If you need crisis support, call Lifeline on 13 11 14, or call Kids Helpline on 1800 55 1800, 24 hours a day. For general support, talk to your GP or local health professional.

3 Suicide by young people

3.1 Suicide by young people in Western Australia

Suicide is defined as the intentional taking of one's own life.[22]

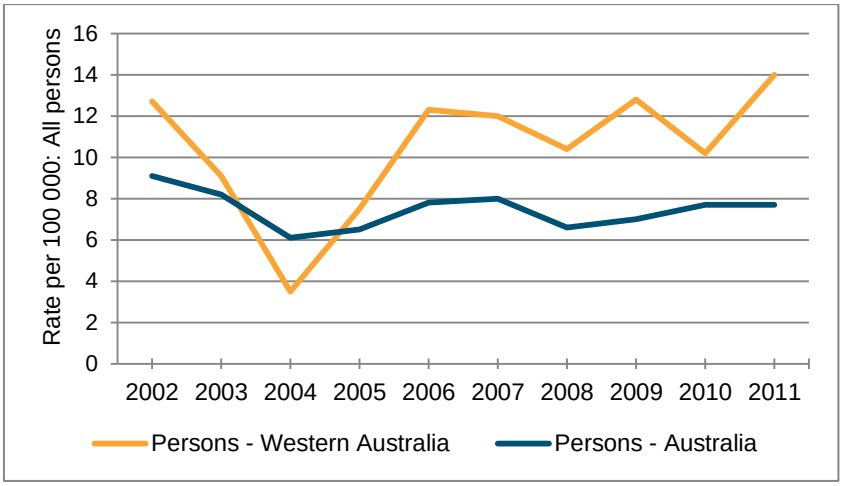
This investigation considers young people who died by suicide who were aged between 13 and 17 years. The Australian Bureau of Statistics reports data about causes of death in five and ten year age groups. The age group used by the Australian Bureau of Statistics that is most relevant to this investigation is the 15 to 19 year age group.

The Australian Bureau of Statistics reports that, in Western Australia in 2011, 22 people aged 15 to 19 years died by suicide.[23] The Australian Bureau of Statistics also reports that, in Western Australia over the period 2007-2011, there were five children aged under 15 years who died by suicide.[24]

In 2011, the rate of suicide by people aged 15 to 19 years in Western Australia was 14 deaths per 100 000 persons (Figure 2).[25] This is almost twice the national rate. Australia-wide, in 2011, 115 people aged 15 to 19 years died by suicide.[26] This equates to a rate of suicide by people aged 15 to 19 years in Australia of 7.7 deaths per 100 000 persons.[27]

[22] J Mendoza & S Rosenberg, *Suicide and suicide prevention in Australia: Breaking the silence*, Lifeline Australia & Suicide Prevention Australia, Sydney, 2010, p. 12.
[23] Australian Bureau of Statistics, *Causes of Death, Australia,* cat. no. 3303.0, customised report, ABS, Canberra, 2010.
[24] Australian Bureau of Statistics, *Causes of Death, Australia, Appendix 1, Table A1.2, Suicide, Number of deaths by age group and state or territory of usual residence, 2007-2011*, ABS, Canberra, 2011.
[25] Australian Bureau of Statistics, *Causes of Death, Australia,* cat. no. 3303.0, customised report, ABS, Canberra, 2010.
[26] Australian Bureau of Statistics, *Causes of Death, Australia, Table 11.1, Suicide, Number of deaths, 5 year age groups by sex, 2002–2011*, cat. no. 3303.0, ABS, Canberra, 2011.
[27] Australian Bureau of Statistics, *Causes of Death, Australia, Table 11.2, Suicide, Age-specific death rates, 5 year age groups by sex, 2002–2011*, cat. no. 3303.0, ABS, Canberra, 2010.

Figure 2: Death by suicide – age specific rates, persons aged 15-19 years, 2002-2011



Source: Australian Bureau of Statistics

Figure 2 also shows that, over the period 2006-2011, the rate of suicide by people aged 15 to 19 years in Western Australia remained fairly steady. However, over that same period, death by suicide as a proportion of all deaths of people aged 15 to 19 years in Western Australia increased (Figure 3).

Figure 3: Death by suicide as a proportion of all deaths, persons aged 15-19 years, 2002-2011

Source: Australian Bureau of Statistics

In 2011, suicide was the most common cause of death of people aged 15 to 19 years in Western Australia. In 2011, suicide accounted for 22 (31.4 per cent) of the deaths of people aged 15 to 19 years, while transport accidents (including motor vehicle, motorcycle and other land transport related accidents) accounted for 16 (22.9 per cent) of the deaths

of people aged 15 to 19 years.[28] Australia-wide, in 2011, suicide accounted for almost one quarter (24.1 per cent) of deaths of people aged 15 to 19 years.[29]

Suicide is also a significant cause of death for people aged 20 to 24 years. Australia-wide, in 2011, 27.8 per cent of all deaths of people aged 20 to 24 years were due to suicide.[30] Males aged 85 years and over have the highest rate of suicide (32.1 deaths per 100 000 persons), followed by males aged 80 to 84 years (24.4 deaths per 100 000 persons).[31]

3.2 Young people with higher rates of suicide

The research literature identifies several sub-groups within the 15 to 24 year age group, which have relatively high rates of suicide. These sub-groups are:

- **Young males** – Australia-wide, in 2011, the rate of suicide for males aged 15 to 19 years was 10.4 deaths per 100 000 persons while the rate of suicide for females aged 15 to 19 years was 4.8 deaths per 100 000 persons.[32]
- **Aboriginal young people**[33] – across the five Australian states and territories included in the relevant Australian Bureau of Statistics report, in 2011, the rate of suicide for Aboriginal people aged 15 to 24 years was 41.2 per 100 000 persons compared to 8.1 per 100 000 persons for non-Aboriginal people aged 15 to 24 years. (Data for Aboriginal people aged 15 to 19 years old was not available from the Australian Bureau of Statistics).[34]
- **Young people living in rural and remote communities** – the Australian Institute of Health and Welfare reports that suicide rates for people aged 15 to 24 years living in rural and remote locations throughout Australia are elevated, with this group having a suicide rate three times that of their counterparts living in major cities.[35] This is particularly true for young men.[36]
- **Young people who identify as same-sex attracted and/or transgender** - reliable suicide mortality statistics for young people who identify as same-sex attracted are not available as unlike other demographic characteristics this is not identified in most

