Although suicide is a complex human behaviour that cannot easily be predicted, a range of factors has been shown to contribute to it.

While these factors have been generally known for almost a century, the particular combination that leads any one individual to suicide remains unclear. The Task Force has been presented with a diverse range of views about what leads a person to suicide, and is therefore reluctant to postulate a specific ‘cause’ of suicide.

From all of the evidence before the Task Force, the conclusion reached is there is no single reason to explain why a person ends their life. There are complex, multiple factors involved in suicide and suicidal behaviour.

**Case Study**

Andrew was the 26-year-old son of a professional couple living in a suburb of Melbourne. His parents returned home from work one evening to the news that Andrew had been discovered dead in his car, suffocated by carbon monoxide poisoning. From the moment they heard the terrible news, the lives of Andrew’s family members were altered irrevocably. They recall with great clarity the events that led to that moment.

Andrew had been an excellent student at primary school. His academic success continued through high school, and teachers’ reports often commented on his quiet, sensitive nature. During his VCE years, he had a lot of absences due to glandular fever. He had seemed somewhat depressed during these two years, but this had been dismissed as a side-effect of his illness. After passing his VCE, he decided to defer tertiary study for a year, and he found a series of short-term jobs. He also formed a close but difficult relationship, and spent much of his time at his girlfriend’s apartment and only gave his parents minimal information.

At the time of his death, Andrew had recently broken up with his girlfriend and had started to spend time with a group of young men who seemed to enjoy ‘raging’ or partying in particular nightclubs. His parents knew he smoked marijuana when he was with this group, but he never smoked at home. In the weeks before his death, he had seemed uncommunicative and uncooperative to his parents, and had left very few clues as to what he was doing. His father had argued with him during the week about his need to inform them of his comings and goings while he stayed living in their house. This led Andrew to storm out in an uncharacteristic sullen rage.

Andrew’s parents were left with more questions than answers. A scribbled note was found in his car, saying ‘Sorry, Mum and Dad...’ This still left the big question unanswered—Why? Maybe the signs of early depression had been missed. Maybe something had happened at work to upset or humiliate him. Maybe his broken relationship had affected him more than anyone realised. Maybe he had concerns about his developing sexual identity. Maybe his drug usage was a factor. Four years later, Andrew’s parents are still agonising over the legacy of questions and grief Andrew’s death raised.

Some individuals who experience many of the predisposing conditions of risk identified in this chapter may experience no vulnerability to suicide. Others may experience few conditions of risk but nevertheless complete suicide. Thus, identifying risk factors does not, by itself, allow suicide to be predicted.

Evidence presented to the Task Force has identified a range of primary risk factors that may contribute to suicide and suicidal behaviour.

Research undertaken by the Centre for Adolescent Health and others has demonstrated three factors in particular stand out as antecedents of suicide in the young, as well as being important causes of death in their own right. They are:

- Prior attempt or deliberate, severe self harm.
- Mental illness.
- Drug and alcohol abuse.

In addition, a range of social factors has been associated with suicide and suicidal behaviour.
3.1 PRIOR ATTEMPTS AND DELIBERATE SELF HARM

A past history of attempted suicide has been shown to be a strong predictor of future death by suicide. Relative risk estimates for suicide have been shown by a Western Australian study to be significantly higher for those who have a history of prior attempt (figure 3.1).

A considerable body of international research also supports this view. Previous suicidal behaviour increases the risk of eventual death by suicide, particularly among those individuals who have been hospitalised for psychiatric illness.

While prior suicide attempts must be seen as distinct from self harming behaviour, there is evidence to show young people engaging in severe self harm are also at higher risk of suicide. Distinguishing ‘true’ suicide attempts from deliberate self harm can be difficult. Young people do not always have a clear perception of the potential lethality of a particular method; therefore, deliberate self harm without suicidal intent may result in death, while attempts to die may result in minimal injury. Moreover, there is research to suggest some adolescents have a distorted concept of death that may be a further risk factor for death by suicide (Halasz, 1985).

Self harm among young people is said to be more common than generally thought, but does not often result in medical attention. Deliberate self harm such as cutting oneself, overdosing on medication, or taking risks that are potentially life-threatening occur mostly when the person is depressed or emotionally distressed. Therefore, such self-destructive behaviour must be seen as a serious sign of mental distress.

In studies of youth who had attempted suicide, one of the most common warning signs was deliberate self harm. The Centre for Adolescent Health Adolescent Health Survey in Victoria revealed symptoms of depression such as persisting low mood, tiredness, difficulty sleeping, poor concentration and loss of self-confidence were found in the majority of students who had deliberately hurt themselves.

3.2 MENTAL ILLNESS

The Task Force defines mental illness, in its broadest sense, to include emotional, psychological and behavioural disorders that range in severity and vary in intensity at different stages across the life span, of which depression is the most common.

