

2014-16: Suicide and Contributing Factors in the ACT, Abridged Summary

Disclaimer

In 2013 ACT Health commissioned the Australian National University (ANU) Medical School Academic Unit of Psychiatry and Addiction Medicine to undertake research to improve knowledge of suicide in the ACT. The work commenced in 2014, and the final report was received by ACT Health on 21 December 2016.

The project examined instances of suicide that occurred in the ACT between 2006 and 2013. The review looked to establish an understanding of the data including associated characteristics, demographics and circumstances of these cases. The health services used by people in the five years leading up to their suicide were also investigated. The project analysed input from clinical staff and members of the community (including people affected by suicide) on what they considered to be helpful and not helpful in suicide prevention, risk assessment, management and support. The research activity of each component was approved by a Human Research Ethics Committee.

This activity has been summarised for release on the ACT Health website. The entirety of the Final Report (the Report) has not been approved for public release due to the following reasons:

- The Report contains sensitive and potentially re-identifiable information pertaining to the small number of participants that is not suitable for release;
- The Report does not propose to provide a comprehensive conclusive understanding of the core issues and does not provide robust methodology to draw reliable conclusions as a stand-alone analysis;
- Service data has not been approved for release due to issues with data integrity;
- The nature of the final Report may vary from the original ethics approvals; and
- The Report was incomplete in a number of content areas.

The Report does not reflect the views of ACT Health in regard to the assumptions and conclusions of the Report or the personal opinions captured. The Report provides point-in-time qualitative data that should be considered as one factor when developing a Suicide Reduction Framework for the ACT.

Instead of continuing to finalise the Report, ACT Health is engaging the Black Dog Institute to implement a Lifespan Suicide Prevention Framework for the ACT. This Framework will indicate where future research activity should be supported, amongst a number of other evidenced-based strategies for a localised response to suicide in the ACT.

The Summary has been provided publicly on this website as an acknowledgment of the sincere information and stories collected. ACT Health acknowledges that it provides part of the narrative that strives to better understand suicide in our region. However, the Report does not reflect all the priorities ACT Health has identified in relation to suicide and suicide prevention in the ACT. Furthermore, ACT Health acknowledges that there are a number of diversity groups vulnerable to suicide that aren't considered in sufficient detail in this summary and they need to be prioritised in any ACT future Suicide Reduction Framework.

Questions or Concerns

If this Abridged Summary raises any mental health and well-being concerns for you or others, please contact and seek the assistance the appropriate health services such as your local mental health services, your GP or the following 24 hour information and crisis services:

- Lifeline - 13 11 14;
- Suicide Call Back Service - 1300 659 467;
- Kids Helpline (for young people aged 5 to 25) - 1800 55 1800; and
- ACT Mental Health Crisis Assessment and Treatment Team - 1800 629 354.

If you have any concerns or complaints about the conduct or content of this study, please contact the Human Research Ethics Committee (HREC) secretariat who is nominated to receive complaints about research projects. You can contact the HREC secretariat by phone on 6174 7968 or by email ethics@act.gov.au

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ACT Health would also like to express our sincere thanks towards volunteers and participants who contributed their time, experience and knowledge to this important work.

Introduction

The ACT has the third lowest standardised suicide rate of all Australian states and territories [1]. The Personality and Total Health (PATH) Through Life Project [2] surveyed people from the ACT and surrounding region about mental health and suicide. Suicide statistics are routinely reported by the Australian Bureau of Statistics (ABS) [3, 4, 5] and have been reported by the Australian Institute of Health and Welfare (AIHW) [6]. The ABS reports that each year an average of 34 people (15 years and older) are recorded to die by suicide in the ACT [4]. This data is sourced from coronial data. The experiences of people who have attempted suicide are explored further in SANE Australia's Lessons for Life report [7] and in other notable research [8, 9]. However, these reports have an overall national focus and although they include state/territory comparisons, they do not provide complete information specifically by jurisdiction.

The literature recognises that people with mental illness have higher rates of suicide than other populations. However, not all people who suicide have a diagnosable mental illness. In one study of coronial data in the Northern Territory, mental illness was identified as a trigger for suicide in approximately 30% of deaths [10].