[28] Australian Bureau of Statistics, *Causes of Death, Australia,* cat. no. 3303.0, customised report, ABS, Canberra, 2011.
[29] Australian Bureau of Statistics, *Causes of Death, Australia, Suicide, Proportion of total deaths, 5 year age groups by sex, 2002–2011*, cat. no. 3303.0, Table 11.6, ABS, Canberra, 2011.
[30] Australian Bureau of Statistics, *Causes of Death, Australia,* Suicide, Proportion of total deaths, 5 year age groups by sex, 2002–2011, cat. no. 3303.0, Table 11.6, ABS, Canberra, 2011.
[31] Australian Bureau of Statistics, *Causes of Death, Australia*, *Suicide, Age-specific death rates, 5 year age groups by sex, 2002–2011*, cat. no. 3303.0, Table 11.2, ABS, Canberra, 2011.
[32] Australian Bureau of Statistics, *Causes of Death*, *Australia, Suicide, Age-specific death rates, 5 year age groups by sex, 2002–2011*, cat. no. 3303.0, Table 11.2, ABS, Canberra, 2011.
[33] The Australian Bureau of Statistics refers to 'Aboriginal and Torres Strait Islander peoples' and 'non-Indigenous' people. In this report, unless taken from a direct quote we refer to Aboriginal and non-Aboriginal people in line with the policy of the Western Australian Government.
[34] Australian Bureau of Statistics, *Causes of Death, Australia, Underlying cause of death, Selected causes by Indigenous status, Numbers and Age-Specific Death Rates, Males, Females and Persons, NSW, Qld, SA, WA, NT, 2007-2011*, cat. no. 3303.0, Table 12.4, ABS, Canberra, 2011.
[35] Australian Institute of Health and Welfare, *Rural, regional and remote health: A study on mortality, 2nd edition*, Canberra, AIHW, 2007.
[36] Australian Institute of Health and Welfare, *Rural, regional and remote health: A study on mortality, 2nd edition*, Canberra, AIHW, 2007.

existing data collections. The research literature indicates that same-sex attracted young people may be up to six times more likely to commit suicide than the general population. Higher rates of suicide are also associated with transgender young people.[37]

3.3 Explanations of suicide

There is a large body of research literature examining suicide, with much of this research examining suicide by people of all ages. This is discussed below. The following section discusses the research literature that focuses on suicide by young people.

Researchers agree that there are no simple explanations and no single solution for suicide.[38] For example, in their report '*Suicide and Suicide Prevention in Australia: Breaking the Silence'*, Mendoza and Rosenberg note that the reasons behind a person's decision to commit suicide are 'complex and interrelated' and that the research literature has 'yet to identify a defined, discrete set or constellation of characteristics or circumstances that precipitate suicidal thoughts and/or behaviours.'[39]

Mendoza and Rosenberg go on to say that 'studies have determined that there are a variety of predisposing or risk factors, warning signs and precipitating events that may increase the risk of suicidal behavior or alert others of the possible risk of suicidality in someone else.'[40] An explanation of the pathway from risk factors to warning signs, precipitating events and imminent risk, commonly referred to as 'Bycroft's model', is shown in Figure 4 (In the model, Bycroft adopts the term 'tipping points' when referring to precipitating events).

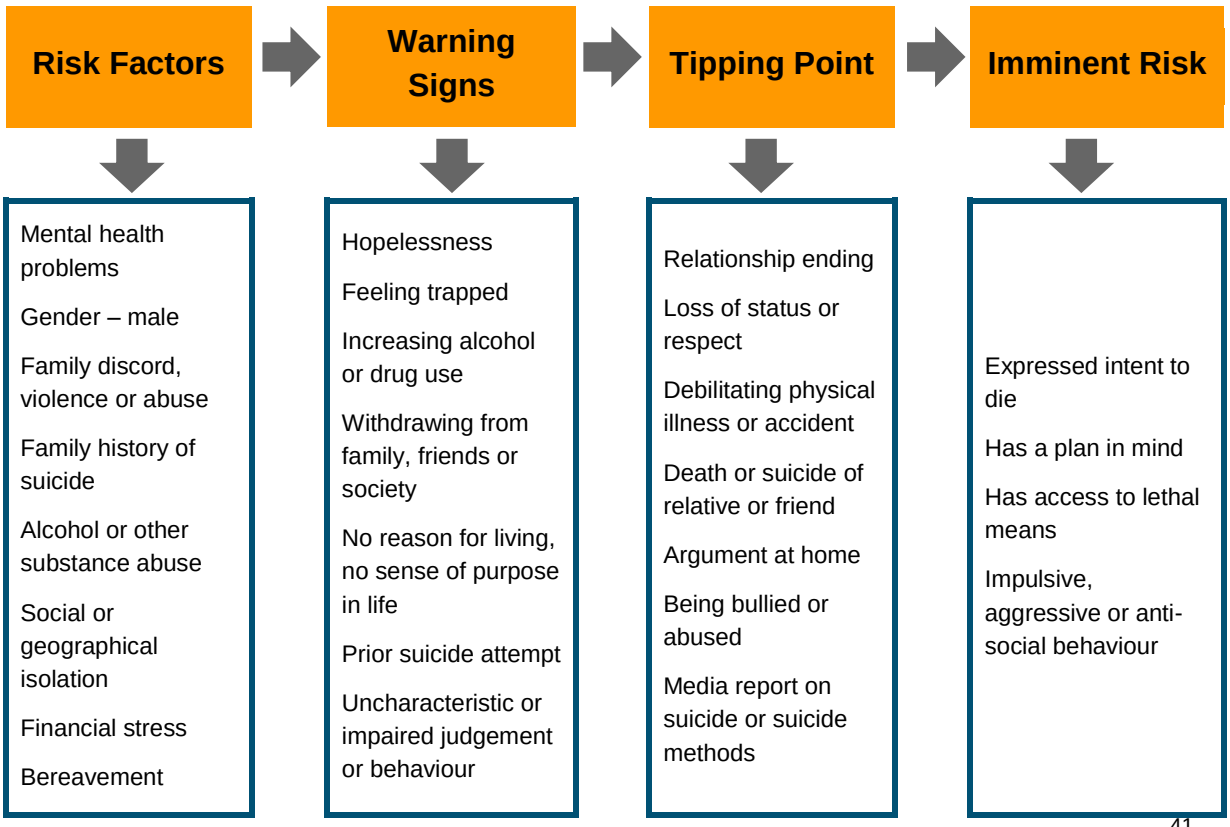
[37] Government of Western Australia, Department of Health, *Western Australian Suicide Prevention Strategy 2009-2013 Everybody's Business*, Department of Health, Perth, 2009, p. 23; S Dyson, A Mitchell, A Smith, G Dowsett, M Pitts & L Hillier, *Don't Ask, Don't Tell, Hidden in the crowd, The Need for Documenting links between Sexuality and Suicidal Behaviours About Young People*, The Australian Research Centre in Sex, Health and Society, La Trobe University, Melbourne, 2003.