As a group, people who have been diagnosed with a psychiatric disorder face a statistically higher risk of suicide than the general population. However, as previously stated, each suicide involves a complex interaction of various factors, and existing evidence indicates no single determinant including psychiatric disorder is necessary or sufficient for it to occur.
Case Study

The Task Force heard from a professional person, speaking in a private capacity, who talked about her extended family’s experience of suicide. In the past three years, they had faced three completed suicides by male members of the family using hanging, gunshot and overdose. In addition, in the past 15 years, they had witnessed 17 attempts (three by males and 14 by females through overdose, self-mutilation and staged car accident). Three of the attempted suicides had been made by the speaker.

At the age of 17, I was diagnosed with a mental illness known as manic depression—now known as bipolar mood disorder. Suicide is a part of my life. I kept that secret from my family and friends from the age of 17 until five years ago when I had my last breakdown: one of three. Then I decided to come clean and tell my employer, family and friends, because I wanted to highlight that mental illness is a problem, and that one of the derivatives of mental illness is suicide in a lot of cases.

When I looked back at all the attempted and successful suicides in my family, I saw that there was the incidence of domestic violence, and of high expectations placed by parents on children to achieve university degrees, instead of the children turning to trades to suit their IQs, for instance. There was also sexual or other abuse, separation, divorce and custody battles.

The Report of the Coroner’s Working Party on Suicide (1997) states ‘even where there is a clinical suspicion that an individual is at high risk of completing suicide, it is extremely difficult to predict when an attempt may follow’. However, information presented to the Task Force by the Mental Health Research Institute (MHRI) indicated there is considerable evidence that risk for suicide among those with a history of mental illness is much greater than for the general population. Indeed, the risk of suicide among the mentally ill in Victoria is estimated as being 15 times higher than for the general population.

It is noteworthy that the MHRI research indicates significant differences between those people with severe mental illness who have been patients of the public mental health system, and those who have not. Suicides by people with severe mental illness who have been patients of the public mental health system are more likely to:

- Be female rather than male.
- Be aged in adult years rather than younger or older.
- Die by means of overdose or trains.

Tanney’s (1992) review of the literature supports the view that mental illness is more common in populations of persons completing suicide, and that suicide and suicidal behaviours occur much more frequently in populations of psychiatric patients. Tanney warns, however, ‘the diagnosis of a mental disorder is not a sufficient explanation for suicidal behaviour. Among the majority of causes, mental disorders can lay claim to a position in the first rank of the matrix of causation. But the issues are complex and multiple explanations may be operating simultaneously’.

A number of oral and written submissions received by the Task Force point to mental illness and, most commonly, clinical depression as an underlying factor in many suicides, especially in the adolescent and aged populations.
Only about 7 per cent of unsuccessful attempts occur in older people, but 75 per cent of these have higher suicidal intent. Unlike younger age groups, there appear to be few differences in the profiles of completed suicides and attempted suicides. This is further emphasised by follow-up studies showing 9 per cent of older people make further suicide attempts within a year, a third being successful. Thus, survivors of suicidal behaviour in old age remain a high-risk group and require close monitoring (Draper, 1995).

Although many people who are depressed never attempt or complete suicide, considerable evidence links suicide and suicide attempts with depression, schizophrenia, bipolar disorder, conduct and personality disorders. The Department of Human Services Framework for Child and Adolescent Mental Health Services (1996) identified between 10 per cent and 20 per cent of young people suffer from diagnosable psychiatric disorders, and 3 per cent to 5 per cent of these have a more severe mental illness. It is essential that such illness is appropriately identified and treated to relieve suffering, and diminish the impact of persisting disorder on their development, their families and their communities.

Several psychological autopsy studies have estimated up to 90 per cent of people whose death results from suicide have a mental disorder (predominantly depression) that varies in severity for different age groups and occurs at different times across the life span.

### 3.2.1 Depression

Mood disorders have consistently been found to be associated with suicidal ideation, attempts, and completed suicide. Depressive disorders affect up to 10 per cent of adults, and there are higher rates in women than men. These disorders vary in severity but constitute a significant health and social burden for those affected and their families.

The Task Force was informed depression in children and young people often went undetected.

The National Health & Medical Research Council (NHMRC) has recently published a series of monographs on Depression in Young People (March 1997), comprising Clinical Practice Guidelines, Guide for GPs and Guide for Mental Health Professionals. They point out that the key to detecting depression in children and adolescents is to realise that ‘depression exists, and is something more than angst...Between 60 per cent and 90 per cent of young people who attempt suicide are depressed... Many young people—about 40 per cent in any 6 month period—suffer prolonged periods of sadness or unhappiness which may affect their ability to cope. Although not a clinical disorder, this lowered mood is important because it may be a risk factor for long-term social problems and for clinical depression’.

Depression can be associated with severe psychological distress; social withdrawal; moodiness; a breakdown in family, personal and social relationships; poor work and academic performance; delinquency; low self-esteem; drug and alcohol abuse; eating disorders or attempted suicide. Most young people with depression receive no treatment for it because much of it goes unrecognised and is mistakenly assumed to be normal adolescent ‘acting out’ behaviour.
Case Study

The Task Force heard from a mother whose son attempted suicide at age 21 and died in 1994 by suicide at age 24.

