AUSTRALIAN INSTITUTE OF CRIMINOLOGY

trends & issues

in crime and criminal justice

No. 52
Social Factors in Suicide in Australia

Riaz Hassan

Every day there are about 6 suicides in Australia, and a further 180 attempts. Notwithstanding the enormous personal and family emotional costs, and the great financial costs, suicide is a significant concern for the criminal justice system.

Since 1964, suicide rates in Australia for females (except teenagers) have fallen dramatically, and for men over 30 have fallen significantly. For teenage boys the rate has tripled, for men in their early twenties it has almost tripled, and for those in their late twenties it has increased by more than two-thirds. Young men of these ages are also the prime focus of the criminal justice system.

When we combine this with Institute findings for the period 1990-95 that 43 per cent of deaths in custody or custody-related police operations were the result of suicide (again predominantly young men), and Institute homicide data for the period 1989-93 which indicate that 7 per cent of identified offenders committed suicide after a homicide event, we have a picture of despair, despondency and "aimlessness" which cries out for preventive programs. The criminal justice system can focus on part of the problem only, and collaborative work with other agencies is needed in order to have any effect on the incidence of suicide.

Adam Graycar
Director

Suicide is a major social and public health problem in Australia. Since 1990, suicide has become more common than motor vehicle accidents as a cause of death for Australian men. The rate of suicide among young adult and adolescent males has been increasing gradually for the past 25 years. Among 15 to 19-year-old males it is now the leading cause of death. As a result of these trends the median age of suicide victims has been gradually declining since 1971.

According to a report by the National Health and Medical Research Council, the suicide rates in Australia are "at an unacceptably high level". The same report also estimates that in Queensland alone suicide costs due to loss in productive life-years lost is around $40 million. Extrapolated to the whole country, this represents an enormous cost. When it is considered that there are around 30 parasuicides in Australia for every completed suicide these costs increase dramatically. The loss, pain and grief suffered by family, friends and the community is far greater and more profound than the economic loss.

Notwithstanding its seriousness as a social and health problem, the study of suicide in Australia is relatively underdeveloped. It is generally viewed as one of the major forms of mortality from mental illness. This is reflected in most of the

February 1996

ISSN 0817-8542
ISBN 0 642 24009 4

Australian Institute
of Criminology
GPO Box 2944
Canberra ACT 2601
Australia

Tel: 06 260 9200
Fax: 06 260 9201

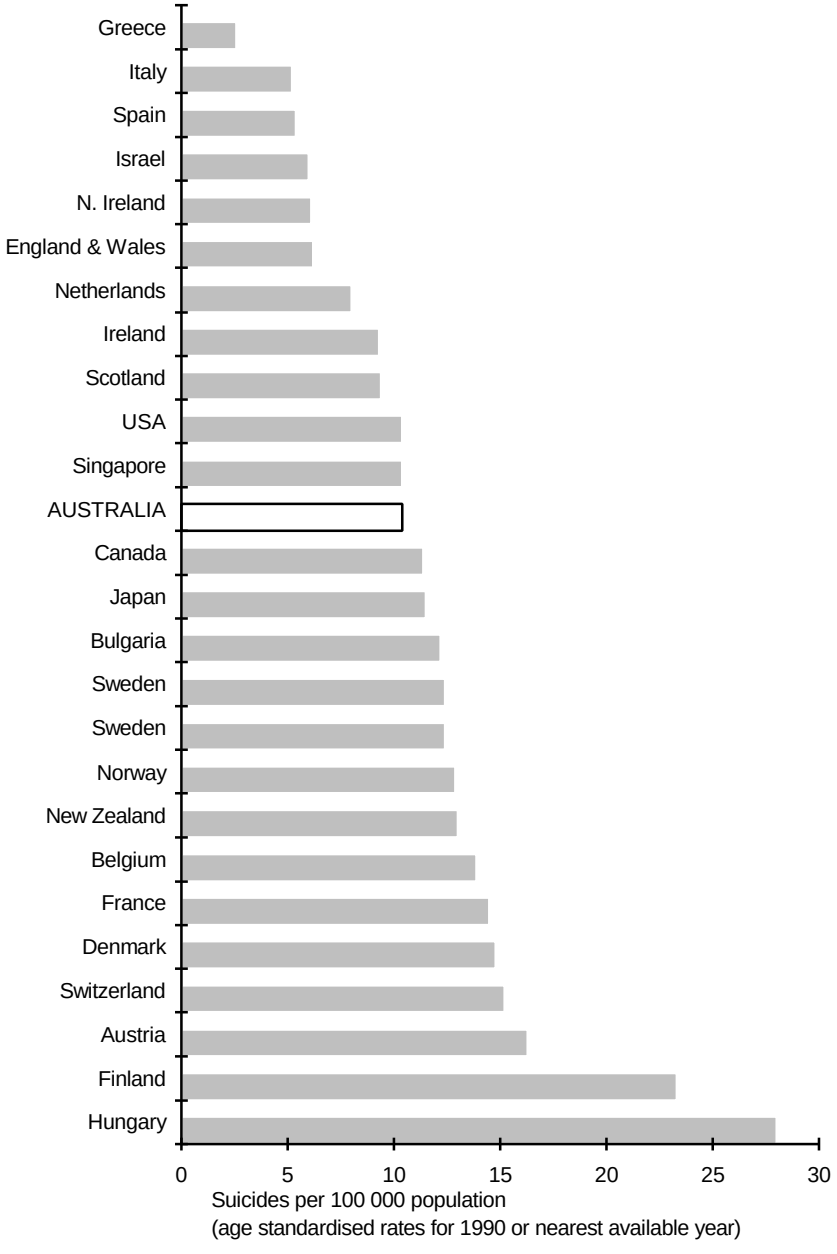
existing studies. Suicide is ultimately a deadly violence against self. The weight of existing evidence indicates that besides the psycho-biological causes, social factors play a central role in its causes and distribution.

