Suicide in Queensland

Annual Report 2022

Griffith UNIVERSITY
Queensland, Australia

Australian Institute for Suicide Research and Prevention

Suicide in Queensland: Annual Report 2022

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Queensland
Mental Health Commission

The Queensland Mental Health Commission commissioned this report on behalf of the Queensland Government.

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Dedication

The Australian Institute for Suicide Research and Prevention (AISRAP) dedicates this report to people with a living or lived experience of suicide – people who have had thoughts of suicide, survived a suicide attempt, cared for someone through a suicidal crisis or are bereaved by suicide.[1] We acknowledge that these experiences are substantially different for Aboriginal and Torres Strait Islander peoples[2], who understand social and emotional wellbeing in different ways.[3]

Acknowledgements

We acknowledge the Queensland Government for funding the Queensland Suicide Register (QSR) since 1990. We acknowledge the efforts of the Queensland Police Service and the Coroners Court of Queensland to share police reports with us. We acknowledge others who have contributed information in this report: families, friends, police, forensic pathologists, registrars and coroners. We also recognise the many people who support these roles.

We acknowledge the Victorian Department of Justice and Community Safety as the source organisation of the National Coronial Information System (NCIS) data which also informs the QSR and, to a lesser extent, the interim Queensland Suicide Register (iQSR). We acknowledge the NCIS as the database source of that data. We want to thank current and former QSR investigators and research assistants. We also thank reviewers of this report at the Queensland Mental Health Commission; the Coroners Court of Queensland; the Queensland Health Mental Health, Alcohol and Other Drugs Branch; and the Australian Institute for Suicide Research and Prevention.

Acknowledgement of Country

AISRAP acknowledges the Yugarabul, Yuggera, Jagera and Turrbal peoples as the Traditional Custodians of the land where we prepared this report. We pay respect to Elders past and present. We extend that respect to other Aboriginal and Torres Strait Islander peoples. The land where we prepared this report has long been a place of research and learning. We advise Aboriginal and Torres Strait Islander readers that this report includes information on deaths by suicide of Aboriginal and Torres Strait Islander peoples. We acknowledge that readers may find some content in this report distressing.

Acknowledgement of lived experience

People with lived experience have a critical role informing how we understand and reduce suicide. Each person who died by suicide had lived experience. Those they leave behind have a lived experience of being bereaved by suicide.

The information in this report has limited information on the person's experience. We hear from people with a lived experience of dying by suicide in the coronial data through their words, either said to others or communicated in writing.

Each death by suicide in this report is more than a number. They are a person with a rich collection of stories. Collectively, their experiences help us quantify commonalities and differences among those we have lost to suicide.

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Support services

The information in this report refers to real people, lives lived and lives lost too early to suicide. One suicide is one too many, and we work with urgency to reduce the deaths by suicide in Queensland.

Aboriginal and Torres Strait Islander readers are advised that this report has information on the deaths by suicide of Aboriginal and Torres Strait Islander peoples. All readers may find some content in this report distressing. These services can offer support.

Organisation	Target group	Availability	Phone number	Website
Lifeline	All	24/7	13 11 14	lifeline.org.au
Suicide Call Back Service	All	24/7	1300 659 467	suicidecallbackservice.org.au
Beyond Blue	All	24/7	1300 224 636	beyondblue.org.au
State Mental Health Crisis Line Queensland	All	24/7	1300 642 255 (1300 MH CALL)	
National StandBy Response Service	People affected by suicide	24/7	1300 727 247	standbysupport.com.au/#Contact
eheadspace	Youth and young people	9am to 1am Melbourne time every day	1800 650 890	eheadspace.org.au
Kids Helpline	Youth and young people aged 5 to 25, parents and carers, schools and teachers	24/7	1800 55 1800	kidshelpline.com.au
ReachOut	Youth and young people	24/7		au.reachout.com
MensLine Australia	Males	24/7	1300 78 99 78	mensline.org.au
Open Arms – Veterans & Families Counselling	Current and ex-serving Australian Defence Force members and their families	24/7	1800 011 046	openarms.gov.au
Thirrili	After suicide support for Aboriginal and Torres Strait Islander Australians	24/7	1800 805 801	thirrili.com.au
Care Leavers Australasia Network	People who have grown up in orphanages, children's homes, missions and foster care	9am to 5pm weekdays	1800 008 774 0425 204 747	clan.org.au
Carers Australia	Carers	9am to 5pm weekdays	1800 422 737 (02) 6122 9900	carersaustralia.com.au
GriefLine	Anyone experiencing grief, loss or trauma	6am to midnight AEDT, every day	1300 845 745	griefline.org.au
headspace Be You	Bereavement in secondary schools	9am to 5pm weekdays	0455 079 803	headspace.org.au/professionals-and-educators/educators/contact-us/
QLife	Lesbian, gay, bisexual, transgender, intersex or queer Australians	3pm to midnight every day	1800 184 527	qlife.org.au
SANE Australia	Those affected by mental health issues	10am to 10pm weekdays	1800 187 263	sane.org
Wellways Helpline	Those affected by mental health issues	9am to 9pm weekdays	1300 111 400	wellways.org
Alcohol and Drug Support	Those seeking support and information about alcohol and other drugs	24/7	1800 177 833	adis.health.qld.gov.au/
Alcohol and Drug Foundation	Those seeking support and information about alcohol and other drugs	9am to 5pm weekdays	1300 85 85 84	adf.org.au
MATES in Construction Helpline	Support and services for those working in the construction, mining and energy	24/7	1300 642 111	mates.org.au/construction/support

Glossary

aftercare: Treatment after self-harm or a suicide attempt to reduce the possibility of future self-harm or suicide attempts.

age-specific rate: The crude (i.e. unadjusted) rate in a specific age group, expressed per 100,000 males, females or persons. This report does not calculate rates for numbers under five.

age-standardised suicide rate: An adjustment to the crude rate to consider differences in population age structures over time and expressed per 100,000 males, females or persons.[4] It addresses whether changes in the crude suicide rate may be due to increases in the age groups of people who typically die by suicide in a specific year. This report does not provide age-standardised rates for numbers under 10.

confidence interval: A range around an estimate showing how precise the estimate is.[5]

crude rate: Suicides in a period divided by the estimated resident population size halfway through that period.[6]

Hospital and Health Service: The statutory bodies providing public health services across Queensland.[7]

geocoding: Geocoding takes an address or place and provides output for geographical areas and the coordinates (latitude and longitude) of that address or location.

numbers: The number of deaths by suicide. This report does not provide numbers less than five.

police reports: Formally called the *Form 1 police report of death to a coroner*, a Queensland Police Service officer completes this to provide details on reportable deaths to support the coroner in their investigation, including deciding whether to order an autopsy and help the pathologist performing the autopsy to establish a cause of death.[8]

post-mortem examination: The examination of a body after death to determine the cause of death.

postvention: Support provided to families, friends, colleagues, students and others after someone dies by suicide.[9]

primary health network: Independent organisations funded by the Australian Government to manage health regions.[10]

public health surveillance: Using data to monitor health problems to support prevention or control.[11]

public health model of suicide prevention: A framework for identifying, developing, applying and revising suicide prevention programs.[12]

Queensland resident: A person whose main place of residence is in Queensland.

real-time: Real-time refers to information on suspected suicides received and collated as soon as possible after an event occurs, using police reports of deaths to coroners.

reportable deaths: Deaths may be reportable to the coroner where:

- the person's identity is unknown
- the death was violent or unnatural
- the death happened in suspicious circumstances
- a 'cause of death' certificate has not been issued and is not likely to be
- the death was related to health care
- the death occurred in care, custody or as the result of police operations.[13]

social-ecological model of suicide prevention: A four-tier framework of individual, relationship, community and societal levels, providing a comprehensive picture of risk and protective factors associated with at least one aspect of suicide-related thoughts, behaviour or both.[14]

suspected suicide: A death that appears to be a suicide, but the coronial investigation and determination of the type of death is still ongoing. Coroners are responsible for determining whether a death is by suicide after investigating and considering all available evidence. Coroners may use common standards of practice to aid them in determining a suicide.[15] Until a coroner finalises their investigation, deaths are referred to as suspected suicides. Deaths in the interim Queensland Suicide Register with a probability code of 'probable' or 'confirmed' are termed 'suspected suicides' to acknowledge the ongoing coronial processes.

List of acronyms

ABS	Australian Bureau of Statistics
ADF	Australian Defence Force
AISRAP	Australian Institute for Suicide Research and Prevention
HHS	Hospital and Health Service
iQSR	interim Queensland Suicide Register
LGBTIQ+	lesbian, gay, bisexual, transgender, intersex, queer, questioning and other people with diverse sexual orientations or gender identities
NCIS	National Coronial Information System
NESB	non–English speaking background
PHN	Primary Health Network
QSR	Queensland Suicide Register

How to share suicide statistics with others

This report discusses suicides. It is crucial to carefully discuss suicide. The Mindframe program[16] has recommendations on discussing suicide data and statistics. Mindframe highlights problematic and preferred language to use when talking about suicide.

Preferred language when discussing suicide

Issue	Problematic	Preferred
Presenting suicide as a desired outcome	✗ successful suicide unsuccessful suicide	✓ died by suicide took their own life
Associating suicide with crime or sin	✗ committed suicide commit suicide	✓ took their own life suicide death
Sensationalising suicide	✗ suicide epidemic	✓ increasing rates higher rates
Language glamorising a suicide attempt	✗ failed suicide suicide bid	✓ suicide attempt non-fatal attempt
Gratuitous use of the term 'suicide'	✗ political suicide suicide mission	✓ refrain from using the term 'suicide' out of context

Source: Reproduced with permission from Everymind from https://mindframe.org.au/suicide/communicating-about-suicide/language

Summary

Suicide is a significant and far-reaching public health issue in Queensland. Reducing the incidence and tragic impacts of suicide is a priority of the Queensland Government.