Perhaps psychiatrists are used to dealing with depressed people, but it needs to be made clear to the family—parents in particular—that once a person has made a suicide attempt they are at very high risk of trying again and completing suicide if the medication and counselling are not ongoing. It is vital that doctors communicate and share concerns with family members. In our case, our son had seen his counsellor two days before his death and said ‘I’m feeling like dying’.

While not betraying trust between patient and doctor, a phone call warning us to be vigilant in checking our son’s wellbeing may well have avoided the tragedy our family will live with for the rest of our days.

Often families are too close to the problem and accept the poker-faced attitudes and quiet, withdrawn manners of their sons as being normal, not realising that may pre-empt the final decision to die.

Two months after the death of her son, a public ‘depression awareness’ meeting was held to raise awareness of mental illness. At that meeting, the family learned there is a danger in seeing emotional upheavals in teenage years as normal because they can be the start of depression or some other mental illness; that if the condition of major depression is picked up right at the start and the correct medication and counselling are given, a person can go on to a normal life; that after two recurring episodes of major depression, it is considered a chronic condition and should be treated with ongoing medication, like the chronic conditions of high blood pressure and diabetes.

I certainly miss my son in my life and have thought a lot about how much more we could have done if we had been more aware. The main thing I feel now is that, no matter how loving your family and friends are, they cannot be there for you all the time. You have to be there for yourself as your own best friend, if you like.

Maybe we have to work harder at helping our children from the earliest age to gain self-confidence and self-esteem and letting them know it is okay to talk about feelings and problems, that it is a very good thing to do, so that when the bad times come, our children will reach out in time for the help that they need.

Depression is more common in adolescents who have a family history of depression, are anxious, are unable to establish positive social relationships, have a conduct disorder, misuse drugs and alcohol, have concerns about their sexuality, or who suffer negative life events such as bullying, domestic disharmony or physical, emotional or sexual abuse.

Moreover, certain circumstances and experiences associated with loss, deprivation or disadvantage (such as being homeless, being of Aboriginal or Torres Strait Islander descent, being an immigrant refugee or being in custody) may make adolescents susceptible to depression.

Consequently, suicide risk should be assessed in every young person with depression. As previously noted, the main risk factors for suicide attempts are a previous suicide attempt, mental illness (particularly depression), drug and alcohol abuse, or antisocial or aggressive behaviour. A suicide attempt may then be triggered by a rejection, loss, failure, conflict or a humiliating experience.

Much of the evidence provided to the Task Force points to an increasing risk of suicide arising from depressive disorders. Lifetime prevalence rates for depression appear to be higher for adolescents and young adults today than they were for their parents at that age. One of the features of this increase seems to be the lower age of onset of depression. Evidence also suggests the gap is closing between females and males in terms of rates and risk of depression in younger age groups.

The view that an increase in depressive disorders might help explain the increase in suicidal behaviours is corroborated by several findings:

- The increase in depressive disorders and suicide is particularly conspicuous in young males.
- There is evidence to suggest the percentage of adolescent male suicides who suffered from a depressive disorder at the time of their death has increased over time.
- The earlier age of onset observed for depressive disorders is paralleled by an increase in suicide deaths at an early age.
The increase in depressive disorders evident among young people has, in part, been attributed by some researchers to the earlier onset of puberty that may cause increased disjunction between biological, psychological and social development. This, in turn, may cause stresses and strains that overtax the coping skills of young people and their families.

The rise in depressive disorders has also been shown to apply to older people. In a study of psychiatric disorder and risk factors for elderly persons over 65 who had attempted suicide, Draper (1994) found 41 per cent had a major psychiatric disorder (psychotic depression, schizophrenia), 30 per cent had a minor psychiatric disorder (reactive depression, anxiety, personality disorder), and 29 per cent suffered from organic brain syndromes (dementia, delirium).

The Task Force was informed for people over 65, up to 80 per cent with severe to moderate depression have consulted a general practitioner, although depression was only detected in 25 per cent of these cases, and there were even lower rates of treatment in those detected. This is despite evidence the depression had often been present for at least six months and fulfilled the criteria for a major depressive episode (Draper, in expert opinion to Task Force).

However, since the majority of depressed people never attempt or complete suicide (Brent & Kolko, 1990), it is clear other factors must come into play in the causality of suicidal behaviour in depressed individuals.

### 3.2.2 Schizophrenia and Psychotic Disorders

Schizophrenia occurs in 1 per cent of the population. Sufferers experience a severe illness with a high risk of related maladies and suicide. The onset of schizophrenic illness frequently occurs in late adolescent/early adult life and is often associated with impairment of school or academic performance, and failures in work, personal and social relationships.

Suicide has been shown to be the major cause of premature death in persons with schizophrenia, and as many as 10 per cent of persons diagnosed with schizophrenia eventually die by suicide. Among those with diagnosed schizophrenia, suicide risk appears to be greatest in young, unmarried, unemployed males who are depressed. Often there is a history of previous suicide attempts and recent stressful life events.