The psychological explanations largely focus on "suicide personality" and on depression and aggression as the principal causes of suicide. Psychological theories usually concern some psychodynamic mechanism as the determining factor in suicide. Psychobiologists investigating aggressive, self-assertive and deviant behaviour have suggested that somatic alterations may be an important factor(s). Recent studies in this area have especially focused on the relationship between CSF5-HIAA (5-hydroxyindoleacetic acid) and suicide. It has been suggested by researchers that lower concentration in cerebrospinal fluid of CSF5-HIAA is associated with suicidal behaviour. But the clinical evidence is still a long way from establishing the manner in which paroxysmal or other brain functions influence the development and expression of suicidal behaviour.

Suicide and the Law in Australia

In Australia, the criminal law concerning suicide varies according to the jurisdiction in question. In all jurisdictions, suicide is no longer a crime and, except in the Northern Territory, the crime of attempted suicide has also been abolished. It is, however, still an offence for a person to assist another person to commit suicide or to attempt to commit suicide (the precise wording differs according to the jurisdiction), and if the act occurs as part of a suicide pact, the survivor will be guilty of manslaughter rather than murder in Victoria and South Australia, while in New South Wales such a person will be subject to liability for aiding and abetting a suicide or attempted suicide (*see, generally,* Waller & Williams 1989, para 5.4, pp. 120-1; and Fisse 1990, pp. 131-2).

Figure. 1 *Suicide Rate, Selected Countries, 1990 (or nearest available year)*



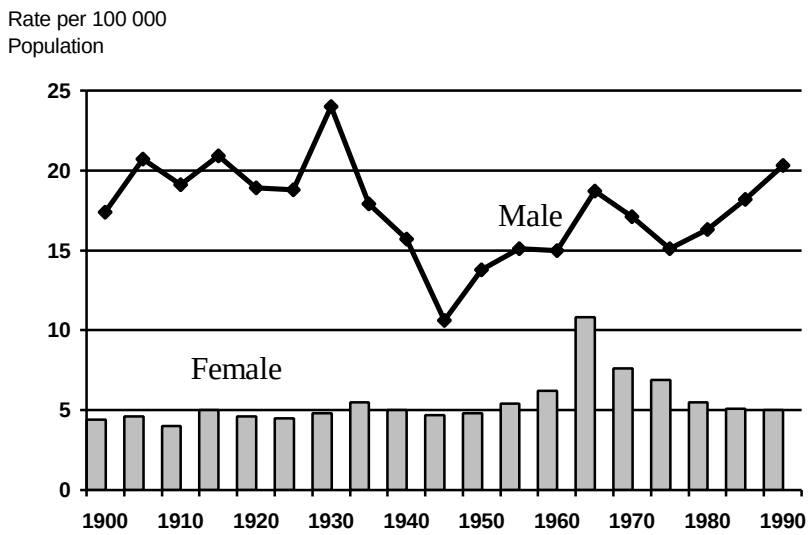
Data Source: *WHO World Health Statistics Annual 1993*, WHO, Geneva

