



BIEDO Fast Facts

Information compiled and researched by BIEDO specifically for the Inland Burnett

Rural Suicide Fast Facts
Issue One, July 2011

About This Rural Suicide Fast Facts

This series of Fast Facts, as part of BIEDO's 'Beating the Blues' program, uses plain language to summarise the key issues around suicide and suicide prevention in Australia, specially focusing on the rural sectors.

The data presented here is from:

- publicly available resources from government and non-government organisations;
- resources from organisations in the Wide Bay Burnett;
- resources from BIEDO's research team.

Fast Facts aim to increase awareness and understanding of suicide and suicide prevention in our region. As with all other public health issues, involvement of the whole community is essential to ensure effective intervention. It is hoped that the information presented here aids in your readiness and willingness to take on this issue in your home, school, networks, enterprise and community.

In This Issue

This issue covers the following topics:

- General suicide statistics and trend
- Suicide in the Burnett Inland
- Suicide among high risk groups
- Costs of suicide
- Impacts of suicide underreporting on rural areas



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Nanango, Kingaroy, Wondai, Proston, Murgon, Cherbourg, Goomeri, Kilkivan, Biggenden, Mt Perry, Gayndah, Mundubbera, Eidsvold, Monto, and Towns and Districts

Rural Suicide Issue One: What does the suicide data tell us?

The Burnett Inland may have one of the highest incidences of mature male suicide in Australia, and an unusually high rate of depression among our population. It is estimated that suicide and depression costs this region approximately \$33.6M pa. The human cost is incalculable.

In 2007, BIEDO received "Local Answers" funding from the Federal Government for the 'Beating the Blues' (BTB) program. While this program originally focused on drought impact issues, BTB has expanded to include many challenges that lead to depression, reduced resilience, stress, anxiety and even suicide. Today, BTB works with Lifeline North Burnett, North Burnett Regional Council, South Burnett Regional Council, Healthy Communities Committee, Centacare South Burnett, GP Links (North Burnett & Wide Bay), R Health and over 30 other service agencies as well as churches, police, RSL, community groups and businesses. From 2007 to 2011, BTB has assisted more than 6100 people in the Inland Burnett.

BTB has three aims and objectives:

- Prevention
- Management
- Post suicide intervention to manage the damage to families and communities

BTB program has three aims:

- Awareness and understanding (leading to collaborative action and attitudinal change to reduce stigma and taboo)
- Knowing early warning signs and appropriate forms of prevention or intervention;
- Collaborative action to increase services, resources and effective responses by individuals, communities businesses and agencies.

"Every three and half hours someone takes their own life in Australia ... every eight minutes a person attempts suicide and eighty-six people every day inflict self harm requiring hospitalisation. This is more than those requiring hospitalisation due to road accidents¹ and yet we hear nothing about this problem" – from "Breaking the Silence: Suicide and Suicide Prevention in Australia"

Every suicide in the region has devastating impacts on the families, social groups, workplaces and communities of the Burnett Inland. There are no simple ways to reduce the risk of suicide in our region, as its causes and consequences are complex.

The region is in a time of rebuilding; and resilience is low following drought, flooding and economic pressures. It is vital that we are aware of the impact of prolonged adversity on individuals, communities and enterprises and are able to respond appropriately. Each of us has met, serviced, or known people whom we believe to be highly stressed, depressed or even suicidal. They may be family members, friends, colleagues, clients or community members.

1. It is estimated that deaths due to suicide is 3-5 times higher than deaths due to road accidents in Australia

Many of us have been shocked by a suicide that is totally unexpected. In many cases we wonder what we should do; or more tragically how we could have seen it coming and what we should have done.

“Why could I not see the warning signs...”

“What could I have done...”

“How to help...”

Behind such questions is the combination of grief, guilt and remorse. We hope that people in our community understand that not every suicide is preventable. However we can make a difference if we, as individuals and communities, have better understanding of this issue and more resources are put into suicide prevention and post-vention².