Suicide is a multidimensional phenomenon, and its prevention is complex. Therefore, a cross-sectoral policy and service response with targeted interventions for high-risk groups and population-wide strategies to promote the health and wellbeing of all people is required.[17] Reducing suicide risk depends on coordinated cross-sectoral policy and practice efforts across health, social care, and criminal justice agencies.[18, 19]

Surveillance is a central part of the public health model of suicide prevention.[20] Effective suicide surveillance systems provide suicide data and statistics, as well as timely and fit for purpose information to inform responses to suicide. The Queensland Government has funded the monitoring of suicide deaths with a suicide register for over three decades. The Queensland Suicide Register (QSR) includes suicide data since 1990, and the interim Queensland Suicide Register (iQSR) was established in 2011 to provide real-time information on suicide deaths. The Australian Institute for Suicide Research and Prevention has managed the QSR since 1996.

Existing and ongoing reform to suicide prevention policies by state and federal governments provide more opportunities to improve suicide prevention efforts in Queensland. However, reducing suicide is not the responsibility of governments alone – we each have a role to play by watching out for family, friends and colleagues when we think they might need help, which could make the difference.[21]

Suicide in Queensland: Annual Report 2022 gives a summary of the nature of suicides and characteristics of those who died by suicide in Queensland.

In total, 813 people died by suicide in Queensland in 2021. Queensland's age-standardised suicide rate, which considers population growth and changes in the population's age structure, has risen by 2.3 suicides per 100,000 people from 2006 (13.2 per 100,000) to 2021 (15.5 per 100,000). In 2021, Queensland's age-standardised suspected suicide rate (15.5) was slightly higher than the past five-year average (15.3).

Since it emerged in late January 2020, the COVID-19 pandemic, has increased suicide risk factors involving uncertainty, unemployment, changes in access to physical and mental health services and financial problems. The data in this report reinforces the need for targeted action to intervene early with those who are at the highest risk of suicide.

Section 1 describes the elements, methods, limitations and context of the suicide surveillance system in Queensland.

Section 2 reports on population groups and areas with higher suicide rates in Queensland from 2019 to 2021.

Section 3 presents the characteristics of those who died by suicide, and factors that contributed to suicides in Queensland in 2016 to 2018.

Section 4 summarises the critical results of the report, highlighting policy and practice implications.

Key findings

This section summarises key findings from the iQSR in 2021 and the QSR from 2016 to 2018.

2021

Total suspected suicides

- Overall, **813 Queensland residents** died by suspected suicide in Queensland in 2021. This figure was 35 more (3.6%) suspected suicides of Queensland residents than in 2020 (778). Seven more suspected suicides occurred in 2021 than in 2017 (806), which was previously the highest number of suicides of Queensland residents in a calendar year. More suicides would likely occur over time in Queensland due to population growth, which increased by 0.9% from June 2020 to June 2021.
- Less than five interstate or overseas residents died by suspected suicide in Queensland in 2021.
- In 2021, Queensland residents had an age-standardised suspected suicide rate[22] of **15.5 suspected suicides per 100,000** people. This rate was 3.1% higher than the rate in 2020. The difference in rates from 2020 to 2021 was 0.46 more suspected suicides per 100,000 people in 2021.
- The rate difference, which shows the public health impact[23] of suicide in Queensland, reflected 24 more suspected suicides of Queensland residents from 2020 to 2021 after accounting for population growth and changes in the population's age structure.

Groups

- Of the Queensland residents who died by suspected suicide, 610 were male (75.0%), and 203 (25.0%) were female.
- Queensland males had an age-standardised suspected suicide rate of 23.7 per 100,000. This rate decreased from 24.0 per 100,000 in 2020, a decrease of 1%, and a rate difference of 0.23 per 100,000 males less in 2021. This rate difference amounted to six fewer suspected suicides by male Queensland residents in 2021 compared to 2020, after accounting for population growth and the changing age structure of Queensland males.
- The age-standardised suspected suicide rate for females in Queensland in 2021 was 7.6 per 100,000, showing an increase from 6.5 per 100,000 in 2020. This increase in females from 2020 to 2021 was 16%, and a rate difference of 1.07 per 100,000 females in 2021. The rate difference indicated an increase of 28 female suspected suicides from 2020 to 2021, after accounting for population growth and changing age structure of the female population in Queensland. This requires further monitoring and understanding of potential implications for prevention.
- The rate for males decreased and the female rate increased from 2020 to 2021. However, the male rate was 3.1 times higher than the female rate in 2021. This disparity was a rate difference of 16.1 more suspected suicides per 100,000 males than females in 2021.
- People aged 50 to 54 had the highest number of suspected suicides for both sex (63 for males and 22 for females) and the highest age-specific suspected suicide rates (39.0 per 100,000 for males and 12.8 for females).
- In total, 57 people who identified as Aboriginal and Torres Strait Islander died by suspected suicide in 2021. They accounted for 7.0% of all suspected suicides.[24]
- Aboriginal and Torres Strait Islander peoples had an age-standardised suspected suicide rate of 30.0 per 100,000, compared to 14.9 per 100,000 for non-Indigenous people. The rate was 2.01 times higher in Aboriginal and Torres Strait Islander peoples than non-Indigenous people.

Regions from 2019 to 2021[25]

Remoteness areas

Very remote Queensland had the least suspected suicides (35) but the highest age-standardised suspected suicide rate at 27.4 per 100,000 persons.

Per 100,000 males, age-standardised suspected suicide rates were lowest in major cities (19.6) and highest in very remote areas (39.8), followed by remote areas (32.3).

Per 100,000 females, age-standardised suspected suicide rates were lowest in major cities (6.36) and highest in remote areas (15.5). They were too small to calculate for very remote Queensland.

Hospital and Health Services (HHS)

HHS catchment areas with the lowest numbers of suspected suicides included Central West (6), South West (11), North West (18) and Torres and Cape (21). Age-standardised suspected suicide rates per 100,000 people across all HHS catchment areas were highest in Torres and Cape (30.4), followed by North West (22.2). Central West had too few suspected suicides to calculate a rate.

Metro South HHS had the most suspected suicides (442) and the lowest age-standardised suspected suicide rates (12.2 per 100,000 people). Following Metro South, Metro North (420, 12.9 per 100,000 people) and Gold Coast (258, 12.7 per 100,000 people) had the highest number of suspected suicides but the lowest age-standardised suspected suicide rates.

Primary Health Networks (PHN)

Western Queensland PHN had the least suspected suicides (35) but a high rate (20.1 per 100,000 people). Northern Queensland PHN had the highest rate of suspected suicides (20.6 per 100,000 people), and the second-highest number of suicides (430) after Brisbane South PHN (442).

Brisbane South PHN had the most suspected suicides (442), but the lowest suspected suicide rate per 100,000 people of all PHNs (12.2). Other areas with many suspected suicides but low suspected suicide rates per 100,000 people included Brisbane North PHN (419, 12.9 per 100,000 people) and Gold Coast PHN (258, 12.7 per 100,000 people).

2016 to 2018

This section reports all 2,367 deaths by suicides in Queensland from 2016 to 2018. This three-year period is the most recent QSR data. During this period, most people dying by suicide were Queensland residents (2,331, 98.5%), with 36 (1.5%) interstate or overseas residents, or around 12 people per year.

Relationship status

In 2016 to 2018, over one in three (841, 35.5%) people dying by suicide in Queensland were reportedly married or in a de facto relationship. This proportion increased slightly compared to the previous reporting period in 2015 to 2017 (780, 33.7%). Proportions of married or de facto people dying by suicide were similar for males (650, 35.8%) and females (191, 34.8%). Males who died by suicide were more often separated (265, 14.6%) than females (43, 7.8%). However, the same number and a greater proportion of females (43, 7.8%) than males (43, 2.4%) were widowed.

Employment status

A quarter (595, 25.1%) of individuals dying by suicide from 2016 to 2018 were reportedly unemployed. This proportion was slightly lower than the 2015 to 2017 reporting period (617, 26.6%).[26]

The employment status of other individuals dying by suicide was retired (340, 14.4%), followed by students or apprentices (94, 4.0%) and disability pensioners (67, 2.8%). There were minor changes compared to the 2015 to 2017 reporting period.[27]

Occupations

Of all individuals who died by suicide in 2016 to 2018, labourers and machine operators/drivers were the largest occupational group (194, 8.2%), followed by technicians and tradespersons (142, 6.0%) and managers (92, 3.9%). The proportions of all three groups had a slight decrease from the 2015 to 2017 period.

Significant life events

The most frequent life events prior to suicide in the 2016 to 2018 period reported for males were relationship separation (504, 27.7%), followed by financial problems (335, 18.4%) and bereavement (272, 14.9%). Compared to 2015 to 2017,[28] the proportion of males reportedly experiencing relationship separation (511, 28.8%) and financial problems (354, 20.0%) decreased. The proportion of males reportedly experiencing bereavement (252, 14.2%) increased slightly. Relationship separation and financial problems remained the top two life events for males. However, bereavement became the third most common life event preceding male suicides.

For females, the most common life events preceding suicide were bereavement (123, 22.4%), family conflict (107, 19.5%) and relationship separation (103, 18.8%). Compared to the 2015 to 2017 reporting period,[29] the proportion of females reportedly experiencing bereavement (123, 22.6%) and family conflict (107, 19.7%) was stable. The proportion experiencing relationship separation (109, 20.0%) decreased. These life events remained in the most common similarly to the previous reporting period.

Alcohol and other drug use

Over one-third of the people who died by suicide from 2016 to 2018 reportedly consumed alcohol recently prior to their death (866, 38.2%). An increase in alcohol use prior to suicide was observed from the 2015 to 2017 period (762, 32.9%).[30]

Males who died by suicide currently used illicit drugs more often than females. Cannabis was the most common currently used substance for males (368, 20.2%) and females (83, 15.1%) who died by suicide. Amphetamine or methamphetamine use was the second most common substance currently used (339, 14.3%). Findings from the 2015 to 2017 reporting period regarding current cannabis use were similar, males (387, 21.9%) and females (88, 16.1%).[31] However, current amphetamine or methamphetamine use by persons who died by suicide was lower than what was reported from 2015 to 2017 (433, 18.7%).