Sociological studies have generally viewed suicide as a product of the nature of the relationship between the individual and society. The relative degree of regulation control, isolation and oppression of individuals in society are seen as the primary causes of varying degrees of suicide rates in different societies. These causes are mediated through social factors. By their very nature social factors are "facts" of society and not of psychobiology. Unlike psychobiological facts, they are characterised by "exteriority", sanctions, meanings and coercion.

Suicide Trends in Australia

In Australia, a verdict of suicide is determined by the state coroners. Under the laws which currently apply, a coroner's inquest is held in order to ascertain the cause or circumstances of any death which has occurred due to violence or under unusual or unknown circumstances. In Australian society suicide generally carries a stigma, which might lead families and professionals to under-report suicide.

***Figure 2**. Male and Female Suicide Rates: Australia 1900-1990*



Data Source:Australian Bureau of Statistics, *Suicide in Australia, Cat. No. 3309.0*, Canberra, April 1983 and special data tabulations

The overall suicide rate in Australia since the middle of the 19th century has increased by about 24 per cent although the number of suicides has increased sevenfold. In 1860, the first year for which reliable data are available, the rate was 10.4 per 100 000 population, in 1990-92 the rate had increased to 12.9. Compared with some of the major European countries and Japan, the Australian suicide rate has remained in the middle range in the last hundred years.

Whilst the suicide rate has fluctuated within a modest range over the last 100 years, Australia's social framework has remained relatively cohesive, despite the enormous socioeconomic and demographic changes which have occurred. Individuals have been cushioned from the disruptive effects of societal change through innovations such as the social security system and cultural patterns which emphasise mateship, equality and an easy-going life style. This is not to suggest that social change has had no disruptive effect at all, but to the extent that one can take the suicide rate as a surrogate for relative social health and well-being, Australia has fared much better than most European countries and Japan over the past century.

It is also important to note that suicide rates have fluctuated over the years and these fluctuations appear to be related to `of social structural change. Recent studies of these fluctuations show that the male suicide rate in Australia since the 1900s appears to be associated with social factors such as the two World Wars and the Depression of the 1930s. As figure 2 shows, during the Depression years Australia experienced a very high unemployment rate and a very dramatic increase in the male suicide rate (to 24 per 100 000 population in 1930). Female suicide rates were not affected to the same degree. A possible sociological explanation for this is the differential impact of unemployment on male and female family roles. The high unemployment during the Depression seriously eroded the customary male role as the economic provider of the family, whereas the traditional family roles such as mother and house-wife became even more important.

The female suicide rate increased from 4.3 to 5.0 per 100 000 population between 1901 and 1990. The fluctuations in these rates have been more complex. Although female rates also experienced very slight decline during the two World Wars and a very slight increase during the Depression, their rates continued to increase gradually through the 1950s and 1960s, registering a peak of 10.8 per 100 000 in 1965. After 1965, the female suicide rate declined dramatically back to the previous levels. By 1985 it had declined by over 50 per cent from its peak in 1965. The decline in female suicide rates appears to be related to the divorce rate, greater female participation in the work force, women's emancipation, changes in the dispensing of hypnotic and sedative drugs following the changes in the pharmaceutical provisions of the *National Health Act* of 1967, advances in intensive care medical technology and welfare transfers.

Recent Trends

The studies of suicide trends over the past 25 years show that suicides have increased dramatically among young males aged 15 to 29 years and have remained relatively high among the elderly (70 years and older). Among male teenagers the suicide rate has increased from 5.8 per 100 000 in 1964 to 17.8 per 100 000 in 1990. Among female teenagers it had increased from 2.9 to 5.0 in the same period. The suicide rate of males aged 20-24 increased from 16.3 in 1964 to 36.1 in 1990, but in the same age cohort among females the suicide rate declined from 7.7 in 1964 to 3.9 in 1990. The suicide rate among elderly