Of course, suicide affects not only the people in distress who have died from or attempted suicide, but also the people who love and care for them. A recent report presented findings from a national survey on Understanding the Exposure and Impact of Suicide in Australia [12]. This survey found that 85% of respondents were exposed to at least one suicide death. For 54% the person who died was not kin, and for 46% the deceased was a member of their family.

The primary intention for commissioning the study was to gather information on suicides in the ACT for suicide prevention related policy making. Local analysis may provide an insight into suicide in the ACT and some of the differences between the ACT and other jurisdictions in a snapshot of the Territory. It is also valuable to understand the impact of suicide on the community from the point of view of people who have a lived experience of suicide.

Fundamentally, this study aims to inform suicide prevention policy making by highlighting the impacts of grief and some of the challenges with the coronial process. It is not an investigation into services and does not seek to point out successful interventions or policies.

Methodology

The research design adopted a mixed-methods approach, utilising both quantitative and qualitative methods. Through four components, the research gathered information in the incidences of suicide in the ACT since 2006 as well as seeking insights into the circumstances that led up to the death in these cases.

In component one, the National Coronial Information System Database (NCIS) for ACT suicide data from the years 2006 to 2013 was investigated to identify the number of residents of the ACT who died in the ACT as a result of self-inflicted harm. Descriptive statistics were used to better understand the prevalence and nature of suicide in the ACT. Specific analysis was undertaken in relation to children and people who identified as Aboriginal and Torres Strait Islander to identify numbers and common factors or issues.

To identify adults, a search was conducted in the NCIS database for deaths in the ACT between 1/1/2006 and 31/12/2013 with recorded intent of injury at notification or case completion set at intentional self-harm, undetermined, still enquiring, or unlikely to be known. This yielded 344 cases. For the 64 cases where ruled intent was unclear (i.e., undetermined or unlikely to be known), police and autopsy reports were examined to determine whether they were possible suicides or deaths as a result of self-inflicted harm.

Cases were excluded from analysis if there was no evidence of self-inflicted harm (these excluded cases were largely deaths due to undetermined medical reasons), if cases were open at the time of extraction (due to insufficient data), or if residency was not in the ACT.

In component two, the individual level information gained from the statistical data was then matched against ACT Health databases, including those for emergency departments, inpatient units, and mental health services. This task was undertaken to provide quantitative information about the person's contacts with ACT Health in the five years prior to their death.

Components three and four provide the qualitative elements of the Report. Component three consisted of interviewing clinicians to identify their perspective on suicide prevention based on their clinical experience and observations. Component four consisted of interviewing people with lived experience of suicide to also gain their perspective on elements relating to suicide prevention.

Results

Quantitative Analysis of Suicide

- The NCIS was searched to identify people who died as a result of self-inflicted injury. The identified sample was 280 residents of the ACT, who died in the ACT, as a result of self-inflicted injury.

Gender and Age

- Three-quarters of those who died were male (N Males = 210, 75%, N Females = 70, 25%).
- Variability was found across life stages, with the sample aged from teenagers to people in their 90s (Mean = 44.7, Median = 42.0, Std.Dev. = 17.9).
- 30-49 year old people were the highest percentage of deaths (N = 118, 42.1%; Table 2).
- For males, the highest percentage of deaths was among 30-49 year olds (N = 91, 43.4%).
- For females, the highest percentage of deaths was among 40-59 year olds (N = 33, 47.1%).

Identity and Culture

- 5 people were recorded to be of Aboriginal and/or Torres Strait Islander origin (1.8% of sample).
- 17% of people were born overseas. Of those, 68% had lived in Australia for 20 years or longer.
- Gender difference did not exist among young people who suicided - boys and girls were equally represented.

Marital Status

- Most people in the identified sample were unpartnered (60%).
- This pattern was seen among males, with 123 (58.6%) unpartnered and 76 (36.2%) married.
- It was also seen among females, with 45 (64.3%) unpartnered and 20 (28.6%) married.

Employment Status

- As a whole, 46.4% of the sample were out of the workforce, being unemployed or retired/on pension
- For males only, 48.6% were employed (N = 102) while a similar number were out of the workforce (N = 95, 45.2%).
- For females only, 50.0% were out of the workforce (N = 35) while a smaller proportion were employed (N = 26, 37.1%). Being engaged in home duties did not account for the difference seen for females compared to males.
- 59 people (21%) were retired or pensioners, while only 40 people (14.3%) were at the retirement age of 65 years and older.