Reported mental health conditions

Over half of all people who died by suspected suicide from 2016 to 2018 had a common mental health condition (1,208, 51.0%) as reported in police reports, coronial findings or both data sources. There was an increase compared to the 2015 to 2017 reporting period (1,068, 46.1%).[32]

Specifically, over one-third of people who died by suspected suicide (889, 37.6%) from 2016 to 2018 reportedly had been diagnosed with depression, which was higher than in the 2015 to 2017 period (832, 35.9%).[33] About one in six people who died by suicide had an anxiety condition (406, 17.2%), increasing from the 2015 to 2017 period (337, 14.5%).[34]

Diagnosed substance use conditions were reported in one in every 10 people dying by suicide (274, 11.6%) from 2016 to 2018, showing a slight increase compared to the 2015 to 2017 period (243, 10.5%).[35] A psychosis or a psychotic disorder or condition was reportedly experienced by 196 (8.3%) people who died by suicide from 2016 to 2018, which was slightly higher than in the 2015 to 2017 period (175, 7.5%).[36]

Just over one in every 20 people dying by suicide (143, 6.0%) from 2016 to 2018 reportedly were diagnosed with bipolar disorder. This proportion was slightly higher than the 5.2% (121) reported for the 2015 to 2017 period.[37] Personality disorders were reportedly less frequently (85, 3.6%) from 2016 to 2018, although there was a slight increase compared to the 2015 to 2017 period (67, 2.9%).[38]

Prior suicidal thoughts and behaviour

Almost six in 10 people (1,384, 58.5%) who died by suicide had expressed an intent to die by suicide in their lifetime. This proportion increased from the 2015 to 2017 period (1,219, 52.6%).[39] Four in 10 people (991, 41.9%) reportedly communicated their intent to die by suicide within 12 months before their death. The proportion was similar to the 2015 to 2017 period (952, 41.1%).[40]

Over one-third of people dying by suicide from 2016 to 2018 (832, 35.2%) had reportedly attempted suicide in their lifetime, representing a slight increase from the 2015 to 2017 data (770, 33.2%).[41] Just over one in six people who died by suicide (401, 17.0%) from 2016 to 2018 had attempted suicide in the past year. This proportion was similar to the 2015 to 2017 period (397, 17.2%).[42]

Help-seeking and service contact

Over one-quarter (646, 27.3%) of people who died by suicide from 2016 to 2018 saw a general practitioner for a mental health condition in their lifetime. The proportion was higher among females (192, 35.0%) than males (454, 25.0%). One in five people (523, 22.1%) who died by suicide from 2016 to 2018 had been past (473, 20.0%) or present (50, 2.1%) psychiatric inpatients. Lifetime outpatient treatment for a mental health condition was reported for 375 (15.9%) people who died by suicide. The number remained unchanged, and the proportion decreased slightly from the 2015 to 2017 reporting period (378, 16.3%).

Section 1

Introduction

Reducing the incidence and far reaching and tragic impacts of suicide is a priority of the Queensland Government. This includes the commitment to quality public health surveillance to inform effective cross sectoral suicide prevention. The Queensland Government has partnered with Griffith University since the early 1990's to collect and maintain the Queensland Suicide Register (QSR).

Public health surveillance in this context is the systematic and timely capture, analysis and interpretation of suicide data and is crucial to understand and reduce suicides.[43] Queensland's suicide surveillance system currently includes the QSR and the iQSR (for further details, see Appendix). The Australian Institute for Suicide Research and Prevention at Griffith University manages these registers for the Queensland Government.[44]

Suicide in Queensland: Annual Report 2022 provides an overview of suicide deaths in Queensland including current and long-term suicide trends based on the QSR and interim QSR.

In 2021, there were 813 suspected suicides of Queensland residents in Queensland. Each suicide has a major impact on families, friends, practitioners and whole communities. Suicide is a multidimensional phenomenon and understanding its underlying factors and their interaction is crucial to reducing suicides.

Since early 2020, the COVID-19 pandemic and natural disasters have impacted the Queensland population's mental, social and emotional wellbeing. Some challenges, like unemployment, social isolation and financial problems, are known risk factors for suicide and make suicide reduction efforts harder.

National picture

This section provides a national overview of suicide and Queensland comparatively. The most recent information about suicides in Australia was released by the Australian Bureau of Statistics (ABS) in September 2021. **Table 1.1** shows key data from *Causes of death, Australia, 2020* for suicide deaths registered and occurring in 2020.[45] Suicide was a leading cause of death for younger age groups, although not for all ages. In Australia, out of all causes of death, suicide was responsible for the most years of potential life lost. After New South Wales, Queensland registered the most suicides in 2020. Of all states and territories, residents of the Northern Territory and Tasmania had higher age-standardised suicide rates per 100,000 persons than Queensland residents.

Table 1.1: Vital Australian and Queensland suicide statistics in 2020

Statistic	Value
The age-standardised suicide rate for Australia	12.1 per 100,000 people
The age-standardised suicide rate for Queensland	14.7 per 100,000 people
Deaths by suicide registered in Australia	3,139
Deaths by suicide registered in Queensland	759
Deaths by suicide occurring in Australia	2,826
Deaths by suicide occurring in Queensland	711
Suicide's position in the leading causes of death in Australia	15th
Suicide's position in the leading causes of death in Australia for people aged 15 to 44	First
The Queensland proportion of all deaths by suicide registered and occurring in Australia	24.2% (registered) and 25.2% (occurring)
Queensland's position in all Australian jurisdictions on the number of suicides	Second, after New South Wales
Queensland's position in all Australian jurisdictions on the proportion of suicides	Second, after New South Wales
Queensland's position in terms of the age-standardised suicide rate	Third, after the Northern Territory (20.4) and Tasmania (15.9)

Source: Australian Bureau of Statistics, Causes of death, Australia, 2020, ABS website, 29 September 2021, accessed 28 March 2022.
https://www.abs.gov.au/statistics/health/causes-death/causes-death-australia/latest-release

This section gives the key demographic characteristics of all deaths by suicide of Queensland residents in Queensland. This section also reports suspected suicides in Queensland in different geographical regions, including remoteness areas, HHSs and PHNs.

Overview of suicides in Queensland

Section 2

Current suspected suicide numbers and rates in Queensland, 2021

In 2021, 813 suspected suicides by Queensland residents were reported in Queensland. There were under five interstate or overseas visitors, who were not included in this report for confidentiality reasons. The age-standardised suspected suicide rate was 15.5 per 100,000 persons.

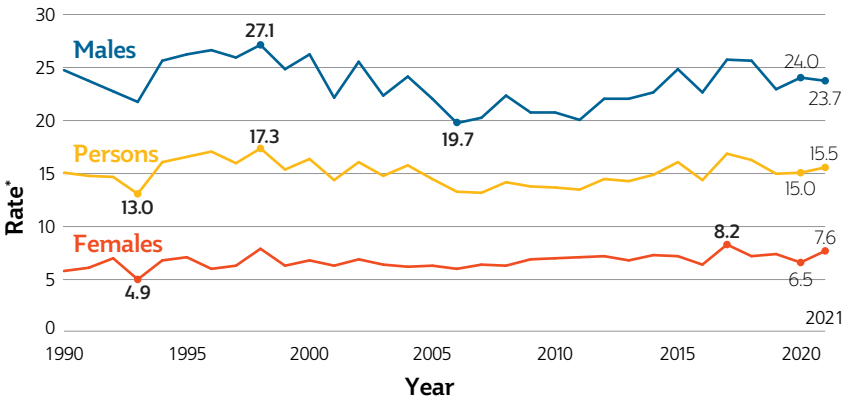
By sex

In 2021, 610 (75.0%) Queensland residents who died by suspected suicide were male, and 203 (25.0%) were female. For males, the age-standardised suspected suicide rate decreased slightly from 24.0 in 2020 to 23.7 per 100,000 males in 2021 (**Figure 2.1**). For females, it increased from 6.5 per 100,000 in 2020 to 7.6 per 100,000 females.

Male age-standardised suicide rates were highest in 1998 (27.1). Rates steadily decreased to their lowest level in 2006 (19.7) (**Figure 2.1**). Since 2006, male age-standardised suspected suicide rates have gradually increased. The highest level recorded since 2000 was in 2017, when they reached 25.7. The rate for males varies more than the rate for females.

Age-standardised suicide rates for females were lowest in 1993 (4.9) and highest in 2017 (8.2) (**Figure 2.1**). They have been more steady than the male rate. However, the female rate has slowly increased over time.

Figure 2.1: Age-standardised suicide rates by sex, Queensland residents, 1990 to 2021



*Age-standardised suicide rate per 100,000 estimated resident population as at 30 June (mid-year) each year.

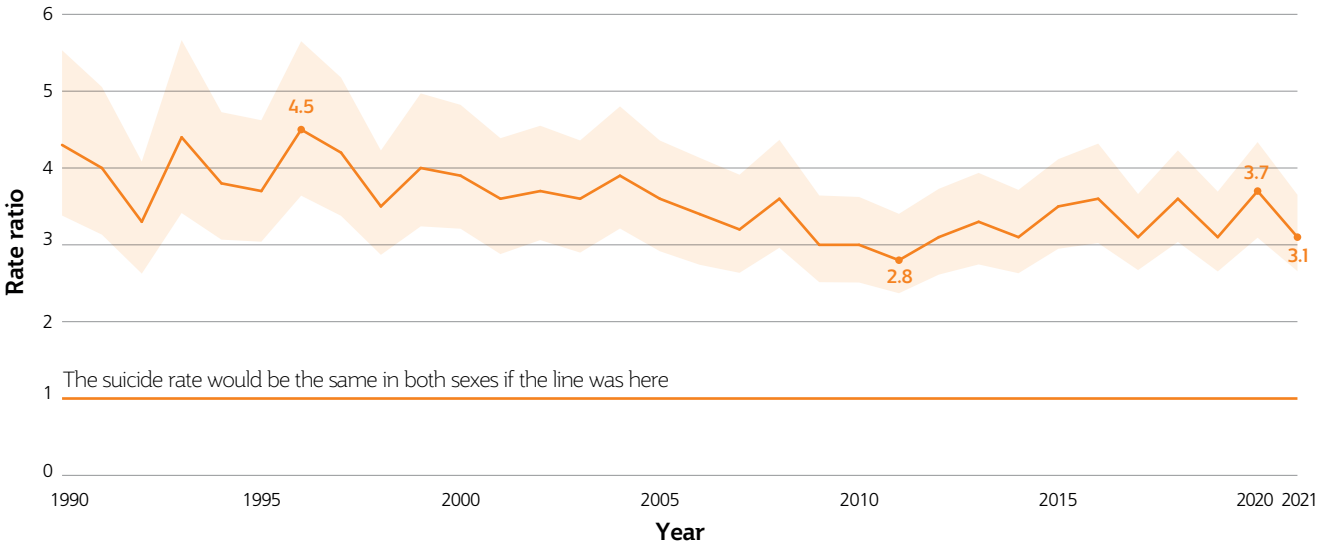
Sources: Queensland Suicide Register (1990 to 2018); interim Queensland Suicide Register (2019 to 2021).