***Table 1.** Suicide Rates per 100 000 Population in Australia 1964 and 1990 by Sex and Age*

	Male		Female	
Age	1964	1990	1964	1990
0-14	0.2	0.3	0.2	0.2
15-19	5.8	17.8	2.9	5.0
20-24	16.3	36.1	7.7	3.9
25-29	19.4	32.8	9.4	6.0
30-34	29.1	25.1	10.7	8.1
35-39	26.3	26.1	14.9	5.3
40-44	34.6	25.1	17.9	6.4
45-49	33.5	20.8	24.4	7.1
50-54	38.4	22.1	21.0	6.5
55-59	34.6	27.7	18.8	6.7
60-64	39.7	22.9	17.1	5.7
65-69	39.7	25.1	21.0	7.7
70-74	36.7	27.7	19.1	8.1
75+	40.0	31.8	8.5	8.1

men and women has remained relatively high. In 1964 the rate for 75 years and older men was 40 per 100 000 and it had declined to 31.8 per 100 000 population which was about 60 per cent higher than the overall male suicide rate in Australia in 1990. The elderly female rates had declined slightly from 8.5 to 8.1 in the same period and this again was about 60 per cent higher than the overall female rate for Australia in 1990.

The evidence about suicide and age suggests that until about 1964 suicide was primarily a problem among the older age groups. By 1990 it had changed. The two groups, the young (15-29) and the elderly (75 and over) have become very high risk age cohorts. Another change since 1964 has been a gradual increase in the suicide rate of men and a decline in the rate for women.

Studies of plausible causes of increase in suicidal behaviour among adolescents and young adults suggest that a number of factors including unemployment, changing family structure, increasing violence and a disjunction between experiential autonomy and citizenship rights appear to have contributed to this trend.

The high suicide rate among the young and the elderly may also be due to the high dependency of these age groups in society. Dependency itself is consequence-neutral but if stigmatised it produces social disruption and disorganisation. The dependency experienced by the young and the elderly in modern societies like Australia is stigmatised due to their reduced ability to engage in reciprocal social exchange as a result of factors such as prolonged unemployment, poverty, disability and ill health. This experience of stigmatised dependency reduces their level of social integration and increases their sense of isolation, thus producing two very potent social factors as contributing causes to their high suicide rates.

Social Factors in Suicide

Explanations of suicide involve a complex interaction between psychiatric and sociological factors. Much of the current debates appear to focus on psychogenic factors. Not much attention is paid to sociological or environmental factors which play an important role in either increasing the incidence of suicidal behaviour in society or reducing it. This part deals with some of the current debates on the role of selected social factors in suicide.

Marital Status. Sociological studies generally show that because of the social and emotional stability and security provided by the "family society", the suicide rate among married people tends to be significantly lower. In Australia, suicide is universally correlated with "domestic integration". Marriage provides the best protection against suicide. In all age groups for men and women, suicide rates are lower for married people. But changing meanings and mores about single status, widowhood and being divorced appear to be positively affecting the suicide rates within these categories of marital status. As a result of this the extremely high suicide rates for people in these groups have registered a decline since the 1960s but they still remain significantly higher than the rates for married people.

Economic Cycles. In this century suicide trends in Australia show a strong correlation between unemployment and the suicide rate. During the Depression, Australia experienced the highest overall and highest male suicide rate. The number of suicides also appear to have increased during the three months before and six months after the stock market crash of late 1987. The incidence of suicide increased during these months by about 15 per cent, although other associated factors may also have played a role.

Occupation. The general pattern in Australia is that those in unskilled and semi-skilled blue-collar occupations which are characterised by low job autonomy, greater external supervision, less on-the-job training, poorer promotional possibilities, lower wage levels and greater sensitivity to market forces tend to have high suicide rates. Furthermore, their suicide rates increase significantly with age. Occupations which are generally high status and have good career paths, and are well paid, have lower suicide rates. Downward occupational mobility appears also to be an important factor in explaining suicide rates, because under downward occupational mobility the "self-image" is impaired and individuals are led to perceive their downward mobility as a sign of rejection and negative evaluation of their self-worth. This increases their sense of alienation and anomie and reduces their level of social integration in society which consequently increases their vulnerability to suicidal behaviour.