[38] J Mendoza & S Rosenberg, *Suicide and suicide prevention in Australia: Breaking the silence*, Lifeline Australia & Suicide Prevention Australia, Sydney, 2010, p. 54; Australian Government, Department of Health and Ageing, *Living Is For Everyone: Research and Evidence in Suicide Prevention*, Australian Government Publishing Services, Canberra, 2008, p. 11; Western Australian Government, Department of Health, *Western Australian Suicide Prevention Strategy, 2009-2013 Everybody's Business*, Department of Health, Perth, 2009, Foreword.

[39] J Mendoza & S Rosenberg, *Suicide and suicide prevention in Australia: Breaking the silence*, Lifeline Australia & Suicide Prevention Australia, Sydney, 2010, p. 55.

[40] J Mendoza & S Rosenberg, *Suicide and suicide prevention in Australia: Breaking the silence*, Lifeline Australia & Suicide Prevention Australia, Sydney, 2010, p. 55.

Figure 4: The pathway from risk factors to the point of imminent risk



Source: Bycroft 2010[41]

3.3.1 Risk and protective factors for suicide

Mendoza and Rosenberg define risk factors as 'personal characteristics or circumstances that may predispose an individual to suicidal behaviours or increased likelihood of suicidality.'[42] The identified risk factors are considered to be correlative, not causal. Mendoza and Rosenberg also identify a set of corresponding protective factors, which they define as 'those characteristics and circumstances that prevent or reduce the likelihood of suicidality.'[43]

As shown in Figure 5 below, risk and protective factors 'may be related to the personal characteristics of the individual, events or incidents that have occurred during their life or

[41] J Mendoza & S Rosenberg, *Suicide and suicide prevention in Australia: Breaking the silence*, Lifeline Australia & Suicide Prevention Australia, Sydney, 2010, p. 55.
[42] J Mendoza & S Rosenberg, *Suicide and suicide prevention in Australia: Breaking the silence*, Lifeline Australia & Suicide Prevention Australia, Sydney, 2010, p. 56; E Agerbo, J Sterne & D Gunnell, 'Combining individual and ecological data to determine compositional and contextual socio-economic risk factors for suicide', *Journal of Social Science and Medicine,* vol. 64, no. 2, 2007, pp. 451-61; Australian Government, Department of Health and Ageing, *Living Is For Everyone: Research and Evidence in Suicide Prevention*, Australian Government Publishing Services, Canberra, 2008, p. 15.
[43] J Mendoza & S Rosenberg, *Suicide and suicide prevention in Australia: Breaking the silence*, Lifeline Australia & Suicide Prevention Australia, Sydney, 2010, p. 56.

their social environment.'[44] Risk and protective factors generally represent opposite ends of the same concept.[45]

Figure 5: Examples of risk and protective factors[46]

Type of factor	Risk factor	Protective factor
Individual	• Sex (male) • Mental illness • Substance abuse • Hopelessness • Poor coping skills • Lack of meaning/purpose in life • Impulsivity	• Sex (Female) • Mental health • No harmful substance use • Positive attitude to life • Adaptive coping skills • Sense of meaning/purpose in life • Controlled Behaviour
Life events or circumstances	• Physical, sexual or emotional abuse • Family breakdown/conflict • Social isolation • Family history of suicide/mental illness • Unemployment • Homelessness	• Physical and emotional security • Family harmony • Social connectedness • No family history of suicide/mental illness • Job security • Safe and affordable housing
Social and environmental	• Low socio-economic status • Lack of support services • Exposure to environmental stressors (e.g. floods, bushfires, war, global financial crisis)	• Mid to high socio-economic status • Access to support services • Limited exposure to environmental stressors

Source: Mendoza and Rosenberg

The research literature has historically focused on identifying and understanding risk factors. Studies focusing on protective factors and how they can be increased in vulnerable individuals to prevent suicidal behaviour, 'to better understand what builds resilience and the ability to cope with adverse life events' have only been undertaken more recently.[47] Mendoza and Rosenberg point to recent studies that have shown that:

> Resilience is by far the most common reaction to adverse life events…However, there are some people who experience greater levels of