Figure 2.2 shows the age-standardised suspected suicide rate ratio, for males over females, from 1990 to 2021. This is the age-standardised suspected suicide rate in males, divided by the rate for females. The orange line is the estimate, while the light orange shading around the line is the 95% confidence interval (a range of values around the estimate). Males had an age-standardised suicide rate 3.1 times higher than the female rate in 2021. The 95% confidence interval suggested that, after accounting for random fluctuations, the male age-standardised suicide rate could be 2.7 to 3.7 times higher than in females. Except for being 2.8 times higher in 2011, the age-standardised suicide rate for males has been at least three times higher than for females each year (**Figure 2.2**).

The rate ratio between males and females was only lower in 2009, 2010, and 2011. The rate ratio was highest in 1996, when it was 4.5 times higher than the rate for females.

The relatively low rate ratio in 2021 can be attributed to the female rate slowly increasing over time compared to the male rate. While males still account for most suicide deaths and have higher rates, suicide rates of females are increasing. Increasing suicide rates among females are attributable to an increasing rate and greater proportion of females using hanging, strangulation or suffocation over time, compared to males. This requires further monitoring and understanding of potential implications for prevention.

Figure 2.2: Age-standardised suicide rate ratio and 95% confidence intervals, males over females, Queensland residents, 1990 to 2021



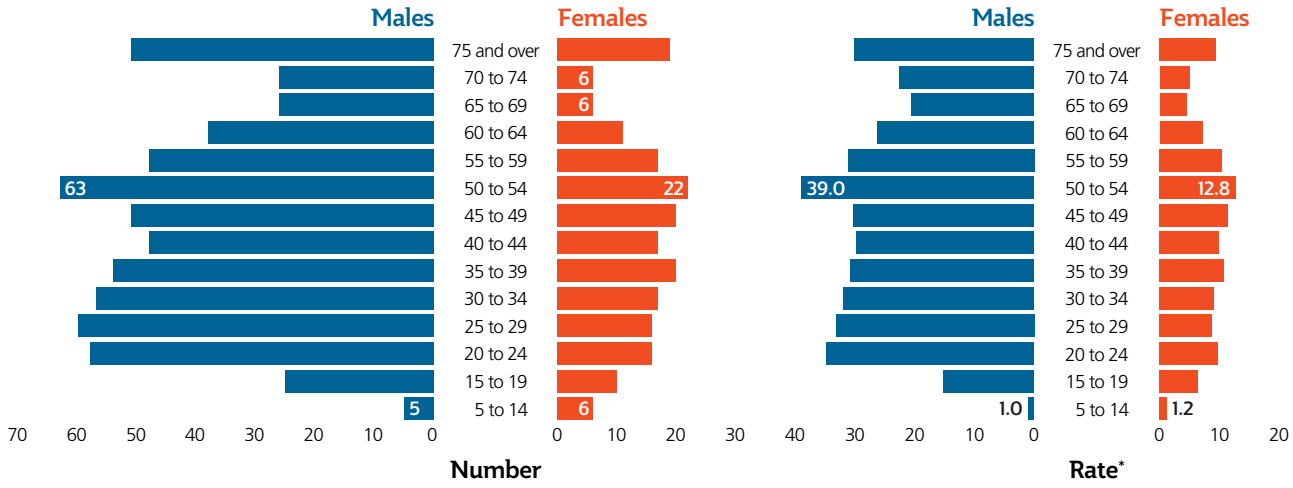
Note: age-standardised suicide rate per 100,000 estimated resident population as at 30 June (mid-year) each year.

Sources: Queensland Suicide Register (1990 to 2018); interim Queensland Suicide Register (2019 to 2021).

By age and sex

Figure 2.3 and **Table 2.1** has numbers and age-specific rates of suspected suicides for males, females and total persons by age groups. Most suspected suicides in Queensland occurred in the age groups from 20 to 59 years old (**Figure 2.3**; 72.0% of males and 71.4% of females). In 2021, males aged 50 to 54 accounted for the greatest number (63) and proportion (10.3%) of suspected suicides. They also had the highest age-specific suspected suicide rate (39.0 per 100,000) for males (**Figure 2.3** and **Tables 2.1**). Similarly, females aged 50 to 54 had the highest number (22) and proportion of suspected suicides (10.2%). Per 100,000 females, they had the highest age-specific suspected suicide rate (12.8).

Figure 2.3: Age-specific suspected suicide numbers and rates by sex, Queensland residents, 2021



Note: The age groups five to nine and 10 to 14 were combined; and 75 to 79, 80 to 84 and 85 and over were combined, due to suspected suicides in one sex in one of these age groups being less than five.

*Age-specific suicide rate per 100,000 estimated resident population as at 30 June 2021 (mid-year).

Source: interim Queensland Suicide Register.

Table 2.1: Suspected suicide numbers and rates by age group and sex, Queensland residents, 2021

	Males		Females		Persons	
Age group	**Number**	**Rate**	**Number**	**Rate**	**Number**	**Rate**
5 to 14	5	1.0	6	1.2	11	1.1
15 to 19	25	15.2	10	6.4	35	10.9
20 to 24	58	34.8	16	9.8	74	22.4
25 to 29	60	33.2	16	8.8	76	21.0
30 to 34	57	32.0	17	9.1	74	20.3
35 to 39	54	30.8	20	10.8	74	20.5
40 to 44	48	29.7	17	10.0	65	19.6
45 to 49	51	30.3	20	11.5	71	20.7
50 to 54	63	39.0	22	12.8	85	25.5
55 to 59	48	31.2	17	10.5	65	20.6
60 to 64	38	26.3	11	7.2	49	16.5
65 to 69	26	20.6	6	4.5	32	12.4
70 to 74	26	22.6	6	5.0	32	13.7
75 and over	51	30.1	19	9.4	70	18.8

Note: Rate refers to age-standardised suicide rate per 100,000 estimated resident population as at 30 June 2021 (mid-year).

Source: interim Queensland Suicide Register.

By location

Analysis of suicide locations supports targeted suicide prevention activities in different regions. This report provides a breakdown of suicide numbers and rates in remoteness areas, HHS catchment areas and PHNs. This section provides suspected suicide rates over a three-year period (2019 to 2021) because population data to calculate rates by smaller geographical regions for 2021 is currently unavailable.

Remoteness areas

The ABS defines remoteness by the road distance to the nearest urban centre and population size.[46] There are five different levels of remoteness areas in Australia.

Examples of remoteness areas in Queensland include:

- **Major cities:** Brisbane, Gold Coast and Maroochydore
- **Inner regional:** Bundaberg, Gladstone, Maryborough, Rockhampton and Toowoomba
- **Outer regional:** Biloela, Cairns, Charters Towers, Emerald, Goondiwindi, Moranbah and Roma
- **Remote:** Cooktown and St George
- **Very remote:** Bamaga, Birdsville, Boulia, Burketown, Charleville, Cloncurry, Cunnamulla, Longreach, Mount Isa, Normanton, Winton and Weipa.

Suspected suicide numbers and rates for 2019 to 2021 (**Tables 2.2** and **2.3**, respectively) differed between remoteness areas in Queensland. In remoteness areas, numbers of suicide decreased as areas became more remote. However, as remoteness increased, suicide rates also increased. This meant that major cities had the most suicides but the lowest age-standardised suspected suicide rates.

Figure 2.4 indicates that age-standardised suspected suicide rates for persons were higher in very remote areas than in all other areas. Males had similar rates in remote, outer regional and inner regional areas. Age-standardised suspected suicide rates for females were similar in inner and outer regional areas. Females did have much higher rates in remote areas of Queensland. Males, females and persons in major cities all had the lowest rates compared to males, females and persons in other remoteness areas.

The iQSR shows that the proportion of males dying by suspected suicide from 2019 to 2021 is slightly higher outside major cities (77.9%) than in major cities (74.4%). However, rates generally increase with remoteness for both males and females, which must be considered in suicide prevention activities.

Table 2.2: Suspected suicide numbers by remoteness area, Queensland residents, 2019 to 2021

Remoteness area (Qld)	Males	Females	Persons
Major cities	964	332	1,296
Inner regional	427	127	554
Outer regional	334	84	418
Remote	28	11	39
Very remote	26	9	35

Source: interim Queensland Suicide Register.