Migration and Ethnicity. The suicide rate of overseas-born is significantly higher than Australian-born and among the immigrant groups from different countries suicide rates also vary considerably. The high migrant rates are attributed to the disruption of established social ties which in turn affect the degree of social and community integration. Other contributing factors include a high incidence of mental illness and alcoholism among immigrants. The differences among the immigrant groups can most likely be attributed to family cohesion, sponsorship of the immigrants, size of the group and cultural affinity with the host society. The last factor has a direct effect on the acculturation process. For example, the English-speaking immigrants who find acculturation to Australian mores easier tend to have lower suicide rates than those

who come from non-English-speaking countries. Related factors which may also contribute to high suicide rates among non-English-speaking migrants are downward occupational mobility, high unemployment and a sense of social isolation. Although no reliable data on religious affiliation is available, indirect evidence such as the main religion in the native country of immigrants shows that those from Roman Catholic and Greek Orthodox religious backgrounds tend to have lower suicide rates in Australia compared with the immigrants from primarily Protestant countries.

Suicide rates of Australian Aboriginal people is significantly higher than the non-Aboriginal community. This is primarily due to the devaluation of their culture and self-identity which has done irreparable harm to their social and cultural institutions through which social life is regulated, reproduced and sustained. This devaluation has accentuated a sense of anomie, hopelessness, despair and depression all of which have contributed to a high incidence of self-destructive behaviour. Their condition is further aggravated by poverty, economic insecurity, alcoholism and subjection to racism.

Temporal Variation. The incidence of suicide appears to follow a distinct weekly cycle. Monday tends to have the highest average daily suicide followed by Tuesday, and Saturday has the lowest average. This cycle is more pronounced for men than women. Suicide occurrence also varies by seasons. Spring has the highest daily average followed by summer. These differences are most probably related to density and intensity of social life especially the one related to work, employment and the family. Density refers to the process of continuous social exchange in the group and intensity refers to the degree of social reciprocity among individual consciences involved in the group. The disequilibrium in the density and intensity of social life affected by the distribution of activities during the week produces the conditions which may contribute to the daily variations in the incidence of suicide.

Media. The average daily rate of suicide in Australia increases significantly after the publication of suicide stories in the Australian media. The increase tends to be primarily due to the increase in male suicide. The most plausible explanation of the non-effect of media stories on female suicide is that most of the stories are likely to report male suicides, with which females may be less inclined to identify. This effect may also be produced by the differential exposure to media of males and females and the lethality of methods of suicide used by them.

Public Welfare. As already mentioned, compared with some European countries and Japan, the Australian suicide rate has remained relatively stable in the "middle range". If we consider the suicide rate as a proxy for relative social health and well-being, Australia has fared better than most European countries and Japan. This is largely due to the provision of a comprehensive social welfare system in Australia which has countered the vulnerability of high risk groups to suicide.

Locality. For much of this century suicide rates have been higher in Australian cities than in rural areas. However, in recent years these differences have been gradually declining. Within urban localities suicide tends to be higher in the inner city areas, because of the concentration in these areas of single people, divorced, unemployed, migrant, the aged and people with mental illness, all of whom tend to have higher suicide rates. In rural areas youth suicide has been increasing more rapidly than the urban areas. This is partly attributable to the "rural crisis" which has accompanied the general downturn in the Australian economy. Other reasons include the difficulty of access to health and welfare facilities in rural areas, lack of knowledge of such facilities in the population and an unwillingness of people to seek help in difficult social and economic circumstances due to the idealised stereotype of country people as hard-working, physically rugged and self-sufficient.

Causes of Suicide

Sociological analysis of the causes of suicidal behaviour reveals that in the cases where it is possible to obtain relevant data, about half of the suicides were primarily "anomic"—caused by a social environment characterised by sudden or emphatic changes which impaired the individual's capacity to regulate desires and aspirations. The other half were primarily "egoistic"—caused by social environments which impaired individuals' bonds to socially given ideals and purposes, thus weakening the bonds with commonly shared meanings, collective activity, values and social purposes.

The evidence from Australian studies also shows that "relational" problems (unhappy love, family/marital problems, shame and guilt), "instrumental" problems (financial and unemployment problems, a sense of failure in life) and "health" problems are some of the principal circumstances preceding suicide. Among young women the principal cause appears to be related to "relational" problems; among middle-aged women the problems tend to be the instrumental type followed by health, and among the aged the main causes are instrumental. Among young men the main "causes" tend to be the instrumental factors, followed by "relational" problems among the middle-aged. The evidence also shows that in Australia prisoners and people suffering from life-threatening illnesses tend also to have very high suicide rates.