[44] J Mendoza & S Rosenberg, *Suicide and suicide prevention in Australia: Breaking the silence*, Lifeline Australia & Suicide Prevention Australia, Sydney, 2010, p. 56.
[45] J Mendoza & S Rosenberg, *Suicide and suicide prevention in Australia: Breaking the silence*, Lifeline Australia & Suicide Prevention Australia, Sydney, 2010, p. 56.
[46] J Mendoza & S Rosenberg, *Suicide and suicide prevention in Australia: Breaking the silence*, Lifeline Australia & Suicide Prevention Australia, Sydney, 2010, p. 83, adapted from M Barry and R Jenkins, *Implementing mental health promotion,* Elsevier Health Sciences, London, 2007.
[47] J Mendoza & S Rosenberg, *Suicide and suicide prevention in Australia: Breaking the silence*, Lifeline Australia & Suicide Prevention Australia, Sydney, 2010, p. 57; A Beautrais, 'Suicide Prevention Strategies 2006', *Journal for the Advancement of Mental Health*, vol. 5, 2006; D Brent & J Mann, 'Familial pathways to suicidal behaviour, Understanding and preventing suicide among adolescents', *New England Journal of Medicine*, vol. 355, 2006, pp. 2719-2721; S Bridge, 'Suicide prevention - targeting the patient at risk', *Australian Family Physician*, vol. 35, no. 5, 2006, pp. 335-338.

> disruption to their functioning, including those individuals who endure ongoing disruption and dysfunction following the occurrence of negative circumstances (sometimes called *vulnerability*). It has been suggested that it is these individuals who may be at the highest risk of suicidal behaviour.[48]

The research literature has found that the 'interaction between a person's predisposing risk factors and protective factors (particularly their level of mental health or illness), their level of vulnerability or resilience and their cumulative experience of negative and positive life events can give an indication of the potential risk of suicide.'[49] Nevertheless, most people who could be categorised as at risk based on Bycroft's model, do not follow the pathway to actually commit suicide. In addition, some people who attempt to take their own life have few risk factors and many protective factors. Recent research literature suggests that:

> … an understanding of risk factors in suicide is best used to identify populations and specific groups that might be at risk. The main reason is that the majority of people who can be categorized as at risk do not and will not ever choose to take their own life. It is extremely difficult to determine from risk factors alone which individuals within an at-risk group are more or less likely to become suicidal.[50]

3.3.2 Warning signs

The research literature has found that although 'the majority of people who commit suicide exhibit one or more common warning signs prior to their attempt, unfortunately, most people are unaware of what these warnings signs are and how to respond to them.'[51] As shown in Figure 4,Figure 4 for example, Bycroft's model identifies a range of warning signs, which are: hopelessness; feeling trapped; increasing alcohol or drug use; withdrawing from family, friends or society; no reason for living; no sense of purpose in life; a prior suicide attempt; and uncharacteristic or impaired judgment or behaviour. For people 15 years and older, symptoms of depression, anxiety disorders and suicide ideation may also be increasingly present.[52]

3.3.3 Precipitating events

The Australian Government Department of Health and Ageing's *A Framework for Prevention of Suicide in Australia* describes precipitating events as:

> … signposts that give early warning of the potential for someone to take their own life. Sometimes referred to as 'triggers' or 'precipitating events' they include mental disorders or physical illnesses, alcohol and/or other substance

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[48] J Mendoza & S Rosenberg, *Suicide and suicide prevention in Australia: Breaking the silence*, Lifeline Australia & Suicide Prevention Australia, Sydney, 2010, p. 57.
[49] J Mendoza & S Rosenberg, *Suicide and suicide prevention in Australia: Breaking the silence*, Lifeline Australia & Suicide Prevention Australia, Sydney, 2010, p. 57.
[50] Australian Government, Department of Health and Ageing, *Living Is For Everyone: Research and Evidence in Suicide Prevention*, Australian Government Publishing Services, Canberra, 2008, p. 15.
[51] J Mendoza & S Rosenberg, *Suicide and suicide prevention in Australia: Breaking the silence*, Lifeline Australia & Suicide Prevention Australia, Sydney 2010, p. 60.
[52] S Madelyn, T Greenberg, D Velting, D Shaffer & S Gould, 'Youth Suicide: A Review', *The Prevention Researcher*, vol. 13, no. 3, 2006, pp. 3-7.

> abuse, feelings of interpersonal loss or rejection or the experience of potentially traumatic life events (unexpected changes in life circumstances).[53]

In one study, for example, suicide attempters reported four times as many negative life events as the general population.[54]

The research literature into suicide by young people in particular identifies the following precipitating events:

- An argument or relationship breakdown usually involving a parent or a partner;[55]
- A stressful life event such as being bullied or having difficulties at school;[56]
- Discharge from an acute psychiatric inpatient unit or any form of custody or detention such as prison,[57] particularly if there has been previously demonstrated suicidal behaviour;[58] and
- The modelling, imitation and social transmission of suicidal behaviour (referred to in the research literature as 'contagion'). Research literature has shown that people who know someone who has died by suicide are at a greater risk of dying by suicide or attempting suicide themselves.[59] This phenomenon is discussed more fully in section 4.2.4.

Another important understanding of suicide that has been considered by this report, particularly the point of imminent risk, has been developed by Thomas Joiner, Professor of Psychology at Florida State University. In 2005, Joiner created the interpersonal-psychological theory of suicidal behaviour, which identifies feelings of isolation and being a burden to others, combined with a desire to die and a lack of fear of dying as 'conditions' for suicide.[60] Essentially, Joiner puts forward the theory that 'people