Method of Injury

- Suicide deaths showed the same methods were used by males and females but a different trend of usage was identified by gender.

Location and Timing of Injury

- Three-quarters of the people who died injured themselves at home.
- There was no clear pattern for whether injuries causing death occurred on particular days of the week. A greater number of people injured themselves on a Monday, followed by Saturday and Thursday.
- The findings highlighted that people can be at risk of suicide across any day of the week and any time of year. The day or month they cause injury is therefore likely to be an individual decision.
- The same is shown for whether injuries occurred more frequently in any particular month. It is often said that people are more likely to harm themselves during holiday periods, such as December/January. However, it was not the case that December/January had higher frequencies of injury resulting in death. Rather, injuries appeared to occur with similar frequency throughout the year.

Young People

- 10 young people aged 14-17 years were recorded to die by suicide in the ACT from 2001 to 2013.
- More suicides were recorded in recent years: 5 deaths occurred in the 4 years from 2010 to 2013.
- Males and females were equally represented. This is unlike the pattern for adult suicides.
- Alcohol and drugs were generally not taken at time of death.
- Many of the young people were dealing with mental health concerns and the areas of life stress faced by most teenagers, such as family and school issues.
- Half of the young people had previously expressed suicidal ideation to others, most often to friends or partners and sometimes to parents. Almost half the young people had previously made an attempt to end their life or taken actions towards it. About half of the young people had deliberately hurt themselves in the past, as reported by family or friends or observed at autopsy.
- For approximately a third of the young people, no identifiable issues were found relating to mental illness, behavioural problems or significant life stress. These were either ruled out after interviews with loved ones or unidentified due to lack of information about such issues.
- The research examined contact with all public health services over the previous five years prior to death. 94% of the target sample was identified to have a matching record within the ACT Health records system.

Qualitative Analysis

- Participants raised the role of emotions in suicide and described the effect that strong negative emotions may have. Three key groupings of emotions were identified:
 - Grief and loss.
 - Depression (including failure).
 - Loneliness or perceived rejection.
- Participants raised some issues specific to Canberra, including a perception that it is difficult to build social connections, that the design of the city contributed to a lack of social interaction and that the reliance on public service employment can bring challenges, with job losses having a particular impact on people in the community.
- Having a mental illness was suggested by participants to have a role in suicide. This included references to mental illness in general, specific mental disorders, and substance use and comorbidity. This has implications for community education about mental illness and access to effective help for suicide prevention.
- Aside from the presence of a mental illness, the intensity, nature and impact of a person's symptoms were suggested to be a factor. For example, a worsening of symptoms or sustained period of symptoms with no improvement may be a factor. This has implications for access to effective help and early intervention for suicide prevention.
- Participants suggested a person's self-worth is an important factor.
- A person's characteristic style included a range of attributes that contributed to their individuality. This included personality, coping style, needs, thinking style and occupying thoughts, thoughts about suicide, and tendency to engage in impulsive behaviours.
- Participants suggested that life events can impact on the inner experiences of an individual and contribute to emotional pain. Suggested events included early trauma in childhood, relationship breakdowns, work problems, job loss or unemployment, financial problems, homelessness or accommodation issues, or physical illnesses.
- Although participants suggested particular events or circumstances, overall they described a combination or series of events to be most damaging.
- A person's relationships, connections, supports and impact of social isolation or perceived isolation was a significant theme. All 27 participants raised this and the theme was brought up the most number of times: more than double the number of times of the next most commonly raised theme.
- Difficulties in existing relationships, lack of connections and social isolation were all suggested to have an impact on people's wellbeing and to contribute to suicide. The types of connections suggested to be important ranged from family support, support networks and connections, supportive people, and groups.
- Having and maintaining connections was raised as having an important role in prevention and recovery, as was the involvement of carers in times of risk