Methods of Suicide

The selection of methods is determined by convenience, accessibility and socio-cultural factors. But within these parameters there appear to be significant differences between men and women. Women tend to use passive methods most frequently whereas men use more violent methods, although in recent years the use of guns to suicide appears to be declining and a preference for passive methods to be increasing. The severity of gun laws appears to be negatively associated with the use of violent methods, especially suicide by gunshots. The empirical evidence from Australia shows that suicidal behaviour, like other forms of social behaviour, has important symbolic content and in the final analysis it is shaped by the same social forces which influence and regulate the other general patterns of social life.

Suicide Prevention

Suicide now claims one life about every four hours. For every completed suicide there are around 30 suicide attempts. The National Health and Medical Research Council regards the current suicide rates as "unacceptably high" and appointed a Working Party on Suicide Prevention, which considered a national strategy to build on the prevention programs proposed by its Mental Health Committee. Another national organisation, Suicide Prevention Australia, has recently been formed with the explicit purpose of suicide prevention in Australia, and is in the process of formulating appropriate policies and programs.

An effective and comprehensive prevention policy would need to focus both at the primary level of prevention and at the "postvention" level. At the primary level the focus should be promotion of conditions which reduce the incidence of suicide. These should include:

- monitoring of risk behaviours in the community;
- targeting health and welfare policies to high risk groups and conditions conducive to suicide vulnerability;
- promotion of awareness of suicidal tendencies and conditions related to them;
- development and promotion of public policies for reducing access to commonly used methods of suicide, namely gun control, safety and security in tall buildings; access to and types of sedatives prescribed for the treatment of depression;
- training of appropriate personnel for suicide prevention programs; promotion of research on the causes of suicide in Australia.

The postvention level of the program should target the survivors of attempted suicide, and may include the following:

- suicide survival groups;
- helping families of para-suicidal individuals to deal with the action and its consequences;
- delivery of appropriate professional help to para-suicidal people and suicide survivors;
- increasing access to appropriate health and welfare facilities for suicide survivors and para-suicidal people.

It is not beyond our collective abilities and capabilities to institute a suicide prevention program which can reduce this enormous loss of life in Australia by at least 10 per cent. To do so we need to recognise the magnitude of the problem and demonstrate willingness to invest resources to develop suicide prevention programs and train people who can implement them. We need to integrate suicide prevention activities better into our existing programs which focus on a whole range of self-destructive or problem behaviours, especially among our youth, such as drug abuse, interpersonal violence, school dropouts, runaway or homeless youth.

We need to inform and educate the public, the media, the entertainment industry and health services about our current knowledge in diagnosis, treatment and prevention of suicide. Public education should tackle the issue of removing stigma associated with alcohol, drug abuse and mental health treatment in order to increase the likelihood of vulnerable individuals facing these problems to seek help freely.

Bibliography

Fisse, B. 1990, *Howard's Criminal Law*, 5th edn, Law Book Co. Ltd, Sydney.

Goldney, R.D. & Burvill, P.W. 1980, "Trends in suicidal behaviour and its management", *Australian New Zealand Journal of Psychiatry*, vol. 14, pp. 1-15.

Harrison, J.E. & Choi, C.Y. 1994, *Some Dimensions of Suicide Mortality in Australia*, National Injury Surveillance Unit, Australian Institute of Health and Welfare, Adelaide.

Hassan, R. 1995, *Suicide Explained: The Australian Experience*, Melbourne University Press, Carlton South.

Kosky, R. 1987, "Is suicide behaviour increasing among Australian youth", *Medical Journal of Australia*, no. 147, August

Waller, L. & Williams, C.R. 1989, *Brett, Waller and Williams: Criminal Law Text with Materials*, 6th edn, Butterworths, Sydney.

Dr Riaz Hassan is Professor of Sociology at Flinders University of South Australia.

The research on which this paper is based was funded by a Criminology Research Council grant.

Submissions for consideration for the Trends and Issues series should be forwarded to:
Dr Adam Graycar, Director
Australian Institute of Criminology
GPO Box 2944
Canberra ACT 2601 Australia