Basic terms / Commonly used definitions

Please note that the following definitions provide brief descriptions of each term.

However the complexity of the issue is far beyond the reach of these definitions. More details on information such as common myths around suicide will be explored and explained in our following issues.

- **Suicide:** the intentional taking of one's own life
- **Attempted suicide:** an uncompleted suicide
- **Self-harm:** self-inflicted harm where death does not occur and the intention may or may not have been to die
- **Suicidal behaviour:** acts such as suicide and attempted suicide
- **Suicidal ideation/thoughts:** thoughts about, or plans for, taking one's own life that may or may not lead to a suicide attempt

General statistics and trend

Suicide is the 14th leading cause of death among Australians in 2009. Based on reliable studies and analysis models, it is estimated that the actual number of suicides in Australia may be between 2,700 and 3000 deaths per annum, or around 8 deaths every day. Deaths due to suicide significantly exceed fatalities from motor vehicle accidents and homicides **combined**. The figure shown here is obviously higher than the official record – the official statistics of suicide rate in 2007 recorded by ABS is 2,054. However it is generally accepted that the ABS suicide numbers are some **20-30% below the actual number**.

What We Know

Many people who attempt/complete suicide may have been thinking about it for some time. Something can be done before the tragedy happens if a) there are warning signs; b) someone knows how to identify the early warning signs and respond appropriately. Responses can range from just listening to organising safe referral to a care, medical or emergency service.

What We Don't Know

The actual number of suicide deaths in Australia is still unknown. Even less data is available when trying to calculate suicide rates in *rural* communities. However, we do know more people die through suicide than through road accidents or skin cancer and the incidence of suicide is many times more common than homicide.

What's happening in the Inland

Agencies in the Inland region estimate that approximately 40 persons in the Inland take their lives each year. This is 10 times the national per capita average.

National statistical averages indicate that for every completed suicide, there are between 20 and 30 attempted suicides.

For every attempted suicide, there are approximately 5 people in a state of severe depression and/or are suicidal.

No data in the official records doesn't mean no suicides in our region. Research (and confirmed reports by eye witnesses and service/care agencies and counsellors) in this region shows that on average there are 40 suicides each year in the Inland³. This is around 91 suicides per 100,000 head of population which is significantly higher than the national rate at 9.6 per 100,000 people (ABS, 2010)⁴. Or to put it more simply, the incidence of suicide in the Inland is around ten times the national average. However it should be noted that the incidence of suicide in specific communities in our region is 16 to 20 times higher than the national average.

2. Post-vention - effective management of the impacts of suicide on family, friend, colleague and community networks after a suicide – to reduce ongoing depression, anger, grieving and potentially – further suicides.

3. BIEDO is recognised by governments and NFP's as a credible source of rural suicide data. BIEDO's research process is based on best academic practice; and is mentored and supervised by two universities and one federal department.

4. The rates used here don't adjust the impact of age composition.

Are there any gender differences

Between 75% and 80% of all completed suicide victims in Australia are men.

Suicide is the 10th leading cause of death for males. It accounts for 20% of all deaths for males aged 15-24 years old.

The rate of **completed** suicide is higher for males than for females and has been higher since at least the 1920's. Even though the male suicide rate dropped more significantly than that of females between 2000 and 2009 (24% dropped compared to 13%), it is still 3.3 times higher (at this time). By contrast, the **attempted** suicide rate among women is higher than that of men.

The most significant factors contributing to such gender differences appear to include: men are more likely to choose a more lethal means of attempting suicide than women; and lack of individual support networks; reluctance and/or inability of men to recognise and identify their own risks and seek help. Some other factors appear to be specific to rural communities and may contribute to a higher overall suicide rate among rural men. Gender difference is covered in more detail in the following paragraphs.

