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Suicide in Australia: some good news

Robert D Goldney

Current data are encouraging, but no reason for complacency

Since 1997, when the number of Australians committing suicide peaked at 2720, there has been a sustained reduction in the number of suicides each year. The most recently available figure — 2098 suicides in 2004¹ — represents an age-standardised suicide rate of 10.4 per 100 000 population, 29% lower than the rate of 14.7 per 100 000 in 1997. The figures are even more striking for people aged 15–24 years, for whom there was a reduction in suicide rates of about 50% — from 19.3 to 9.6 per 100 000 between 1997 and 2004.¹ These figures have not achieved the media publicity that they warrant.

Although suicide accounts for only 1.6% of all deaths in Australia, it comprises more than 20% of deaths for men aged between 20 and 39 years, and men remain four times more likely than women to die by suicide, with overall age-standardised rates of 16.8 and 4.3 per 100 000, respectively.¹ The reduction in male and female suicide rates has been similar: 28.8% for males and 30.6% for females between 1997 and 2004.¹ Remarkably, there was a reduction in all 5-year age groups for men and women between 1997 and 2004, except for women in the 45–49-years age group, for whom the rates were 7.0 and 7.1 per 100 000, respectively.¹ The highest suicide rates in 1997 were for men aged 15–34 years, and in 2004 the peak was in that same group of men, now aged 25–44 years. This is consistent with a “cohort effect”, with that group carrying forward their increased propensity to suicide, a phenomenon noted previously in Australia in 1983.²

Methods of suicide have changed between 1997 and 2004, with the proportion using firearms reducing from 12.1% to 8.1%. This has been a continuing trend over the past 25 years, although it appeared to accelerate following the enactment of stricter firearms legislation after the Port Arthur massacre in 1996.³ In contrast, hanging has increased from 36.3% to 47.6%. This is of particular concern, as legislating against hanging is difficult, and it probably requires an education program to bring the dangerousness of hanging to the attention of the community. Poisoning by drugs has remained relatively constant (11.4% of suicides in 1997 compared with 10.9% in 2004). This is reassuring and is consistent with recent data, which have allayed previous concerns that use of antidepressants could be associated with suicidal behaviour.⁴

Naturally, there are always reservations in interpreting data of this nature. The figures are for deaths registered in each calendar year rather than the year they occurred, and about 7% of suicides over the past decade have not been registered until the year after they occurred.¹ It is also possible that coronial practices and medical certification of cause of death may have changed.

Notwithstanding such caveats, these most recent figures are gratifying, particularly in view of Australia-wide initiatives in the past decade to reduce suicide.⁵ The question arises of what may have been the reason or reasons for this reduction. The problem in determining this is that there is no clear-cut cause of suicide. Furthermore, even though suicide may seem all too frequent when it occurs, and retrospective analysis may suggest a plausible precipitant, the low base rate of suicide and ethical constraints preclude randomised controlled trials to assess the effectiveness of any one prevention program.⁶

Nevertheless, it can reasonably be assumed that the causes are several: better community awareness of both the antecedents of suicide and the fact that suicide prevention is possible has probably played a role, along with the provision of more accessible services. More specifically, it is likely that programs promoting better recognition and treatment of depression (the mental disorder most commonly associated with suicide) are paying dividends. That this is so is suggested by the research of Hall et al,⁷ who found an inverse relationship between antidepressant prescribing and suicide, and concluded:

The increase in antidepressant prescribing may be a proxy marker for improved overall management of depression. If so, increased prescribing of selective serotonin reuptake inhibitors in general practice may have produced a quantifiable benefit in population mental health.⁷

This observation is consistent with the recent report by Ludwig and Marcotte,⁸ who, after analysing antidepressant use and suicide rates in 27 different countries, calculated that the rate of suicide for those 27 countries would have been 17% higher in 1999 than in 1990, but for the introduction of newer antidepressants.

Although these latest Australian Bureau of Statistics data are gratifying, they are no reason for complacency, as illustrated by the increase in suicide in the Northern Territory reported by Measey et al (page 315).⁹ Furthermore, the general reduction in suicide rates does not negate its tragedy for the individuals and families affected. Continuing vigilance is required, with ongoing acknowledgement and acceptance of the unique role and responsibility that medical professionals, particularly general practitioners, have in identifying and treating the mental disorders, particularly depression, that are associated with suicide.

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