- A key theme identified in participants' transcripts was having:
 - Hope in life – such that life events and internal experiences could wear down a person's hope. Hope was also about having options in life, such that there were alternatives to the person's current state or pain and the person could choose these options to change their circumstances. Without these options, and without hope, people may think of suicide as the only real option or solution to their pain.
 - Social networks – such that social isolation could negatively impact a person's hope and social contact and connections were important in helping the person to build hope.
 - Responses to suicide risk and recovery – supports that helped the person to build hope were seen as very helpful, whether this came from carers, family, friends, social networks or professionals delivering health services.
- Participants indicated that suicide can be a considered solution to pain and problems of life. Here, suicide may present as a considered, thoughtful process. A person can have emotional and life pain, feel there is no hope for the future, and think they may be out of options (as described above). Therefore some might see suicide as the only real solution they can see at that point in their lives. However, although it may be a considered thought process, participants indicated this is a function of the moment and the person's distress. Thus there may be other options that the person, during that time, cannot see.
- Analysis of interview transcripts with people with lived experience revealed their experiences of recovery after a suicide attempt. These findings were raised by some participants as they chose to share their own experiences of having attempted suicide and their recovery from a suicide attempt. These discussions emphasised that recovery is a process that occurs over time and that relies on small action steps that build empowerment, hope, achievement and connection.
- Reports for half of the young people indicated school-related stress, such as feeling "overwhelmed" at school and difficulty keeping up with the work load. School difficulties are commonly observed in young people with mental disorders and are considered in diagnosis. Thus, it is not known whether stress over school was an issue in itself or whether perceived stress at school was associated with the presence of a mental disorder.
- For half of the young people, observed or perceived family disconnect was identified, including estrangement from a parent, being placed out of care of parents, feeling disconnected from family, communication difficulties, or parental depression. However, as reported above, most were living with parent/s and siblings, and few were identified to have significant or sustained family disruption.
- For half of the young people, the analysis identified moods or emotions the individuals likely experienced. This information was identified in police reports containing interviews with family and friends as well as personal expressions of distress written by four of the young people themselves found by police. These were diary notes, poems, drawings and suicide notes. The most common emotional groupings reflected:
 - Sadness (including depression, despair, feeling down and unmotivated);

- Disconnection from love (including grief, feeling disconnected from others, unloved, burdensome);
 - Negative self-focus or demoralisation (including self-pity, guilt, regret, jealousy, psychological pain); and
 - Anger (including agitation and hate).
- Unhelpful responses from other people were being dismissive, trivialising, being judgmental, over-reacting and only providing solutions. Helpful responses from others were acknowledging and validating, being a safe support person, and referring to competent professionals.
 - Unhelpful (if absent) and helpful (if present) aspects of service teams were consumer and carer involvement, providing carer supports, care plans and follow-up, and peer consult for clinicians.
 - Unhelpful aspects of service structures were simplistic assessment procedures and risk driven care. Helpful aspects were holistic care centres and access to quality care.
 - Stigma from the community was considered unhelpful and was suggested to contribute to shame and silence.
 - Participants suggested it was much more helpful for people to respond with compassion and understanding.
 - Helpful responses from others were acknowledging and validating, being a safe support person and being competent.
 - Participants suggested the involvement of carers and loved ones in care was extremely important. This was suggested by all participant groups: those with personal lived experience of suicide, those bereaved by suicide, and clinicians.
 - Providing supports and information to carers and loved ones was suggested by participants to be very helpful, both in supporting care plans and assisting carers to support the person at risk. The application of privacy legislation was considered by participants to be over zealous at times and it was suggested that this can limit carer involvement that could otherwise be helpful.
 - Participants suggested that developing effective care plans that are personalised and involve follow-up, especially after discharge from hospital, would be helpful for both the person at risk and carers or support people.
 - It was noted that the competence of clinicians and workers was identified by participants to be helpful. Clinician participants suggest that access to peer review teams is very helpful for clinicians, to improve skills, guard against burnout and develop care plans.
 - A related theme raised by clinicians was the difficulty of being able to accurately predict risk of suicide. Therefore they suggested that the provision of care that was based on simplistic risk assessment processes is very problematic.
 - Participants suggested that holistic care centres are helpful for recovery that focuses on a person's overall wellbeing, including accommodation, finances, nutrition, participation and social engagement, and spirituality.