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[53] Australian Government, Department of Health and the Ageing, *A Framework for Prevention of Suicide in Australia*, Canberra, 2008, p. 14.
[54] E Paykel, B Prusoff & J Myers, 'Suicide attempts and recent life events: A controlled comparison', *Archives of General Psychiatry*, vol. 32, no. 3, 1975.
[55] J Mendoza & S Rosenberg, *Suicide and suicide prevention in Australia: Breaking the silence*, Lifeline Australia & Suicide Prevention Australia, Sydney, 2010, p. 61.
[56] M Steele & T Doey, 'Suicidal behaviour in children and adolescents: Part 1, etiology and risk factors', *Canadian Journal of Psychiatry*, vol. 52, 2007; State of Queensland, Commissioner for Children and Young People and Child Guardian, *Reducing Youth Suicide in Queensland Discussion Paper,* Commissioner for Children and Young People and Child Guardian, Brisbane, 2009, p. 11.
[57] C Kan, T Ho, J Dong & E Dunn, 'Risk factors for suicide in the immediate post-discharge period', *Social Psychiatry and Psychiatric Epidemiology*, vol. 42, no. 3, 2007, pp. 208-214.
[58] S Pirkola, B Sohlman, H Heila & C Wahlbeck, 'Reductions in post-discharge suicide after deinstitutionalization and decentralization: A nationwide register study in Finland', *Psychiatric Services*, vol. 58, no. 2, 2007, pp. 221-226.
[59] D De Leo & T Heller, 'Social modeling in the transmission of suicidality', *Crisis, the Journal of Crisis Intervention and Suicide*, vol. 29, no. 1, 2008, pp. 11-19; State of Queensland, Commission for Children and Young People and Child Guardian, '*Reducing youth suicide in Queensland Discussion Paper*', Commission for Children and Young People and Child Guardian, Brisbane, 2009; Child Death Review Unit, *Looking for something to look forward to, A five-year retrospective review of child and youth suicide in BC*, British Columbia Coroners Service, 2008.
[60] T Joiner, 'The Interpersonal-Psychological Theory of Suicidal Behaviour', Current Empirical Status', *Psychological Science Agenda*, vol. 23, no. 6, June 2009, viewed 14 March 2014, <http://www.apa.org/science/about/psa/2009/06/sci-brief.aspx>; T Dokoupil, 'The Suicide Epidemic', *Newsweek*, 22 May 2013, viewed 27 February 2014, http://realtalkrealdebate.wordpress.com/2013/05/30/newsweek-the-suicide-epidemic/>.

will die by suicide when they have both the desire to die and the ability to die.'[61] He went on to distill his theory into the following concepts, which intersect to form Joiner's theory of suicide:

- Thwarted belongingness ("I am alone");
- Perceived burdensomeness ("I am a burden"); and
- Capability for suicide ("I am not afraid to die").[62]

3.3.4 Risk factors, warning signs and precipitating events for suicide by young people

The research literature identifies a range of risk factors associated with the suicide of young people. In addition to mental illness and substance abuse (that are generally acknowledged to be risk factors for all groups), risk factors for suicide by young people also include sexual and physical abuse, neglect, family and domestic violence, self-harming behaviour and homelessness. Each of these is discussed briefly below.

3.3.4.1 *Sexual abuse, physical abuse, neglect and family and domestic violence*

The research literature finds that adolescents who are sexually or physically abused in childhood are two to five times more likely to attempt suicide than those who do not have such experiences.[63] A 2008 American study identified an association between childhood physical abuse and witnessing domestic violence, and a substantial proportion of psychiatric disorders and suicide related behaviours.[64] A 2010 Canadian study confirmed the link between physical abuse and suicide-related behaviours in children and young people under 18 years of age.[65] Neglect in early childhood, impaired parenting and poor family functioning, including parental separations and chronic domestic conflict can also impact on the quality of care for the child leading to increased vulnerability and a heightened risk of suicide.[66]

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[61] T Joiner, 'The Interpersonal-Psychological Theory of Suicidal Behaviour', Current Empirical Status', *Psychological Science Agenda*, vol. 23, no. 6, June 2009, viewed 14 March 2014, <http://www.apa.org/science/about/psa/2009/06/sci-brief.aspx>; T Dokoupil, 'The Suicide Epidemic', *Newsweek*, 22 May 2013, viewed 27 February 2014, http://realtalkrealdebate.wordpress.com/2013/05/30/newsweek-the-suicide-epidemic/>.

[62] T Joiner, 'The Interpersonal-Psychological Theory of Suicidal Behaviour', Current Empirical Status', *Psychological Science Agenda*, vol. 23, no. 6, June 2009, viewed 14 March 2014, <http://www.apa.org/science/about/psa/2009/06/sci-brief.aspx>; T Dokoupil, 'The Suicide Epidemic', *Newsweek*, 22 May 2013, viewed 27 February 2014, http://realtalkrealdebate.wordpress.com/2013/05/30/newsweek-the-suicide-epidemic/>.

[63] S Dube, R Anda, V Felitti, D Chapman, D Williamson & W Giles, 'Childhood Abuse, Household Dysfunction, and the Risk of Attempted Suicide Throughout the Life Span: Findings from the Adverse Experiences Study', *Journal of the American Medical Association*, vol. 266, no. 24, 2001, p. 3094; P Mironova, A Rhodes, J Bethell, L Tonmyr, M Boyle, C Wekerle, D Goodman & B Leslie, 'Childhood physical abuse and suicide-related behaviour: A systemic review', *Vulnerable Children and Youth Studies*, vol. 6, no. 1, 2011, pp. 1-7.

[64] T Afifi, M Enns, B Cox, G Asmundson, M Stein & J Sareen, 'Population Attributable Fractions of Psychiatric Disorders and Suicide Ideation and Attempts Associated with Adverse Childhood Experiences', *American Journal of Public Health,* vol. 98, no. 5, 2008, pp. 946-952.

[65] S Dube, R Anda, V Felitti, D Chapman, D Dilliamson & W Giles, 'Childhood Abuse, Household Dysfunction, and the Risk of Attempted Suicide Throughout the Life Span: Findings from the Adverse Experiences Study', *Journal of the American Medical Association*, vol. 266 no. 24, 2001, p. 3094.

[66] M Sankey & R Lawrence, *Suicide and risk taking deaths of children and young people,* New South Wales Commission for Children and Young People, Sydney, 2003.