What does age specific rate tell us

Suicide represented 22.1% of all deaths for males in the age group 15-24 in 2009 in Australia. For males in the age groups 35-39 and 40-44 years, 18.5% and 13.8% of all deaths were due to suicide respectively. Males aged 85 years and over had the highest age-specific suicide death rate, but suicide only represented 0.2% of all deaths in this age group. (Causes of Death 2009, ABS)

While suicide accounts for only a relatively small proportion (1.5%) of all deaths in Australia, it accounts for a much greater proportion within specific age groups.

For women, no one age group has consistently had a higher rate of suicide than other age group. However, for men, age differences are significant. Suicide accounts for almost a quarter of all deaths among young Australian men aged 20 to 34 years.

Middle-aged men are also an identified 'at risk' group, particularly in rural or remote areas. The overall incidence of suicide among mature men, in the Inland, is higher than that of 15-24 years old.

Age specific suicide rates among males also highlight the differences between rural and urban areas. Based on the *AIHW Mortality Report* (2007), 15-24 years old males in regional areas are 1.5-1.8 times more likely to end their life by suicide than their urban counterparts. The incidence is up to six times higher in very remote areas. The inter-regional comparison is almost as bad for males aged 25-34⁵ years old and 45-64 years old. Inter-regional differences for males aged 65 and over are less obvious.

Suicide among Aboriginal and Torres Strait Islander Australians

Accurate suicide statistics and population estimates are difficult to obtain for Aboriginal and Torres Strait Islander people. Thus data on suicide levels and rates for Aboriginal and Torres Strait Islander people are likely to be, at best, minimum figures and the information must be interpreted cautiously.

The rate of suicide among Aboriginal and Torres Strait Islander people is at least 4 times the rate of non-Indigenous Australians in major cities⁶.

In Queensland, more than a quarter of youth suicides occurred among Aboriginal or Torres Strait Islander children and young people, although the Aboriginal and Torres Strait Islanders aged 10 to 17 years make up less than 6% of the total Queensland youth population.

Over the past 30 years Indigenous suicide has increased, with young Indigenous males being the most at risk. Suicide is more concentrated in the earlier adult years for Aboriginal and Torres Strait Islander Australians compared with the general Australian population. The highest concentration of suicide among both male and female is in the 15-24 years age group. Sadly, there are increasing numbers of children committing suicide in Indigenous communities.

5. Males age 25-34 years old have the highest national suicide rate.

6. As there is only limited data available, it's difficult to make a comparison of suicide rates between Aboriginal people and non-Aboriginal people living in rural communities. Based on the 2004-2006 data from the Australian Institute of Health and Welfare, the difference in suicide rates of men outside major cities in general had no significant difference from that of non-Aboriginal men outside major cities.

As for other Australians, Aboriginal and Torres Strait Islander males are more likely to die by suicide than are Aboriginal and Torres Strait Islander females. Using combined data for 1998 to 2002, 6.7% of all male deaths were due to suicide compared with 1.9% of all deaths for females.

Understanding of how Indigenous people perceive suicide is limited. Any initiatives seeking to address the suicide problems within Indigenous communities should be highly aware of cultural contexts, values and traditions which could vary even between Indigenous communities, and between tribes.

Suicide in rural Australia

Overall rates of suicide and attempted suicide are much higher in rural localities than metropolitan areas.

Rural inland towns with populations of less than 4,000 have experienced the most significant increases in male youth suicide (Dudley et al., 1998).

Anecdotal evidence in the Inland suggests that suicide among mature males is particularly high (and may be higher than youth suicide) although the occurrence tends to be obscured by data recording shortfalls, as well as cultural and other factors.

At any given time, overall rates of suicide tend to increase with increasing rurality. Whilst suicide rates have been declining slowly in major cities, the suicide toll has shown no decline in rural areas.

Recent comprehensive research has shown that suicide rates are 33% higher in rural areas than in major cities, rising to 189% higher in very remote areas⁷ (the Australian Institute of Health and Welfare, 2010).

Male youth suicide in rural areas has been identified as a pronounced problem estimated to be double that of metropolitan figures (Dudley et al., 1998; Sidoti, 1999). However it should be noted that suicide among mature males may be as high or higher, but may be obscured by underreporting, the tendency among mature men to **not** seek formal assistance, and the mode of self-harm.