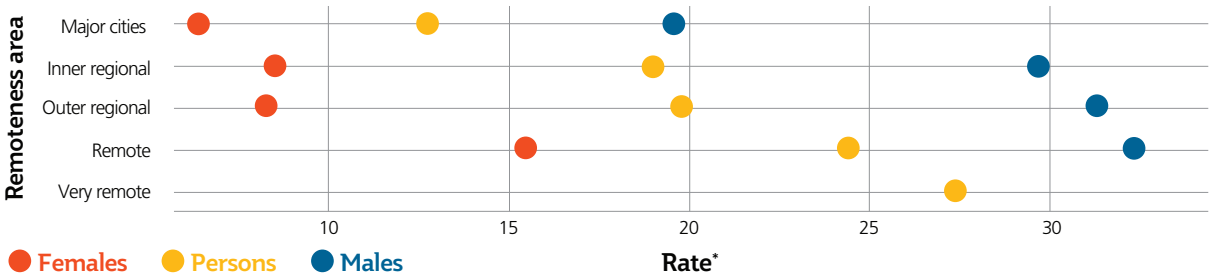
Table 2.3 Age-standardised suspected suicide rates by remoteness area, Queensland residents, 2019 to 2021

Remoteness area (Qld)	Males	Females	Persons
Major cities	19.6	6.4	12.8
Inner regional	29.7	8.5	19.0
Outer regional	31.3	8.2	19.7
Remote	32.3	15.5	24.4
Very remote	np	np	27.4

Note: np = not provided (under 10 suspected suicides in one or both sexes). Age-standardised suspected suicide rate per 100,000 estimated population as at 30 June 2020 (period midpoint).

Source: interim Queensland Suicide Register.

Figure 2.4: Age-standardised suspected suicide rates by sex and remoteness area, Queensland residents, 2019 to 2021



*Age-standardised suspected suicide rate per 100,000 estimated population as at 30 June 2020 (period midpoint).

Source: interim Queensland Suicide Register.

Hospital and Health Service catchment areas

The Queensland Government has designed HHS catchment areas as regions regulating and separating health services. Tables 2.4 and 2.5 present suspected suicide numbers and rates in HHS catchment areas for the period 2019 to 2021.

In Queensland Government HHS catchment areas with larger populations, suspected suicide numbers were higher (**Table 2.4**). However, age-standardised suspected suicide rates were lower in these areas (**Table 2.5**).

Over a third (36.8%) of suspected suicides occurred in Metro North and Metro South HHSs, the HHS catchments with the largest populations. These two HHSs and Gold Coast HHS accounted for almost half (47.8%) of all suspected suicides from 2019 to 2021.

Despite this, all three HHS catchments had the lowest age-standardised suspected suicide rates (**Table 2.5**). Metro South HHS was the lowest at 12.2 per 100,000 people, followed by Gold Coast HHS at 12.7 and Metro North HHS at 12.9.

In contrast, Torres and Cape and North West HHSs together only accounted for 1.7% of all suspected suicides. However, they had the highest age-standardised suspected suicide rates per 100,000 people, with 30.4 for Torres and Cape HHS and 22.2 for North West HHS.

Table 2.4: Suspected suicide numbers by Hospital and Health Service catchment area, Queensland residents, 2019 to 2021

HHS	Males	Females	Persons
Cairns and Hinterland	122	38	160
Central Queensland	81	24	105
Central West	np	np	6
Darling Downs	129	40	169
Gold Coast	184	74	258
Mackay	85	20	105
Metro North	312	108	420
Metro South	334	108	442
North West	13	5	18
South West	np	np	11
Sunshine Coast	134	43	177
Torres and Cape	14	7	21
Townsville	121	22	143
West Moreton	130	37	167
Wide Bay	107	33	140

Note: HHS = Hospital and Health Service, np = not provided (under five suspected suicides for one or both sexes).

Source: interim Queensland Suicide Register.

Table 2.5: Age-standardised suspected suicide rates by Hospital and Health Service catchment area, Queensland residents, 2019 to 2021

HHS	Males	Females	Persons
Cairns and Hinterland	32.1	10.2	20.9
Central Queensland	25.3	7.7	16.4
Central West	np	np	np
Darling Downs	33.5	10.4	21.7
Gold Coast	19.0	7.0	12.7
Mackay	31.3	7.8	19.8
Metro North	19.6	6.6	12.9
Metro South	18.8	5.9	12.2
North West	np	np	22.2
South West	np	np	16.2
Sunshine Coast	21.4	5.6	13.2
Torres and Cape	np	np	30.4
Townsville	33.7	6.4	19.9
West Moreton	29.9	8.0	18.7
Wide Bay	33.9	9.4	21.3

Note: HHS = Hospital and Health Service, np = not provided (under 10 suspected suicides for one or both sexes).
Age-standardised suspected suicide rate per 100,000 estimated resident population as at 30 June 2020 (period midpoint).

Source: interim Queensland Suicide Register.

Primary Health Networks (PHNs)

The Australian Government funds PHNs, as independent primary health care organisations, to support ongoing reform and development of the primary health care system.[47] PHNs commission services but do not provide them. Among the priority areas guiding the work of PHNs are mental health, Aboriginal and Torres Strait Islander health, population health, and alcohol and other drugs.[48] PHNs partner with HHSs and other local stakeholders to support regional efforts to reduce suicide.[49]

Tables 2.6 and **2.7** show the numbers and rates of suspected suicides in PHN catchment areas in the period from 2019 to 2021. Areas with larger populations had larger numbers of suspected suicides (**Table 2.6**). However, age-standardised suspected suicide rates were lower in these areas (**Table 2.7**).

Brisbane South PHN had the most suspected suicides from 2019 to 2021 (442), while Western Queensland PHN had the least (35). Northern Queensland had the highest age-standardised suspected suicide rate per 100,000 people (20.6), while Brisbane South PHN had the lowest (12.2), closely followed by Gold Coast PHN (12.7) and Brisbane North PHN (12.9).

Table 2.6: Suspected suicide numbers by Primary Health Network, Queensland residents, 2019 to 2021

PHN	Males	Females	Persons
Brisbane North	311	108	419
Brisbane South	334	108	442
Central Queensland, Wide Bay, Sunshine Coast	322	100	422
Darling Downs and West Moreton	260	76	336
Gold Coast	184	74	258
Northern Queensland	342	88	430
Western Queensland	26	9	35

Note: PHN = Primary Health Network.

Source: interim Queensland Suicide Register.

Table 2.7: Age-standardised suspected suicide rates by Primary Health Network, Queensland residents, 2019 to 2021

PHN	Males	Females	Persons
Brisbane North	19.5	6.6	12.9
Brisbane South	18.8	5.9	12.2
Central Queensland, Wide Bay, Sunshine Coast	25.3	7.1	16.0
Darling Downs and West Moreton	31.5	8.8	19.9
Gold Coast	19.0	7.0	12.7
Northern Queensland	32.7	8.7	20.6
Western Queensland	np	np	20.1

Note: PHN = Primary Health Network, np = not provided (under 10 suspected suicides for one or both sexes).
Age-standardised suspected suicide rate per 100,000 estimated resident population as at 30 June 2020 (period midpoint).

Source: interim Queensland Suicide Register.

Readers may wish to skip this section if they find the discussion of suicide methods distressing.

Suicide methods

Reporting of suicide methods requires sensitivity and care. Mindframe recommends not presenting specific details, discussing the method in general terms (e.g. 'mix of drugs', rather than the exact drug and amount), and avoiding dramatic imagery (e.g. people standing on a ledge), if reporting about the suicide methods is required.[50]

Tables 2.8 and 2.9 display the suicide methods that Queensland residents who died by suicide in 2021 in Queensland used. The most common group of methods used by persons who died by suicide in 2021 was hanging, strangulation or suffocation, for both males (377, 61.8%) and females (103, 50.7%). Poisoning by drugs was the second most common suicide method. A greater proportion of females used poisoning by drugs (27.1%), compared to males (11.5%).

Table 2.8: Suicide methods by sex, Queensland residents, 2021

	Sex				Persons	
	Male		Female			
Method	**Number**	**%**	**Number**	**%**	**Number**	**%**
Hanging, strangulation and suffocation	377	61.8	103	50.7	480	59.0
Poisoning by drugs	70	11.5	55	27.1	125	15.4
Poisoning by other means	23	3.8	8	3.9	31	3.8
Firearms and explosives	47	7.7	5	2.5	52	6.4
Jumping from height	31	5.1	9	4.4	40	4.9
Other	62	10.2	23	11.3	85	10.5
Total	**610**	**100.1**	**203**	**99.9**	**813**	**100.0**

Note: Percentages for males and females are 100.1 and 99.9, respectively, due to rounding.

Source: interim Queensland Suicide Register.

Table 2.9: ICD-10 suicide methods, Queensland residents, 2021

ICD-10 code for suicide method	Persons	
	Number	%
X60 Intentional self-poisoning by and exposure to nonopioid analgesics, antipyretics, and antirheumatics	np	np
X61 Intentional self-poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism, and psychotropic drugs	9	1.1
X64 Intentional self-poisoning by and exposure to other and unspecified drugs, medicaments, and biological substances	112	13.8
X67 Intentional self-poisoning by and exposure to other gases and vapours	26	3.2
X68 Intentional self-poisoning by and exposure to pesticides	np	np
X69 Intentional self-poisoning by and exposure to other and unspecified chemicals and noxious substances	np	np
X70 Intentional self-harm by hanging, strangulation, and suffocation	480	59.0
X71 Intentional self-harm by drowning and submersion	14	1.7
X72 Intentional self-harm by handgun discharge	9	1.1
X73 Intentional self-harm by rifle, shotgun, and larger firearm discharge	40	4.9
X74 Intentional self-harm by other and unspecified firearm discharge	np	np
X76 Intentional self-harm by smoke, fire, and flames	13	1.6
X78 Intentional self-harm by sharp object	29	3.6
X80 Intentional self-harm by jumping from a high place	40	4.9
X81 Intentional self-harm by jumping or lying before moving object	11	1.4
X82 Intentional self-harm by crashing of motor vehicle	11	1.4
X83 Intentional self-harm by other specified means	5	0.6
X84 Intentional self-harm by unspecified means	np	np
Total	**813**	**100.0**

