet: suicide. Cat. no. PHE 193. Canberra: AIHW.

ISBN 978-1-74249-793-8 (PDF)

Any enquiries about copyright and/or this fact sheet should be directed to the Head of the Digital and Media Communications Unit, Australian Institute of Health and Welfare, GPO Box 570, Canberra ACT 2601, Tel: (02) 6244 1000, Email: <[info@aihw.gov.au](mailto:info@aihw.gov.au)>.