A Queensland study (Anderson et al., 2010) found that agricultural workers had a suicide rate two times higher than the general employed population. Main factors that contribute to higher suicide rate in rural areas may include: vulnerability to adverse impacts of climate and economic change, de-population and the withdrawal of essential services, easy access to firearms, less access to support mechanisms (such as counseling services, recreation and friendship networks, etc). More details of rural risk factors will be covered in our following issues.

When interpreting suicide data in rural communities, we should be aware that formal datasets provide only part of the picture, as rigorous analysis can be difficult to obtain due to **significant** under-reporting problems. Based on anecdotal data from police, care agencies, doctors, family members and community eye witnesses, it appears that a significant proportion of suicides are not covered by the formal data collection systems and/or are not reported. For example, there are an unknown number of suicides related to single-vehicle accidents. (Murray & De Leo, 2007)

Think of the costs

Each suicide is estimated to have immediate and direct impacts on at least six other people (Corso et al., 2007). In rural community, the 'impact-effect' could rise up to 12-15 people. In small towns, one suicide can impact on the whole community.

Suicide has massive human, social and economic impacts. A completed suicide will impact on the lives of any number of individuals – from family to friends, colleagues, clinicians, first responders, coronial staff, volunteers of bereavement support services and other associates – who inevitably suffer intense and conflicted emotional distress in response to a death of this kind.

The economic costs are enormous given that the greatest number of suicides occurs before the age of 44 years – resulting in huge loss of years of productivity.

Personal and social costs

The personal and social costs of suicide in Australia are immediate, far-reaching and significant for families, workplaces and communities. Those close to a person who has completed suicide will often blame themselves for the decision of the

7. It should be remembered that 'remoteness' does not necessarily relate to geographic distance, but can also refer to isolation relating to access to information, resources and communications and friendship or family networks.

individual to take their own life. The combination of grief, guilt and remorse can remain for years. Research indicates that people, who have had someone close to them commit suicide, are themselves more likely to commit suicide (Private mental Health Consumer carer Network, 2010). Furthermore, community stigma and perceptions of the act of suicide as a failure on the part of either the deceased or the family exacerbate the impacts of a suicide (e.g. brings stress on the bereavement process and the recovery process for suicide-attempt survivors).

Economic costs

There are still no reliable widely accepted national estimates on the financial costs associated with suicide in Australia. In contrast, road accidents – which contribute to fewer deaths than suicide - have been the subject of modeling and analysis as far back as 1981 with the most recent economic impact data released in June 2009. Even though economic approaches to the cost of suicide may be “uncomfortably close to seeing human value in terms of productivity” (SPA, 2010).

The economic cost of suicide is important in providing guidance as to where the burden is greatest and where research on developing new interventions might best focused to give greatest potential gain.

As Australia lacks accurate reports on suicide rates, it is hard to estimate the actual financial costs of suicide. But indirect estimates suggest that this cost is huge.

Financial costs of suicide - indirect estimations

- **The average cost of a life lost in a car accident is estimated to be \$6 million in 2009. Assuming similar cost values for each of the estimated 2000⁸ deaths by suicide each year in Australia, the total cost would be around \$12 billion per annum (Lifeline, 2010).**
- **Possible components of suicide costs as suggested by the 'Suicide is Preventable' report (2010) include: total number of suicides, lost production value, the cost of ambulatory, first response and other care and coronal, police services, years of life lost due to premature mortality, productivity losses for survivors, cost of insurances and superannuation claims, the cost of prevention and intervention program. The report estimates that the economic cost of suicide is \$17.5 billion every year.**

- **The NSW RailCorp estimated that, on average, each suicide on the NSW railways costs the passenger service operator \$76,000 and an attempted suicide costs \$6,021.**
- **Based on conservative 'costings', each suicide in the Inland 'costs' \$840,000. Given that there are an average 40 suicides per annum, the average economic cost of suicide to this region is approximately \$33.6M pa**

Underreporting is a problem

There is growing concern regarding the accuracy of the ABS and State Government suicide related statistics. This is problematic as these sources are generally relied upon for suicide data. It is estimated that ABS suicide numbers are 20 to 30 percent below the actual numbers of suicide.