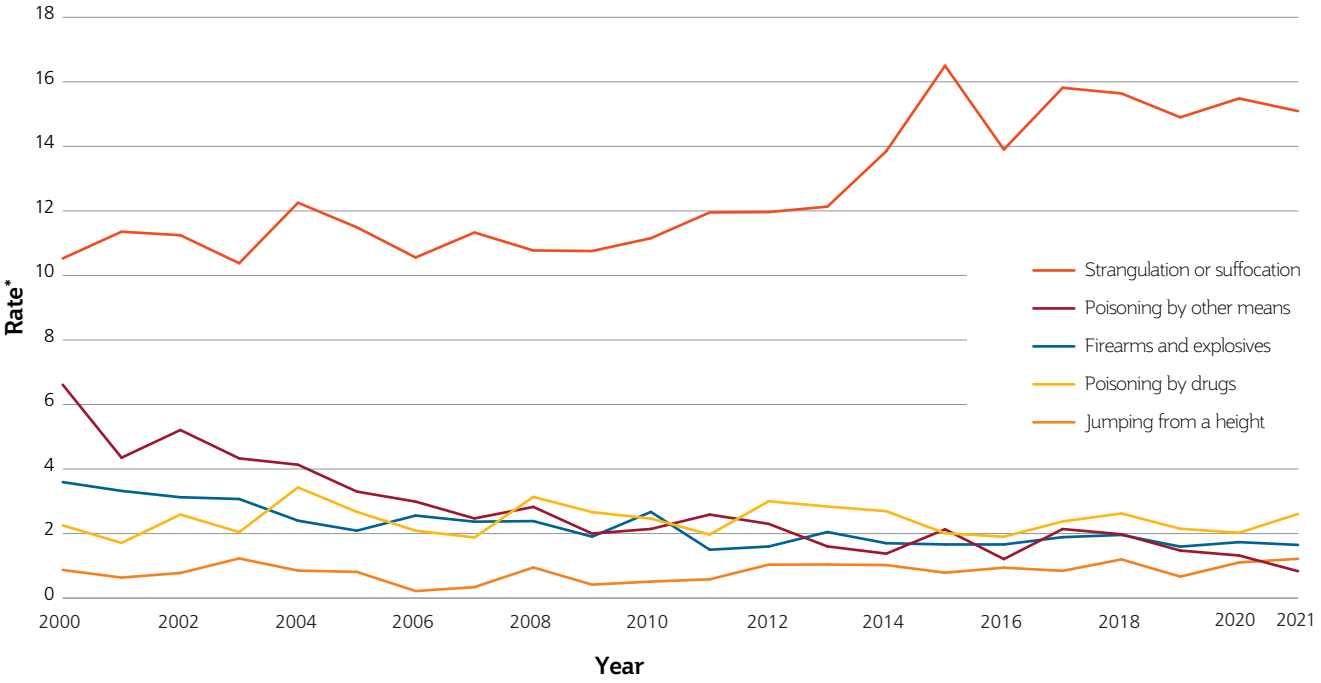
Note: ICD-10 refers to the International Statistical Classification of Diseases and Related Health Problems 10th Revision.
np = not provided (under five people used this suicide method).

Source: interim Queensland Suicide Register.

Figures 2.5 and 2.6 display age-standardised suicide rates for the main suicide methods used by males and females, from 2000 to 2021. Strangulation and suffocation as a method remains the most common method among males and females.

Since 2000, the use of strangulation and suffocation as a method has increased in both sexes, but at a higher rate for females compared to males.

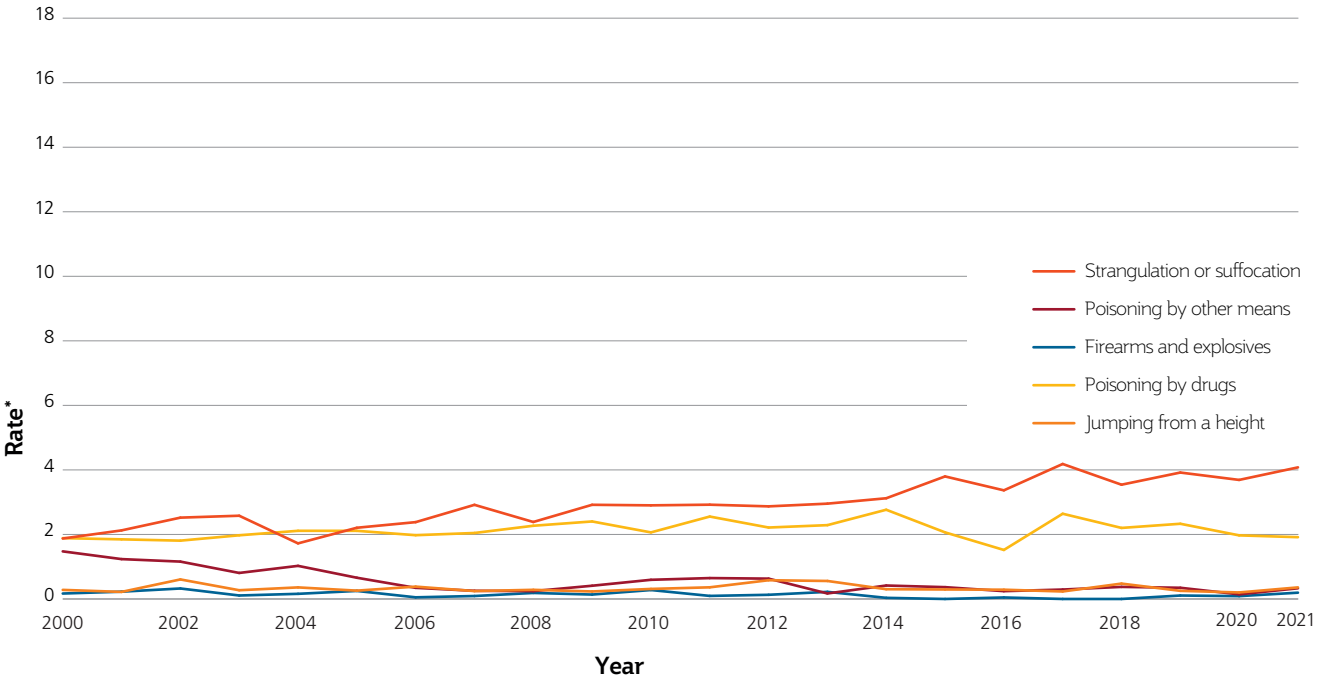
Figure 2.5: Age-standardised suicide rates by method, male Queensland residents, 2000 to 2021



*Age-standardised suicide rate per 100,000 estimated resident population as at 30 June (mid-year) each year.

Sources: Queensland Suicide Register (2000 to 2018); interim Queensland Suicide Register (2019 to 2021).

Figure 2.6: Age-standardised suicide rates by methods, female Queensland residents, 2000 to 2021



*Age-standardised suicide rate per 100,000 estimated resident population as at 30 June (mid-year) each year.

Sources: Queensland Suicide Register (2000 to 2018); interim Queensland Suicide Register (2019 to 2021).

Section 3 considers demographic and health characteristics, life events and service contact of people who died by suicide in Queensland, using data from 2016 to 2018 and from 1990 to 2021 as indicated.

This includes information such as relationship status, employment, reported mental health conditions, adverse life events and contact with health services. Specific population groups are also considered including Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse people, and individuals affected by COVID-19. This may help identify factors that could play a role in a person's suicide and helps identify target populations for Queensland's suicide prevention initiatives.

Demographic factors, significant life events and contact with services

Section 3

Specific population groups

Youth

Looking at age-specific suicide rates across time (**Figures 3.1** and **3.2**) can provide insight into short- and long-term trends of suicides by young people. The age-specific rate is the crude rate for a specific age group. It is obtained by dividing the number of suicides in that age group by the population of that age group, then multiplying that by 100,000, to express as a rate per 100,000 males, females or persons. Age-specific rates can be more informative than the overall age-standardised rate, by highlighting that suicide rates vary in different age groups.

Age-specific suicide rates vary notably for males, females and persons aged 15 to 19 (**Figure 3.1**) and 20 to 24 (**Figure 3.2**) from 1990 to 2021. This variation is due to small numbers of suicides in smaller populations. The rate for females is omitted for 1990 to 1991, 1996 and 2005 because there were under five suicides in this age group for females.

Figure 3.1 shows that the QSR recorded the lowest age-specific suicide rate for males aged 15 to 19 in 2004 at 8.1 per 100,000 males. The highest recorded age-specific rate for males aged 15 to 19 was in 1996 at 29.3 per 100,000 males. While varying greatly, the age-specific rate for males aged 15 to 19 has generally increased over time since its lowest recorded point in 2004. However, it decreased by 29.1% from 21.4 per 100,000 males in 2020 to 15.2 per 100,000 males in 2021.

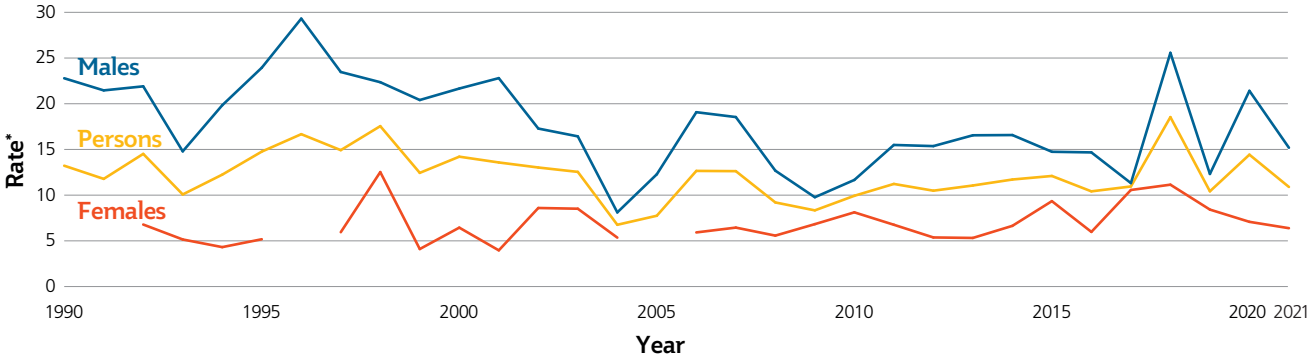
For females aged 15 to 19, the lowest recorded age-specific rate was 4.0 per 100,000 females in 2001. The highest was in 1998 at 12.5 per 100,000 females. In 2021, females aged 15 to 19 had an age-specific rate of 6.4 per 100,000 females, a 9.8% decrease from the 7.1 per 100,000 females recorded in 2020.