3.3.4.2 *Self-harming behaviour*

Self-harm is defined as someone deliberately harming themselves without suicidal intent.[67] Self-cutting and overdose are the most common methods of self-harm in young people, and self-harm is more prevalent in young females than young males.[68]

The research literature finds that self-harm is common among young people, with around 10 per cent of young people reporting self-harming behaviour at some point in their lives. [69] Since some young people's self-harm does not inflict sufficient physical damage to come to the attention of medical services, self-harm is also believed to be under-reported.[70]

In the vast majority of cases, self-harm by young people is a coping mechanism, not a suicide attempt,[71] and the motivation in many self-harm cases is more to do with an expression of distress and a desire to escape. Even when death is the outcome of self-harming behaviour, this may not have been intended.[72] Even so, the research literature shows strong links between suicide and self-harm, with between a quarter and a half of people who died by suicide previously carrying out a non-fatal self-harming act.[73]

3.3.4.3 *Homelessness*

The research literature also associates a range of other factors with suicide by young people. Homeless young people, for example are more vulnerable to mental illness, self-harm and suicidal ideation.[74] They are also more likely to use drugs, stay at unsafe or inadequate shelters and engage in unsafe "survival sex" in an effort to find shelter.[75] They may become homeless as a result of other risk factors for suicide, including abuse, neglect, family and domestic violence or family disunity.[76] According to a survey of 1,480 homeless young people undertaken by an Australian counselling service in 2009, 48 per cent of young people experiencing homelessness presented with either self-harm or suicidal ideation.[77]

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[67] Lifeline Australia, *Self-harm*, Canberra, 2010, viewed 26 February 2014, <http://www.lifeline.org.au/Get-Help/Facts---Information/Self-harm/Self-harm>; F Scanlan & R Purcell, *Mythbuster: Sorting fact from fiction on self-harm*, Headspace National Youth Mental Health Foundation, Australia, 2010, pp. 1-6.
[68] D De Leo & T Heller, 'Who are the kids who self-harm? An Australian self-report school survey'*, Medical Journal of Australia*, vol. 181, no. 3, 2004, pp. 140-144.
[69] D De Leo, T Heller, 'Who are the kids who self-harm? An Australian self-report school survey'*, Medical Journal of Australia*, vol. 181 no. 3, 2004, pp. 140-144.
[70] K Hawton & A James, 'ABC of adolescence: Suicide and deliberate self-harm in young people', *British Medical Journal*, vol. 330, 2005, pp. 891-94.
[71] F Scanlan & R Purcell, *Mythbuster: Sorting fact from fiction on self-harm,* Headspace National Youth Mental Health Foundation, Australia, 2010, pp. 1-6.
[72] K Hawton & A James, 'ABC of adolescence: Suicide and deliberate self-harm in young people', *British Medical Journal*, vol. 330, 2005, pp. 891-94.
[73] K Hawton & A James, 'ABC of adolescence: Suicide and deliberate self-harm in young people', *British Medical Journal*, vol. 330, 2005, pp. 891-94.
[74] Headspace National Youth Mental Health Foundation, *Position Paper – Homelessness*, Headspace National Youth Mental Health Foundation Ltd, 21 June 2011, p. 2.
[75] Kids Helpline, *Information Sheet – Youth Homelessness and Leaving Home*, Brisbane, 19 January 2001, viewed 26 February 2014, <http://www.kidshelp.com.au/upload/22895.pdf>.
[76] A Lamont, *Effects of child abuse and neglect for children and adolescents*, Australian Institute of Family Studies, Melbourne, 2010, pp. 1-7.
[77] Kids Helpline, '*Information Sheet – Youth Homelessness and Leaving Home*', Brisbane, 19 January 2001, viewed 26 February 2014, <http://www.kidshelp.com.au/upload/22895.pdf>.

3.3.5 Emerging risk factors among young people

It is important to note that there is no definitive list of risk factors. Medical and technological developments, particularly those relevant to young people, have recently led to the identification of additional risk factors. For example, the research literature has identified the following as potential or emerging risk factors for suicide by young people.

- **The use of antidepressants as a treatment for depression in young people** – the research literature has not reached consensus on the effect of antidepressants as a treatment for depression in young people.[78] Some research literature proposes that antidepressants have limited effectiveness and may actually increase suicidal thinking and behaviour.[79] Other research literature, on the other hand, claims that the benefits of these drugs outweigh the risks;[80]

- **Media reporting and the impact of social media** - the impact of media reporting and online discussions about suicide on the prevalence of suicide is unknown.[81] Historically, media reports on suicide have been linked to increased suicide attempts in the community.[82] However, a recent Australian Senate inquiry into suicide of young people, as well as other studies, have found that media reporting and online discussions may also assist in preventing suicide;[83] and

- **Cyber bullying, and use of information technology** – the potential risk to young people from the widespread and increasing use of social media for the purposes of cyber bullying and obtaining information on how to attempt suicide is the subject of concern.[84] Some authors see the use of information technology for these purposes as increasing the risk of suicide, while others point to evidence that the same technology can help in providing options for young people at risk.[85] In particular, evidence-based, online support services are considered to have the potential to encourage young people to seek help for themselves or their friends and family and reduce the risk of suicide.[86]

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[78] J Leckman, 'The risk and benefits of antidepressants to treat paediatric-onset depression and anxiety disorders: A developmental perspective', *Psychotherapy and Psychomatics*, vol. 82, 2013, p129.
[79] USA Food and Drug Administration, *Prozac (fluoexetine hydrochloride) capsules label*, Reference ID 2927282.
[80] R Goldney, 'Suicide and antidepressants: what is the evidence?', *Australian and New Zealand Journal of Psychiatry*, vol. 40, 2006, pp 381-385.; M Clark, K Jansen & J Cloy, 'Treatment of childhood and adolescent depression', *American Family Physician*, vol. 86, no. 5, pp 442-448.
[81] J Mendoza & S Rosenberg, *Suicide and suicide prevention in Australia: Breaking the silence*, Lifeline Australia & Suicide Prevention Australia, Sydney, 2010.
[82] J Mendoza & S Rosenberg, *Suicide and suicide prevention in Australia: Breaking the silence*, Lifeline Australia & Suicide Prevention Australia, Sydney, 2010.
[83] House of Representatives Standing Committee on Health and Ageing, *Before it's too late, Report on early intervention programs aimed at preventing youth suicide*, Parliament of Australia, Canberra, 2011; 'There is no 3G in heaven', *Four Corners*, television program, ABC Television, Sydney, broadcast 10 September 2012.
[84] J Mendoza & S Rosenberg, *Suicide and suicide prevention in Australia: Breaking the silence*, Lifeline Australia & Suicide Prevention Australia, Sydney, 2010, p. 84.
[85] J Mendoza & S Rosenberg, *Suicide and suicide prevention in Australia: Breaking the silence*, Lifeline Australia & Suicide Prevention Australia, Sydney, 2010, p. 84.
[86] J Mendoza & S Rosenberg, *Suicide and suicide prevention in Australia: Breaking the silence*, Lifeline Australia & Suicide Prevention Australia, Sydney, 2010, p. 84.