There are a complex range of factors which influence under-reporting including:

- Difficulties in determining the intent of a person who might have completed suicide.

Examples of difficult situation in determining intention

- » **Drug overdoses which may be accidental or a suicide;**
 - » **Single vehicle accidents where the driver has crashed into a fixed object; with no apparent attempt to stop, or swerve or reduce speed;**
 - » **Falls or drowning which could be also be accidental;**
 - » **Incidents of murders/suicide which could also be a double suicide; and**
 - » **Hangings where there is the possibility of autoeroticism or there may be questions about the capacity of the person to understand the seriousness of their actions**
- There was also a 'gray area' between recklessness and intent. For example, a person driving a vehicle in a manner which was so reckless that it would be very difficult to decide whether the person wanted to die or just did not consider the consequences
 - The burden of proof for coroners, changes to the national data collection system, a lack of expert investigations and different reporting protocols across state and territories (Large & Neilssen, 2010; Bradley et al., 2010).

8. This figure is underestimated. It is generally accepted that the ABS suicide numbers are some 20-30% below the actual number.

- No evidence is available which estimates the **extent** to which stigma, values and culture influence the reporting of suicide. However, it is clear that stigma and family pressure does play **some** role.
 - » **Stigma, as well as cultural and religious beliefs, can lead to circumstances where family members either directly or indirectly seek to influence death certificate statements regarding suicide.**
 - » **There may be reluctance to record a finding of suicidal intent because of sympathy with the feelings of the family, or sensitivity to the cultural practices and religious beliefs of the family.**
 - » **There is frequently pressure from families in the case of public inquests to find that the death is by accident or some other mechanism apart from suicide. Family members may believe that a finding of suicide might reflect adversely on their own interaction with the deceased person.**
- Insurance and financial issues: family and relatives may also fear that an official report of a death as a suicide may prevent or delay the payment of life insurance or other forms of financial payment.
- Data collection methodologies and protocols used by health agencies, mental health units, etc. For example, Q Health personnel have reported that suicide which occurs outside the mental health system (i.e. the person is not formally registered in the mental health system when the suicide occurs) are not included in Q Health datasets relating to suicide. As most rural people do not register with the mental health system, this suggests that the rate of rural suicides are underreported by Q Health. Q Health also confirmed that completed suicides within the system, e.g. in a mental health facility, are recorded at the postcode of occurrence (i.e. the mental health centre), not the postcode of origin (i.e. the clients' town).

Consequences of underreporting

The underreporting of suicide deaths was seen as masking the extent of the problem in Australia, and thwarting efforts to assess the efficacy of suicide prevention programs and activities. This problem has greater impacts on rural sectors, as current suicide recording systems tend to, as mentioned left, under-report **rural** incidents.

For example, in Dec 2006, eyewitnesses from care and response agencies confirmed 41 suicides in the Inland. Q Health data indicated 0 suicides in the Inland in the same period.

The consequences

The ratio of direct intervention service to clients in, for example, Brisbane and the Burnett Inland, clearly shows that the Inland region is under-serviced, despite the high incidence rate.

**1 service per 14 people in Brisbane
1 service per 2000 people in South Burnett
0.5 services per 12,000 people in North Burnett⁹**

Under, or inaccurate, reporting adversely affects rural access to services that prevent and manage depression, stress, suicide and its impacts, most of all. If, for example, a rural region cannot **prove** the occurrence of suicide through the formal data, agencies in the region are less likely to be allocated to services, training, infrastructures and equipment that they need to address the problem. Further, their regional need can be invisible in long term policy development and resource allocation; and/or services may be provided that do not target high need groups; or provide services that are not suited to their needs or preferences.



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9. These figures are approximate estimations