Compared to **Figure 3.1**, the age-specific suicide rates for 20- to 24-year-olds (**Figure 3.2**) shows that the rate for males aged 20 to 24 has been much higher than the corresponding rate for 15- to 19-year-old males. The age-specific suicide rates still vary a great deal for males, females and persons from 1990 to 2021, due to small numbers of suicides in these groups.

Figure 3.2 shows that the QSR recorded the lowest age-specific suicide rate for 20- to 24-year-old males was in 2010 at 19.8 per 100,000 males. The highest recorded age-specific rate for males was in 1996 at 48.9 per 100,000 males. While varying greatly, the age-specific rate for males aged 20 to 24 has generally increased over time since its low point in 2010. However, it decreased by 5.9% from 37.0 per 100,000 males in 2020 to 34.8 per 100,000 males in 2021.

For females aged 20 to 24, the lowest recorded age-specific rate was 3.9 per 100,000 females in 2003. The highest was in 2016 at 13.0 per 100,000 females. In 2021, females aged 20 to 24 had an age-specific rate of 9.81 per 100,000 females, a 10.1% increase from the 8.91 per 100,000 females recorded in 2020.

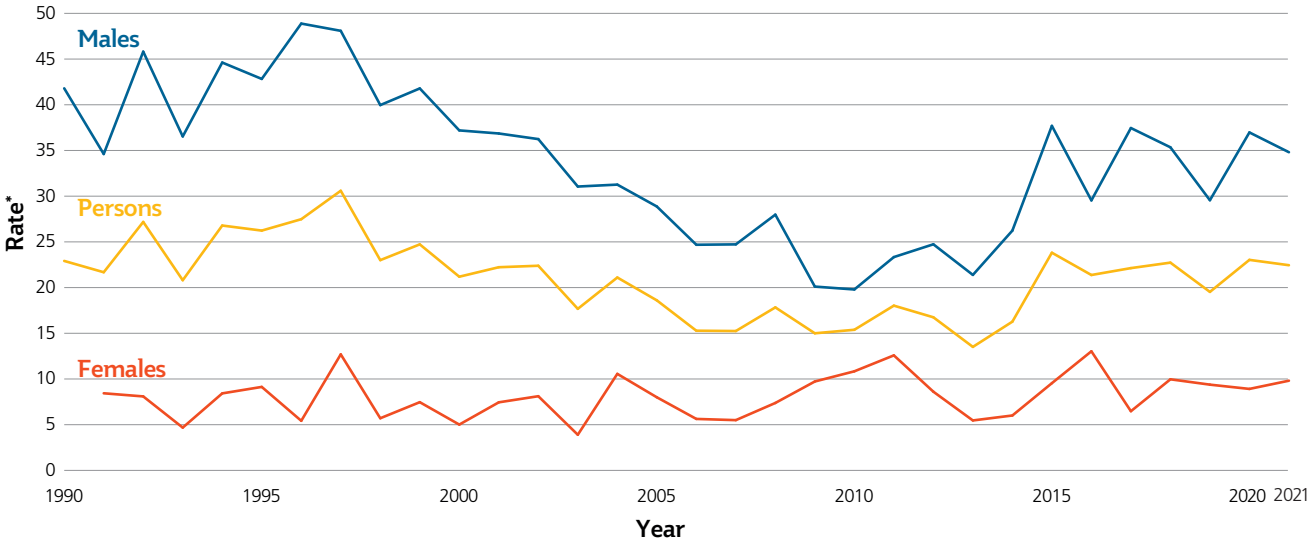
Figure 3.1: Age-specific suicide rates by sex, 15- to 19-year-olds, Queensland residents, 1990 to 2021



*Age-specific suicide rate per 100,000 estimated resident population as at 30 June (mid-year) each year. Rates not shown for years where there were under five suspected suicides.

Sources: Queensland Suicide Register (1990 to 2018); interim Queensland Suicide Register (2019 to 2021).

Figure 3.2: Age-specific suicide rates by sex, 20- to 24-year-olds, Queensland residents, 1990 to 2021



*Age-specific suicide rate per 100,000 estimated resident population as at 30 June (mid-year) each year.

Sources: Queensland Suicide Register (1990 to 2018); interim Queensland Suicide Register (2019 to 2021).

Aboriginal and Torres Strait Islander peoples

Aboriginal and Torres Strait Islander peoples, especially youth, are disproportionately affected by suicide. Police reports, coronial findings and the Registry of Births, Deaths and Marriages provide information to identify Aboriginal and Torres Strait Islander individuals who have died by suicide. These findings may underestimate the suicides of Aboriginal and Torres Strait Islander individuals in Queensland as Indigenous identification may be misclassified, incomplete or inconsistently reported. Various factors might increase the suicide rates of Aboriginal and Torres Strait Islander peoples compared to their non-Indigenous counterparts. Key factors include past and present intergenerational trauma, past and present colonisation, genocide, and past and present racism, both systemic and societal.[51]

2021 findings

In 2021, 57 Aboriginal and Torres Strait Islander individuals died by suicide, accounting for 7.0% of all suspected suicides by Queensland residents. **Table 3.1** presents that Aboriginal and Torres Strait Islander youth aged under 20 accounted for 15.8% of all suspected suicides by Aboriginal and Torres Strait Islander peoples in 2021, compared to 4.9% for non-Indigenous youth who were the same age.

Aboriginal and Torres Strait Islander peoples under 30 years of age accounted for 64.9% of all suspected suicides of Aboriginal and Torres Strait Islander peoples, compared to 20.9% for non-Indigenous people in the same age bracket.

For Queensland residents, age-standardised suicide rates have always been higher from 2001 onwards for Aboriginal and Torres Strait Islander peoples than the non-Indigenous rate (**Figure 3.3**). In the past two decades, the QSR recorded the lowest age-standardised suicide rate for Aboriginal and Torres Strait Islander peoples in 2008. At that time, the suicide rate was 1.1 per 100,000 people higher in Aboriginal and Torres Strait Islander peoples, or 7.91% higher. The rate difference was highest in 2018 at 23.2 per 100,000 people, or 155% (1.55 times) higher.

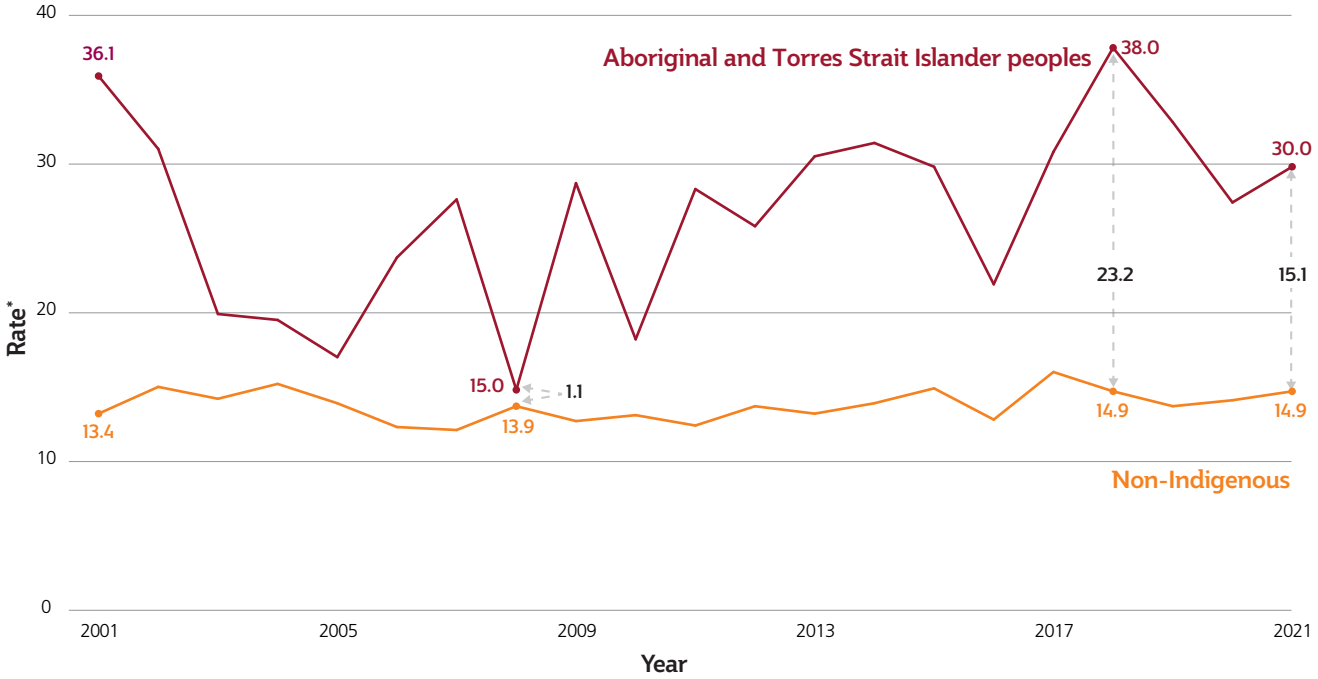
Table 3.1: Suspected suicide numbers by age, Aboriginal and Torres Strait Islander peoples in Queensland, 2021

	Aboriginal and Torres Strait Islander peoples			Non-Indigenous		
Age group (years)	**Number**	**%**	**Rate**	**Number**	**%**	**Rate**
5 to 19	9	15.8	8.3	37	4.9	3.0
20 to 29	28	49.1	64.5	122	16.1	18.8
30 to 39	9	15.8	30.4	139	18.4	20.0
40+	11	19.3	16.8	458	60.6	18.9
Total	**57**	**100.0**		**756**	**100.0**	

Note: Rate refers to the age-specific suspected suicide rate and is per 100,000 estimated resident population as of 30 June 2021 (mid-year).