The period during the onset of schizophrenia can be a particularly high-risk time, especially for young people trying to deal with the complexity and confusion that accompany it. The risk of suicide for this group can be accentuated by high rates of self-medication with prescription and illicit drugs and/or alcohol in trying to deal with mounting problems. Evidence suggests a prolonged period before treatment, where difficulties become consolidated, may significantly impair capacity for full recovery, increase residual disability and worsen prognosis.

The period immediately following discharge from care is a vulnerable time, particularly in the light of several studies supporting the view that suicide in this population tends to be a planned action that is more likely to occur in periods of remission or improved functioning.

### 3.2.3 Conduct and Personality Disorders

Clinical experience suggests particular personality traits may be readily identified in adolescence. However, since personality is still being developed in adolescence, it is unclear whether disorders as such can be diagnosed reliably before adulthood.

A small but significant group of young people who suicide often appear to be successful and admired, but have perfectionist and rigid aspects to their personality. These young people become extremely anxious at times of stress or change, and may take their lives in reaction to a sense of perceived failure (Shaffer & Gould, 1987).

There is a recognised association between suicide in young people who have antisocial delinquent behaviour in which impulsiveness seems to be an important facilitating factor.

Although conduct disorder is not considered a personality disorder, it has been shown a diagnosis before age 15 is the best predictor for the development of antisocial personality. Psychological autopsy studies show conduct disorder is one of the main risk factors for completed suicide, particularly among males. In addition, conduct disordered adolescent inpatients are significantly more suicidal than patients with a primary major depression.

It is well documented that certain personality disorders (particularly antisocial and borderline) constitute a risk factor for suicidal behaviour among adults. Personality disorders, particularly those related to impulsive behaviour, may
also contribute to risk of death by suicide. The suicide rate for people with borderline personality disorder is estimated to be around 9 per cent, although it has been reported as high as 36 per cent among individuals who met all criteria for borderline personality disorder.

A large proportion of those with a diagnosis of borderline personality disorder is female, a majority of whom have been victims of childhood sexual abuse.

Many people with borderline personality disorder have a history of at least one act of self harm. This is particularly significant, since a major individual risk factor for suicide is having made previous attempts.

**Case Study**

Hugh was the youngest of three children. From the age of 19, until he died by suicide at 22, he had made eight attempts to end his life.

Hugh had been diagnosed as having a borderline personality disorder. The diagnosis meant little to his parents, or even to his older sister who was studying psychology. They could only assume having a formal diagnosis was good; it must mean appropriate treatment would follow.

However, the diagnosis did nothing in itself to help Hugh. He became so disturbed and agitated that on three occasions he was admitted to psychiatric care, but each time he was released within 24 hours. Under the Mental Health Act 1986, he did not qualify for ongoing residential care.

Hugh’s life ended only 18 hours after his final discharge from psychiatric care.

Depression, personality disorders, and psychotic conditions become more significant contributors to suicide in older adolescents and young adults compared with younger adolescents. In this context, ‘the proper assessment and treatment of these psychiatric conditions are likely to be the most effective mechanism for the prevention of youthful suicide’ (Raphael et al., 1993).

### 3.2.4 Neurobiological Factors

Recent studies in neurobiology have implicated deficient neurotransmission of serotonin (a chemical messenger in the brain) as a factor in suicide. The results of chemical analyses of the brains of suicide victims, and other biochemical studies, support the serotonin theory. It is likely that serotonin acts in concert with other chemical messengers in the brain; however, the process by which serotonergic dysregulation may play a part in suicide is still the subject of research.

Lester (1992b) concludes, ‘we are a long way from having a clear idea of the biochemical causes of depression, suicide, impulsive behaviour, or assaultive behaviour. It is unlikely that a specific biochemical predictor of suicide will soon be discovered, since the potential predictors appear to be associated with a wide variety of other pathological behaviours’.

### 3.3 Drug and Alcohol Abuse

Many studies have found higher rates of suicide among alcoholics and drug abusers (Lester, 1992). Alcohol and substance abuse by adolescents often immediately precedes suicidal behaviour. Such abuse is frequently related to the suicidal attempt and deliberately part of the attempt itself.

Higher rates of suicidal ideation and behaviours have been shown among people who are substance abusers across populations and over time. As for other risk factors, having this behaviour does not necessarily translate into suicide or suicide attempts. While most substance abusers do not make attempts on their lives, substance abuse does increase risk for people with other vulnerabilities. Gaining access to services and reducing the risk of suicide can be a major barrier for this group.

Many of the physiological, psychological and social effects of severe alcohol abuse (marriage break-ups, disruption of social ties, impairment of work performance and coping skills, lowering of normal restraints on behaviour, increased impulsiveness, and depression) would reasonably be expected to increase the likelihood of suicidal behaviour.
Substance abuse is also a major precipitating factor and may exacerbate impulsiveness by affecting brain function and lowering inhibitions.

The Task Force heard several examples that linked long-term marijuana use with suicidal behaviour and death by suicide.