- During interviews participants raised the problem of stigma from people in the community. This stigma was described to relate to suicide, where a person struggling with thoughts of suicide or recovering from a suicide attempt felt stigmatised, as well as stigma related to mental health issues and mental illness.
- Participants suggested that education for the community and in schools would be a useful strategy for suicide prevention. Participants suggested that important messages in this education were around understanding mental health and emotions, understanding thoughts of suicide, and knowing when, where and how to get help.
- Participants described the usefulness and value of having the stories of people with lived experience of suicide shared and available to others. Participants suggested that sharing stories of individual experiences would be helpful for people struggling with thoughts of suicide and towards recovery. This theme could be included with other suggestions from participants on what could be helpful however because sharing the lived experience has a broader structural element in the way it was described by participants during interviews, it is better described here as a suicide prevention strategy for the community. Participants suggested that stories from people with lived experience of suicide could be shared broadly as part of educating the community.
- Participants suggested that the development of a peer support or buddy program might be beneficial for people struggling with thoughts of suicide and their recovery.
- Some participants also referred to the intense experience of being a support person or carer of a person who has thoughts of suicide or has attempted suicide. They described despair, burnout and powerlessness.
- For people bereaved by suicide, they must not only face the intense sadness, grief and distress of losing a loved one, but may also be involved in a coronial process lasting even several years after the death.

Discussion

The Report provides a unique insight into suicide in the ACT. For example, it captures information about the significance of whether a person is single, partnered, in the workforce, have had contact with mental health services, or have a diagnosis. This is not captured in ABS and AIHW data or other available information on suicides.

Findings are consistent with suicide statistics from other jurisdictions and nationally showing that:

- Men are over-represented in suicides [3, 5, 6].
- The highest proportion of suicides occur during mid-life [3, 5, 6].
- A very large proportion of people who die by suicide do not have a partner [11].
- The unemployment rate is high among people who suicide.

The Report concludes that suicide is an individual human experience. There is not one identifiable factor contributing to suicide in the ACT.

The insights touch on the impact of suicide and why people suicide and highlight the impact of grief and challenges with the coronial process, including how the length of that process can contribute to a person's grief.

Rather than being an investigation into services designed to point out successful interventions or policies, the Report provides an insight into what went wrong for the people involved. This information may be useful when targeting suicide interventions.

The information provides policy makers with useful statistics to guide ACT specific interventions and policies. For example the research revealed that:

- Suicide in the ACT is across the age span. Of the young people (14-17 years) that died by suicide between 2001 and 2013, males and females were equally represented. This indicates mental health and wellbeing promotion and specific suicide prevention needs to be equally targeted at males and females in this age group.
- A majority of the young people who died by suicide were either diagnosed or described as having one or more mental disorders commonly diagnosed in young people in this age group. This highlights the risks associated with young people with anxiety and/or depression.

The Report identified key themes relating to suicide vulnerability. The first theme related to the person and their experience of trauma and life events, emotional or life pain, and negative emotions. The second theme was in relation to a person's networks and social isolation. The third theme related to hope and life options. These themes align with other research available.

This information and the key themes may be useful in identifying possible key communication messages. For example, the information highlighted that over half the males who suicided were not employed, so communications should not just be targeted in workplaces.

Research exploring views on issues relating to suicide within the Aboriginal and Torres Strait Islander community was unable to be completed as intended as part of the Report.

It is recommended that specific views regarding the impact of suicide and culturally appropriate approaches to suicide prevention are explored within the ACT Aboriginal and

Torres Strait Islander community. It is recommended that future qualitative research is conducted in partnership with the ACT's Aboriginal community so as to better understand the impact of suicide in the community, the issues that may be associated with suicide and the types of culturally appropriate suicide prevention and bereavement approaches that can be supported within the community.

The Report found that 52 per cent of people who suicided had no previous contact with mental health services in the five year period before their death. ACT Health is currently looking at options to reach these people. Research to date indicates we need to continually promote mental health and wellbeing across the lifespan. Education, reducing stigma, screening and help-seeking are big components of suicide prevention.

Successful suicide prevention relies on support and intervention from other areas outside of the health sector. Policy making can promote the role of the above in services outside of the remit of the health sector where there is likely to be contact with people who are at risk.

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