3.4 Suicide by Aboriginal young people

3.4.1 Rates of suicide

The research literature on suicide in Australia is consistent in its identification of Aboriginal people as being at significantly elevated risk of death by suicide when compared to non-Aboriginal people.[87] The research literature also identifies that this over-representation in suicide deaths is a common feature among the causes of mortality of Indigenous peoples in New Zealand, Canada and the USA, particularly among young Indigenous people.[88]

The Australian Bureau of Statistics reports that between 2001 and 2010, suicides accounted for 4.2 per cent of all registered deaths of people of all ages identified as Aboriginal and Torres Strait Islander people, compared with 1.6 per cent for all Australians in New South Wales, Queensland, South Australia, Western Australia and the Northern Territory.[89] In the same report, the Australian Bureau of Statistics identifies:

> The greatest difference in rates of suicide between Aboriginal and Torres Strait Islander people and non-Indigenous people was in the 15-19 years age group for both males and females. Suicide rates for Aboriginal and Torres Strait Islander females aged 15-19 years were 5.9 times higher than those for non-Indigenous females in this age group, while for males the corresponding rate ratio was 4.4…The overall rate of suicide for Aboriginal and Torres Strait Islander peoples was twice that of non-Indigenous people, with a rate ratio of 2.0 for males and 1.9 for females.[90]

The Australian Bureau of Statistics also reports in 2011 that the rate of suicide for Aboriginal and Torres Strait Islander people aged 15 to 24 years was 41.2 per 100 000 persons compared to 8.1 per 100 000 persons for non-Indigenous people in the same age group.[91]

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[87] J Mendoza & S Rosenberg, *Suicide and suicide prevention in Australia: Breaking the silence*, Lifeline Australia & Suicide Prevention Australia, Sydney, 2010, p. 76; Government of Australia, Department of Health and Ageing, *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy May 2013*, Canberra, 2013, p. 5.

[88] G Robinson, S Siburn & B Leckning, *Suicide of Children and Youth in the NT 2006-2010: Public Release Report for the Child Deaths Review and Prevention Committee*, Menzies Centre for Child Development and Education, Darwin, 2011, p. 13.

[89] Australian Bureau of Statistics, *Aboriginal and Torres Strait Islander Suicide Deaths, 2010*, cat. no. 3309.0, Table 6.1, ABS, Canberra, 2011. The Overview of this Category notes: 'Data from Victoria, Tasmania and the Australian Capital Territory has been excluded to ensure that the information presented is statistically robust. This is in line with reporting approaches currently recommended by the Council of Australian Governments and the national Indigenous Reform Agreement Performance Information Management Group'.

[90] Australian Bureau of Statistics, *Aboriginal and Torres Strait Islander Suicide Deaths, 2010*, cat. no. 3309.0, Table 6.1, ABS, Canberra, 2011.

[91] Australian Bureau of Statistics, *Causes of Death, 2011,* cat. no. 3303.0, Table 12.4, ABS, Canberra, 2011. This catalogue includes information for New South Wales, Queensland, Western Australia, Northern Territory and South Australia only.

3.4.2 Explanations of higher rates of suicide by Aboriginal young people

The Australian Institute of Health and Welfare (**AIHW**) is Australia's national agency for health and welfare statistics and information.[92] In its report, *Australia's Health 2010* (**the AIHW report**), AIHW describes socioeconomic factors and their role in influencing individual health and wellbeing. The AIHW report observed that:

> Aboriginal and Torres Strait Islander people (Indigenous Australians) generally have significantly more ill health than other Australians. They typically die at much younger ages and are more likely to experience disability and reduced quality of life because of ill health. One of the reasons for this poorer health is that Indigenous Australians are socioeconomically disadvantaged compared with other Australians. On average, they report having lower incomes than other Australians, higher rates of unemployment, lower educational attainment, and more overcrowded households. This socioeconomic disadvantage also places Aboriginal and Torres Strait Islander people at greater risk of unhealthy factors such as smoking and alcohol misuse, as well as overweight and obesity.[93]

In 2008, the Council of Australian Governments (COAG) agreed to six targets relating to Indigenous life expectancy, health, education and employment, collectively known as the 'Closing the Gap initiative'.[94] These targets are to:

- Close the gap in life expectancy within a generation (by 2030);
- Halve the gap in mortality rates for Indigenous children under 5 years within a decade (by 2018);
- Ensure all Indigenous 4-year olds in remote communities have access to early childhood education within 5 years (by 2013);
- Halve the gap in reading, writing and numeracy achievements for Indigenous children within a decade (by 2018);
- Halve the gap for Indigenous students in Year 12 equivalent attainment by 2020; and
- Halve the gap in employment outcomes between Indigenous and non-Indigenous Australians within a decade (by 2018).[95]

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[92] Australian Institute of Health and Welfare, *Australian Institute of Health and Welfare,* Australian Institute of Health and Welfare, Melbourne, viewed 27 February 2014, <https://www.aihw.gov.au/>.
[93] Australian Institute of Health and Welfare, *Australia's health 2010*, Australia's health series no. 12, cat. no. AUS 122, Canberra, AIHW, 2010.
[94] Government of Australia, Department of Social Services, *Closing The Gap On Indigenous Disadvantage: The Challenge For Australia*, Department of Social Services, Canberra, 2009.
[95] Australian Institute of Health and Welfare, *The health and welfare of Australia's Aboriginal and Torres Strait Islander people, an overview 2011*. cat. no. IHW 42. Canberra, 2011.