**CASE STUDY**

Greg was married and had two young boys whom he adored. He had been smoking marijuana daily for over a year, but nobody connected this to his unpredictable bouts of depression. His mental state became so severe at one stage that he was admitted to a psychiatric hospital, but after his discharge he still felt gloomy and despairing. His marijuana smoking continued, always in the company of his mates. Then one night after a long bout of drinking and smoking, Greg decided he ‘couldn’t stand it anymore’ and suicided.

A Western Australian report on youth suicide found alcohol and drug misuse increased the risk of suicide by five to nine times in young people under 25 years of age (Silburn, Zubrick & Hayward, 1988). Most commonly abused substances in the WA study were alcohol, marijuana and cocaine.

Substance abuse, violence, depression and access to means are a particularly lethal combination of risk factors among young males who tend to be more impulsive than females and older men.

### 3.4 SOCIAL FACTORS

A number of reports over the past three or four decades have pointed to the increase in adverse social conditions such as unemployment, economic hardship and family discord and conflict. With the rise in prevalence of such social and interpersonal problems in the community, it may be the growing rates of depression and suicidal behaviours reflect, in part, the increasing presence of these social stressors.

International studies indicate societies, communities and all social groups subject to increasing economic instability and unemployment, breakdown of traditional or primary family group structures, greater inter-generational pressures, domestic and interpersonal violence, criminal behaviour and secularisation increase their risk of suicide mortality. Nonetheless, the exact nature of the association between each of these conditions and suicide mortality remains unclear.

Mental health and personal factors do not operate independently of socioeconomic factors that may, in combination, affect suicidal behaviour. The pressures the environment can give rise to can have a significant impact on vulnerability to suicide.

Some of the social factors that have been linked to the incidence of suicidal behaviours are outlined below. Despite the limitations of studies on causal inferences, the results of such studies are consistent with the view expressed by writers such as Eckersley in *The West's Deepening Cultural Crisis* (1993). Eckersley believes the social conditions prevailing in a country may be a factor in suicide risk, and that changing social and economic structures may contribute to changes over time in rates of suicide and attempted suicide.

#### 3.4.1 SOCIAL ADAPTABILITY

The issues of social adaptability, impaired social skills and poor peer relationships have also been suggested as potential factors that may affect already vulnerable persons, although such findings are controversial. While some studies have shown a strong relationship between chronically impaired social adjustment, mood disorders and suicide, other studies have found no association between social impairment and suicide.

More precise measures of social adjustment may be required to tease out the specific attributes of social environments, and ensuing social difficulties, that cause suicidal behaviour in individuals.

Evidence available to the Task Force suggests impaired social skills and poor social relationships are linked with feelings of hopelessness and helplessness and, in association, they may contribute to suicide. Loneliness and social isolation, particularly when allied with depression, substance abuse and poverty can increase risk of suicide. The Task Force also heard of the particular vulnerabilities of children who have a parent with a mental illness and therefore potential for a disrupted family environment and other pressures.
Moreover, evidence supports the view that risk increases when negative life stresses mount in individuals with poor problem-solving skills and deficient coping abilities. Thus, effective problem-solving skills, enhanced self-esteem and strong social/family relationships serve as protective factors by strengthening resilience to stress, and reducing the impact of adverse factors that could exacerbate vulnerability to suicide.

People who are socially disadvantaged (poor and with few social supports) are more likely to share a range of other risk factors and experience higher rates of mental illness. Young people who are homeless, for example, are also more likely to experience clusters of other risk factors, such as substance abuse, psycho-social problems, and/or a sense of loss. They are also less likely to have access to primary and mental health care, and education and training.

However, the fact that suicide transcends all classes of society was supported by submissions to the Task Force regarding the death by suicide of individuals from middle- and high-income families.

It is sometimes difficult to distinguish between social factors and individual experience. People differ in their views on the extent to which social factors contribute to or influence individual behaviour. However, for some people, the impact of several stressful life events occurring concurrently can activate other suicidal vulnerabilities. Stressful life events may befall many individuals, but the social circumstances of some individuals may expose them to more of these kinds of events.

### 3.4.2 Relationships

Research suggests the recent loss of a spouse or partner through divorce, separation or death can increase suicide risk. Family history of suicide is also a serious risk factor. Family discord, when operating in concert with depression, significantly increases young people’s risk of attempting and completing suicide, and heightens the risk for adolescents who engage in suicidal ideation.

Precipitating events for suicide may reflect severe conflict with parents, spouse or partner; episodes of family and domestic violence; divorce or loss of a significant relationship; serious illness in the family; loss of a family member through death or separation, or the anniversary of one of these kinds of events. Precipitating events are most often characterised by loss or interpersonal conflict, especially when linked to poorly developed coping or conflict resolution skills. The Task Force heard relationship breakdown or difficulties in establishing positive social relationships were associated with suicidal behaviour in young people. A recent study found nearly 75 per cent of suicides occurred within one month of the break up of a significant relationship, and the rate for men was more than nine times higher than for women (Baume, Cantor & McTaggart, 1996).

The *Coroner’s Working Party on Suicide* (1997) states, after mental illness, ‘the next most common [factors] were feelings of worthlessness, general dissatisfaction and relationship problems...Less than a quarter of the attempters regarded family relationships as close and warm’.