A study by the Menzies School of Health Research also points to the impact of alcohol misuse on parenting and family relationships[96] finding that:

> [T]he pattern of risk established in early childhood is compounded by ongoing stress within families related to alcohol and cannabis misuse by parents and young adults within many households, ongoing family violence and the failure of many youth to sustain social connection through education, work or other productive activity.[97]

The Royal Commission into Aboriginal Deaths in Custody in 1991 suggested an additional risk factor of particular relevance to Aboriginal people, namely 'the disproportionate number of [these] deaths (over three-quarters) where there was a history of having been forcibly separated from natural families as children.'[98] The research literature similarly points to the additional disadvantage experienced by Aboriginal people as a result of a history of childhood separation leading to 'trans-generational family issues, with histories of child removal and foster-care in the parents' generation, followed by difficult or failed relationships with spouses.'[99]

The Western Australian Aboriginal Child Health Survey describes the effects of this child removal and trans-generational trauma on children as follows:

> The experience and effects of forced separation of children from their families and communities have been multiple, continuing and profoundly disabling. The trauma of separation and attempts at "assimilation" have damaged their self-esteem and wellbeing, and impaired their parenting and relationships. In turn their children suffer. There is a cycle of damage which people find difficult to escape unaided.[100]

Studies have also found that Aboriginal communities are particularly vulnerable to clusters of suicides.[101] The Western Australian Aboriginal Child Health Survey highlights the interconnection of Aboriginal communities and families as relevant here, as follows:

> The close-knit nature of Aboriginal communities and the extensive interconnection of families through traditional kinship systems means that the

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[96] G Robinson, S. Siburn & B Leckning, *Suicide of Children and Youth in the NT 2006-2010: Public Release Report for the Child Deaths Review and Prevention Committee,* Menzies Centre for Child Development and Education, Darwin, 2011, p. 13.

[97] G Robinson, S. Siburn & B Leckning, *Suicide of Children and Youth in the NT 2006-2010: Public Release Report for the Child Deaths Review and Prevention Committee,* Menzies Centre for Child Development and Education, Darwin, 2011, p. 13.

[98] Government of Australia, Department of Health and Ageing, *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy May 2013*, Canberra, 2013, p. 10.

[99] G Robinson, S Siburn & B Leckning, *Suicide of Children and Youth in the NT 2006-2010: Public Release Report for the Child Deaths Review and Prevention Committee*, Menzies School of Health Research, Darwin, 2011, p. 29.

[100] S Zubrick, S Silburn, D Lawrence, I Mitrou, R Dalby, E Blair, J Griffin, H Milroy, J De Maio & J Li, *The Western Australian Aboriginal Child Health Survey: The Social and Emotional Wellbeing of Aboriginal Children and Young People,* Curtin University of Technology and Telethon Institute of Child Health Research, Perth, 2005, p. 481.

[101] J Mendoza & S Rosenberg, *Suicide and suicide prevention in Australia: Breaking the silence*, Lifeline Australia & Suicide Prevention Australia, Sydney, 2010, p. 76; T Elliott-Farrelly 'Australian Aboriginal suicide: The need for an Aboriginal suicidology?', *Australian e-Journal of Mental Health,* vol. 3, 2004, pp. 1-8; Government of Australia, Department of Health and Ageing, *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice*, Department of Health and Ageing, Canberra, 2010; Senate Community Affairs Reference Committee, *The Hidden Toll: Suicide in Australia*, Canberra, 2010, p. 91.

> death of a young person through suicide can impact on the lives of a considerable number of individuals.[102]

The Menzies School of Health Research study also found:

> While general exposure to suicide in communities creates the conditions for modelling and imitation of suicidal behaviour among young people, it is suggested that the rapid escalation of suicide rates among youth and preadolescent children already exposed to some degree of neglect or trauma may be most powerfully influenced by the frequency of suicide threats and attempts within families and households, and of suicide completions in families and within related social networks…..Prior experience of suicidal behaviour in interpersonal conflict combined with the many antecedent difficulties in individuals, families and their relationships may be the most important general preconditions of serious suicide attempts by young people.[103]

Further risk factors identified by the research literature include cultural dislocation, racism and discrimination.[104]

Responding to the concerns discussed above, the research literature consistently recommends that there should be a separate suicide prevention strategy for Aboriginal people. The *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy* was launched by the Australian Government in May 2013. This strategy is discussed in further detail at Chapter 6.

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[102] S Zubrick, S Silburn, D Lawrence, I Mitrou, R Dalby, E Blair, J Griffin, H Milroy, J De Maio & J Li, The *Western Australian Aboriginal Child Health Survey: The social and Emotional Wellbeing of Aboriginal Children and Young People,* Curtin University of Technology and Telethon Institute of Child Health Research, Perth, 2005, p. 356.

[103] G Robinson, S Siburn & B Leckning, *Suicide of Children and Youth in the NT 2006-2010: Public Release Report for the Child Deaths Review and Prevention Committee*, Menzies Centre for Child Development and Education, Darwin, 2011, p. 14.

[104] S Zubrick, P Dudgeon, G Gee, B Glaskin, K Kelly, Y Paradies, C Scrine & R Walker, 'Social Determinants of Aboriginal and Torres Strait Islander Social and Emotional Wellbeing', in N Purdie, P Dudgeon & R Walker, *Working Together: Aboriginal and Torres Strait Islander Health and Wellbeing Principles and Practice*, Office of Aboriginal and Torres Strait Islander Health, Department of Ageing, Canberra, 2010, pp. 75-90.

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