A review of family relations and suicide found a poor relationship with parents to be an important factor (Tousignant, Bastien & Hamel, 1993). Submissions presented to the Task Force supported this finding, and suggested poor father and son relationships may be a factor requiring increased attention.

Kosky (1983) found 80 per cent of suicidal youths with chronic mental illness had suffered the death of a parent compared to 20 per cent of a non-suicidal psychiatric control group. Many other studies, reviewed by Adam (1990), found a significant relationship between parental loss and increased risk of suicide.

This is consistent with research suggesting family members and close associates of a person who has died by suicide are themselves at heightened risk of suicide, had attempted suicide or had long-term effects on their physical and mental health.

### 3.4.3 Childhood Abuse and Sexual Assault

Many studies have demonstrated a much higher incidence of suicidal behaviours among people who have been subjected to childhood abuse in general, and sexual abuse in particular. Martin (1996) showed a clear association between a history of sexual abuse and increased likelihood of attempted suicide and repeated attempts. Such research findings have been supported by several oral and written submissions to the Task Force.
Case Study

Ricky grew up in country Victoria in a pleasant but somewhat isolated setting, where the weekly visit to town with his mum and dad was the main social activity. At the age of 11, the unthinkable happened. Ricky’s father began taking him aside when his mother wasn’t there for what he called ‘training sessions’ in sexuality. Ricky had nowhere to turn; to everyone in town his father was a pillar of respectability and he thought his father would kill him if he told anyone. For four years, Ricky’s dad continued these so-called training sessions, culminating one night in a violent rape.

In this time, too, Ricky had begun to be attracted to other boys at school. By age 15 he was lonely, desperately unhappy and filled with self-loathing. At 16, he overdosed on sleeping tablets and spent the next week in hospital in a coma. His father’s first words to him when he regained consciousness were ‘You couldn’t even get that right, could you!’

Ricky left home. At 16 he became a street kid, a gay teenager with no-one to talk to. But despite this, Ricky survived. Somehow, he just kept going. Now 10 years later, he holds a position of trust and respect. He hopes his disclosure and his survival can in some measure contribute to the survival of others.

It has been estimated recently that 34 per cent of adolescents in outpatient treatment have experienced physical abuse, while 44 per cent have suffered sexual abuse (Lipschitz, Kaplan & Asnis, 1994). Physically abused children have been reported to have a significantly higher incidence of suicide attempts and other self-destructive behaviours than comparison groups of neglected children and children who have not been abused. A number of other studies have found a significant link between suicide attempts by adolescents and abuse.

The full impact of abuse, in terms of its psychological damage and effect on suicidal behaviour, often does not become manifest until adolescence or later in adult life.

The Task Force also received several submissions that support the view that sexual assault may also be a serious risk factor for suicidal behaviour, even when it has occurred in the distant past.

3.4.4 Unemployment

A popularly assumed link exists between unemployment and suicide. This view was articulated in community consultations conducted by the Task Force.

Higher rates of unemployment have been one of the most significant changes in the labour market in recent decades, especially in the youth labour market. At the start of the 1970s, the unemployment rate averaged around 2 per cent. A quarter of a century later it stands at over 8 per cent.

Despite increases in unemployment and suicide rates occurring in tandem since the 1960s, especially for young people, suicide studies appear mixed about a correlation between the two rates. Platt & Kreitman (1990) found the rate of attempted suicide among unemployed people was over 10 times that of those who had jobs. Other studies have produced results that do not support such a close relationship.

Unemployment impacts on people of different ages and genders, from different socioeconomic backgrounds, ethnicity and location in different ways. In terms of absolute numbers, 20–24 year olds comprise the largest group in unemployment, and people under 30 years of age make up just under half of those unemployed. While unemployment rates are highest for young people aged 15–19 years, suicide rates are highest for 20–24 year olds. As seen in figure 3.3, suicide and unemployment rates for 20–24 year olds appear to have moved in opposite directions in some recent years, although there may be a ‘lagged’ effect of unemployment on suicidal behaviours.

Unemployment rates are generally higher in rural areas, although regional variations exist, and have been higher for young males over the past five-year period.

Unemployment does not operate in isolation of other risk factors. Those factors that may exacerbate despondency and hopelessness include mental illness, homelessness, cultural difference, drug and alcohol abuse, family conflict and/or estrangement, financial pressures, and crime. However, most unemployed people are not suicidal, and case studies before the Task Force confirm deaths by suicide are in no way restricted to those without jobs.
Participants in the unemployed youth forums commissioned by the Task Force, characterised rural environments as stressful in terms of the lack of work opportunities for young adults, the seasonal nature of work, and social isolation. This is especially true for males, many of whom behave in stereotypical ways that further impair their ability to seek help.

The Task Force heard some evidence of the impact of redundancy on suicidal behaviour in Victoria, particularly on older people and those in industries and areas where alternative employment opportunities were poor.

For example, evidence provided by the Victorian Building Workers indicates, from May 1996 to April 1997, 50 of 396 total death benefit claims on the Building Industry Superannuation Fund were for suicide. Industry sources attribute this to the diminishing employment opportunities for older males in the building industry; a factor common to other industries.

The Task Force also received submissions relating to high rates of suicide risk within the armed forces, police force and among medical practitioners. Inasmuch as this suggests a possible industry-by-industry variation in rates of suicide, it remains an area for further research.

3.4.5 Rural Communities

Rates of suicide are higher in rural areas of Australia, and remote settlements of fewer than 4000 people are the worst affected. A range of theories exist as to why this is the case. The risk factors described in this chapter apply equally to rural and urban populations; however, people in small rural communities face additional problems associated with distance, greater social isolation, and the relative lack of easily accessible supports and services.

Some rural areas are facing economic hardship and population decline. This may result in a drift of young people from the area and a decline in services. The pressure on young people who have to leave families and move from the country to the city can exacerbate suicidal risk.

Other factors identified as contributing to rural suicides include gender roles that discourage male help-seeking behaviour, limited access to clinical services, the strong sense of isolation, the conservative nature of some rural communities, issues of sexual identity conflict, and ready access to firearms.

Compared with their metropolitan counterparts, non-metropolitan young people have lower participation in:

- Secondary schooling, particularly for those living in remote areas.
- Higher education and TAFE.
- Skills training and award- and industry-based training programs across a range of enterprises.
CASE STUDY

At age 18, James left home in country Victoria to begin an apprentice course in the hospitality industry. He was delighted to have won the position, particularly because he had to face extra stresses such as being unfamiliar with using the intricate city transport system just to get to the job interview.

On a weekend visit home, James started a lengthy argument about how he needed more money to live in the city. He wanted to get into a place of his own, and saw no way of doing that on his present salary. His parents urged him to be patient. James went out that night and when he returned he was still in a huff. Later that night he suicided.

James’s family agonise about what happened. They felt perhaps they had underestimated the stress of moving from the country to the city: the pressures of finding work, or coping in a new and complex environment without a car and having insufficient money.

The tragedy of James’s suicide has drawn attention to the stresses many young rural youth face on leaving home for city living. James’s parents now watch anxiously over their other children and hope that, somehow, James’ death was not in vain.

3.4.6 Non-English Speaking Background Communities

International data shows suicide rates vary substantially from country to country. As shown in figure 2.1 in chapter 2, countries such as Greece, Italy and Spain have relatively low rates of suicide compared with most other developed nations, whereas countries such as Norway, Finland and Latvia have suicide rates higher than those of Australia. It is suggested immigrants to Australia are likely to have similar rates of suicide to those existing in their country of origin.

3.4.7 High-Risk Groups

The previous sections identify some of the factors that have been found to contribute to the risk of suicide or non-lethal suicidal behaviours including psychiatric conditions, substance abuse, relationship breakdown, family background, socioeconomic and biological factors. The interaction of such factors may help to explain why certain groups within the Australian population are vulnerable to suicide at higher than average rates.

Populations of special concern include:

- Males over 80 years.
- Aboriginal people.
- Young males aged 20–24 years.
- The homeless.
- People with HIV/AIDS.
- People in custody.
- Gays and lesbians.

The reasons for elevated risk in a particular population are multiple and complex, and high-risk categories often overlap. It is important to recognise a comparatively high statistical risk in a certain population (based on past trends) does not translate into a risk for all members of that population.

As noted earlier, suicide knows no age, gender, cultural, occupational or socioeconomic boundaries. Within the community, the social circumstances of some groups place them at higher risk than others. Some of these groups, identified as having elevated risk of suicide, are discussed below, but not in order of priority.

3.4.7.1 Aboriginal and Torres Strait Islander Communities

Submissions received by the Task Force indicate there is limited data on the level of suicide risk among Aboriginal and Torres Strait Islander communities in Victoria. No data on Aboriginal youth are available through the Office of the State Coroner, and it does not currently ask about Aboriginality as a matter of course.

The Australian Institute of Health and Welfare reported suicides and homicide account for 5 per cent of Aboriginal and Torres Strait Islander male deaths and 3 per cent of female deaths compared with 2 per cent in the total
Australian population. The institute also found the indigenous youth suicide rate was 1.4 times that of non-indigenous young people.

The limited evidence available suggests youth suicide rates are much higher for indigenous people. Data in the report *A Comprehensive Study of Suicide in Queensland 1990–1995* showed rates of suicide for 15- to 25-year-old Aboriginal and Torres Strait Islanders (ATSI) were more than 65 per cent higher than for non-ATSI groups of the same age.

Victorian Aboriginal hospital liaison officers reported 65 Koori deaths in 1994, of which three were recorded as being due to overdose. Anecdotal evidence from the Victorian Aboriginal Community Services Association Incorporated (VACSAI) indicates there have been 33 Koori youth suicides or suicide-related deaths in the Melbourne metropolitan area over the past three years. The Victorian Aboriginal Funeral Service suggests there may be one or two youth suicides a year.

The Task Force is unable to verify the accuracy of these figures due to widespread underreporting of Aboriginality in suicides, particularly in remote areas, and the limited data collected for Victoria. Therefore, the full extent of the problem cannot be delineated until more data are available.

In their work on suicide among Aboriginal and Torres Strait Islander peoples, Raphael & Martinek (1994) and Radford et al. (1990) draw attention to the impacts of socioeconomic problems on indigenous people and the isolation they experience in urban communities.

These research findings were confirmed by comments made by participants in the Aboriginal community focus groups commissioned by the Task Force. A common response was the generic risk factors discussed earlier in this chapter were all of significance ‘ten times over’. The view was also expressed that ‘being born Aboriginal puts you at risk’ because of the unique mixture of social, cultural and economic factors, including:

- Unresolved spiritual and emotional anguish as a result of the effects of settlement by Europeans and successive government policies.
- Loss of identity as a Koori person.
- Perceptions that Koori people are unemployable.
- Regular experiences of racism and discrimination.
- Expectations that Koori people will fit into mainstream societal structures and no recognition of the validity of their cultural values.
- Family breakdown and dislocation.
- History of interaction with the welfare and criminal justice systems.
- Drug and alcohol abuse.
- Limited number of relevant programs and services to access when needed.
- Lack of trained Koori counsellors.

All these factors were seen as contributing significantly to a sense among young Koori people of powerlessness, alienation, and of having no future, which may precipitate a decision to end life. Consequently, reducing the risk of suicidal behaviours among indigenous people relates closely to preserving their culture and to more broadly defined levels of social wellbeing.

### 3.4.7.2 The Homeless

Victorian studies indicate homeless young people have high rates of suicide attempts as they are more likely to experience clusters of risk factors including substance abuse, psycho-social problems, sense of loss, life stressors, diminished access to primary and mental health care, education and training.

### 3.4.7.3 People with HIV/AIDS

People living with AIDS may be at greater risk of suicide. Rates of suicide among US AIDS patients in California, New York and Texas have been found to be extraordinarily high (Baume, 1996). They may suffer depression and consider suicide because they are in chronic physical pain, or because they are socially isolated in a way that seriously impairs their quality of life. Submissions to the Task Force have supported this view.
3.4.7.4 Offenders in Custody

For most prisons around the world, suicides in prison populations are significantly higher than suicides in the general community. Suicides in the Victorian juvenile justice system are, in fact, extremely rare. Modifications have been made to the physical environment of Victorian prisons following the Muirhead Inquiry into Aboriginal Deaths in Custody. However, prison populations remain a group at high risk, within custody and particularly during the period immediately following release from secure confinement.

3.4.7.5 Gay, Lesbian and Bisexual People

US research suggests rates of attempted suicide among gay and lesbian people may be as much as six times higher than for the population as a whole. Studies have indicated 25 per cent to 40 per cent of young lesbians and gays have attempted suicide, and that 65 per cent to 85 per cent feel suicidal (US Task Force on Youth Suicide, 1989; Rotheram-Borus et al., 1994). Submissions to the Task Force have also indicated gay and lesbian youth have significantly higher rates of other risk factors (Gibson, 1989; ALSO Foundation, submission to Task Force).

Risk is believed to be particularly high for adolescent gays at the time of acknowledging their sexual orientation, and exacerbated by being subject to community violence, loss of friendship or family rejection.

Case Study

At a community consultation meeting in rural Victoria, the Task Force heard from a speaker who was raising concern about the suicide of gay and lesbian young people whose secret sexuality is ‘tearing them apart to the extent that they believe the easy way out is to take their own lives. Rural people are isolated, but young gay people living in rural communities are particularly isolated and they are struggling with this issue from an early age.

‘Approximately one in 10 people are gay, and in today’s society people discover their sexual identity and come to terms with it at an early age. They do not get any help through the education system, and often cannot speak to their families about the problem. Society is still homophobic, and these young people do not receive any support. It is an important issue and something needs to be done about it.

‘Parents must think how they would deal with a gay son or lesbian daughter. When confronted with the knowledge that their teenage son is gay or their daughter is a lesbian, the majority of parents disown them, kick them out of home and cut off all family ties. Many parents would make their children seek an appointment with the doctor or the psychiatrist in an attempt to cure them. Very few parents accept their sons or daughters for who they are.’

Gibson (1989) estimated gay and lesbian young people account for as many as 30 per cent of completed youth suicides each year. He attributed the problem to a society that stigmatises homosexuality and fails to recognise a substantial number of young people have a gay or lesbian orientation.

Theoretical models linking suicide risk to stress and alienation tend to support this view, although further research is required to clarify the epidemiology of suicide and attempted suicide among gay men and lesbians. Moreover, confirmation of the role of sexual orientation as a causal factor in completed suicides is complicated by the fact that the stigma of identification may limit its recording.

The stress caused for gay and lesbian people who have not ‘come out’ is believed to place some at risk. While comprehensive data on gay and lesbian suicide risk is limited, written and oral evidence provided to the Task Force suggests they are a particularly high-risk group, especially in rural areas.