Source: interim Queensland Suicide Register.

Figure 3.3: Aboriginal and Torres Strait Islander peoples and non-Indigenous age-standardised suspected suicide rates, Queensland residents, 2001 to 2021



*Age-standardised suicide rate per 100,000 estimated resident population as at 30 June (mid-year) each year.

Sources: Queensland Suicide Register (1990 to 2018); interim Queensland Suicide Register (2019 to 2021).

Lesbian, gay, bisexual, transgender, intersex and queer or questioning people

The QSR seeks to identify suicide deaths of individuals who identify as lesbian, gay, bisexual, transgender, intersex, queer or questioning and other people with diverse sexual orientation, gender identity and expression, and sex characteristics (LGBTIQ+). The iQSR recorded 24 suspected suicides of people identified as lesbian, gay, bisexual or transgender in 2021 (**Table A.4**). Due to the small numbers, no further breakdown by sexuality or gender diversity is available.

Police reports and coronial findings provide information for identifying the sexuality or gender identity of a person who has died by suicide. These findings likely underestimate the suicides of LGBTIQ+ people in Queensland as estimations rely on police or coroners having access to this information, family or friends knowing and disclosing this information to police, or identification of sexual or gender diversity. Significant knowledge gaps remain regarding suicide in these populations because data regarding sexual orientation, gender identity and intersex status are rarely collected. The QSR or iQSR have not recorded any suicides of intersex, questioning or queer people, so these groups are not further presented—though, it might be underestimated.

Non–English speaking background and region of birth

The iQSR records information on non–English speaking background (NESB) and region or country of birth as provided by police reports. The police record NESB as either 'yes', 'no' or 'unknown'.

Table 3.2 shows the proportion of Queensland residents dying by suspected suicide in 2021 whom police identified as being from a NESB. Under one in 10 (8.1%) of all suspected suicides in Queensland were by individuals from a NESB. Of all Queensland residents, females who died by suicide had a higher proportion (13.3%) of NESB than males (6.4%).

Table 3.3 shows that the proportion of Queensland residents born in New Zealand and dying by suicide in 2021 in Queensland was slightly higher than their population proportion in Queensland in the 2016 Census. The 2021 Census data that has population estimates of the region and country of birth for people residing in Queensland will be released in June 2022.[52]

Table 3.2: Suspected suicide numbers by non–English speaking background, Queensland residents, 2021

	Sex				Persons	
	Males		Females			
NESB	**Number**	**%**	**Number**	**%**	**Number**	**%**
Yes	39	6.4	27	13.3	66	8.1
No	493	80.8	146	71.9	639	78.6
Unknown	78	12.8	30	14.8	108	13.3
Total	**610**	**100.0**	**203**	**100.0**	**813**	**100.0**

Note: NESB = non-English speaking background.

Source: interim Queensland Suicide Register.

Table 3.3: Suspected suicide numbers by country or region of birth, Queensland residents, 2021

	Sex				Persons	
	Males		Females			
Country or region of birth	**Number**	**%**	**Number**	**%**	**Number**	**%**
Australia	467	76.6	132	65.0	599	73.7
New Zealand	32	5.2	13	6.4	45	5.5
United Kingdom	26	4.3	5	2.5	31	3.8
Continental Europe	22	3.6	8	3.9	30	3.7
Asia	12	2.0	14	6.9	26	3.2
Africa	9	1.5	7	3.4	16	2.0
Other	9	1.5	7	3.4	16	2.0
Unknown	33	5.4	17	8.4	50	6.2
Total	**610**	**100.1**	**203**	**99.9**	**813**	**100.1**

Note: Percentages for males, females and persons sum to 100.1, 100.1 and 99.9 due to rounding.

Source: interim Queensland Suicide Register.

COVID-19

There have been concerns and discussion about whether the COVID-19 pandemic and related public health measures might change the number of suicides occurring worldwide. A preliminary analysis of suicide numbers from 33 countries observed no evidence of more-than-expected suicides in most countries/areas-within-countries in the first nine to 15 months (up to mid-2021) since the COVID-19 pandemic began.[53] However, analysis below extends the analysis period until December 2021 for Queensland to provide more up-to-date information. The analysis is conducted separately by gender and age groups.

Figure 3.4 provides the ratio of age-specific suspected suicides rates before and during COVID-19 for males. The pre-COVID-19 period is January 2015 to January 2020. The COVID-19 period is February 2020 to December 2021. The blue circle in **Figure 3.4** is the estimate of the rate ratio. The rate ratio is the age-specific suspected suicide rate during COVID-19, divided by the age-specific suspected suicide rate before COVID-19. For example, a rate during COVID-19 of 1.5 per 100,000 people, divided by a rate before COVID-19 of 1.0 per 100,000 people, would produce a rate ratio of 1.5. The rate ratio of 1.5 indicates that suicide rate is 1.5-times or 50% higher during the COVID-19 period compared to pre-COVID19.

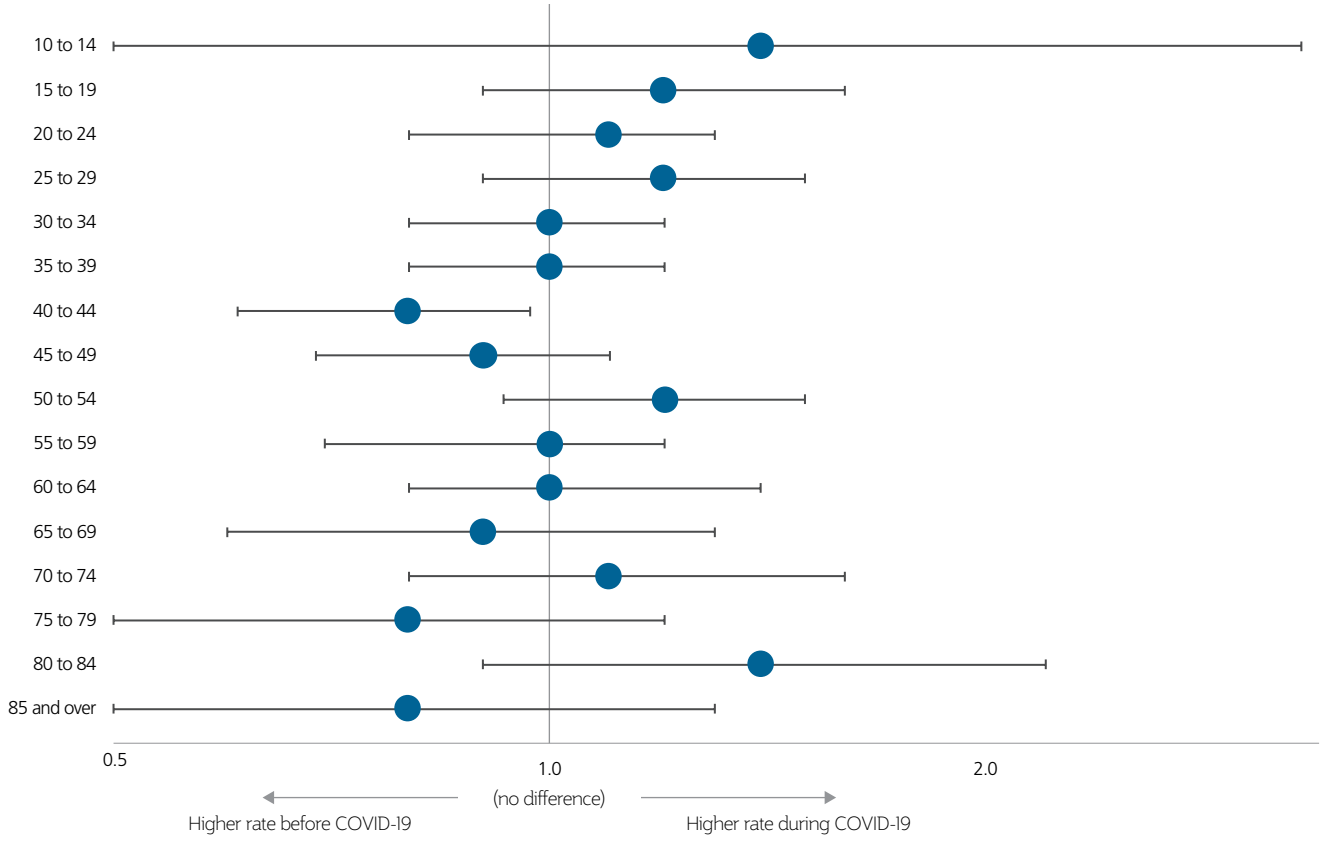
The bars that extend either side of the yellow dots are 95% confidence intervals. They indicate the precision of an estimate, and convey how much uncertainty there is associated with it.

The figure shows that the suspected suicide rate ratios during COVID-19 have differed, depending on the age group of males. Some male age groups who have experienced higher rates during COVID-19 include boys aged 10 to 14 and males aged 80 to 84 (both 1.4 times higher, or 40% higher). However, there is a lot of uncertainty associated with both of these estimates, indicated by the wide confidence intervals.

Following these two age groups were males aged 15 to 19, 25 to 29 and 50 to 54 (all 1.2 times higher, or 20% higher). These estimates were more precise. Following these age groups, males aged 20 to 24 and 70 to 74 had suicide rates 1.1 times higher (10% higher) during COVID-19.

Some male age groups, though, had lower suspected suicide rates during COVID-19. They included males aged 40 to 44, 75 to 79 and 85 and over (all 0.8 times lower, or 20% lower). Following this, males aged 45 to 49 and 65 to 69 also had a suspected suicide rate 0.9 times lower, or 10% lower, than the pre-COVID-19 period.

Figure 3.4: Age-specific suspected suicide rates in the COVID-19 period (Feb 2020 to Dec 2021), compared to the pre-COVID-19 period (Jan 2015 to Jan 2020), Queensland males



Note: Bars represent 95% confidence intervals.

Source: interim Queensland Suicide Register (2015 to 2021).

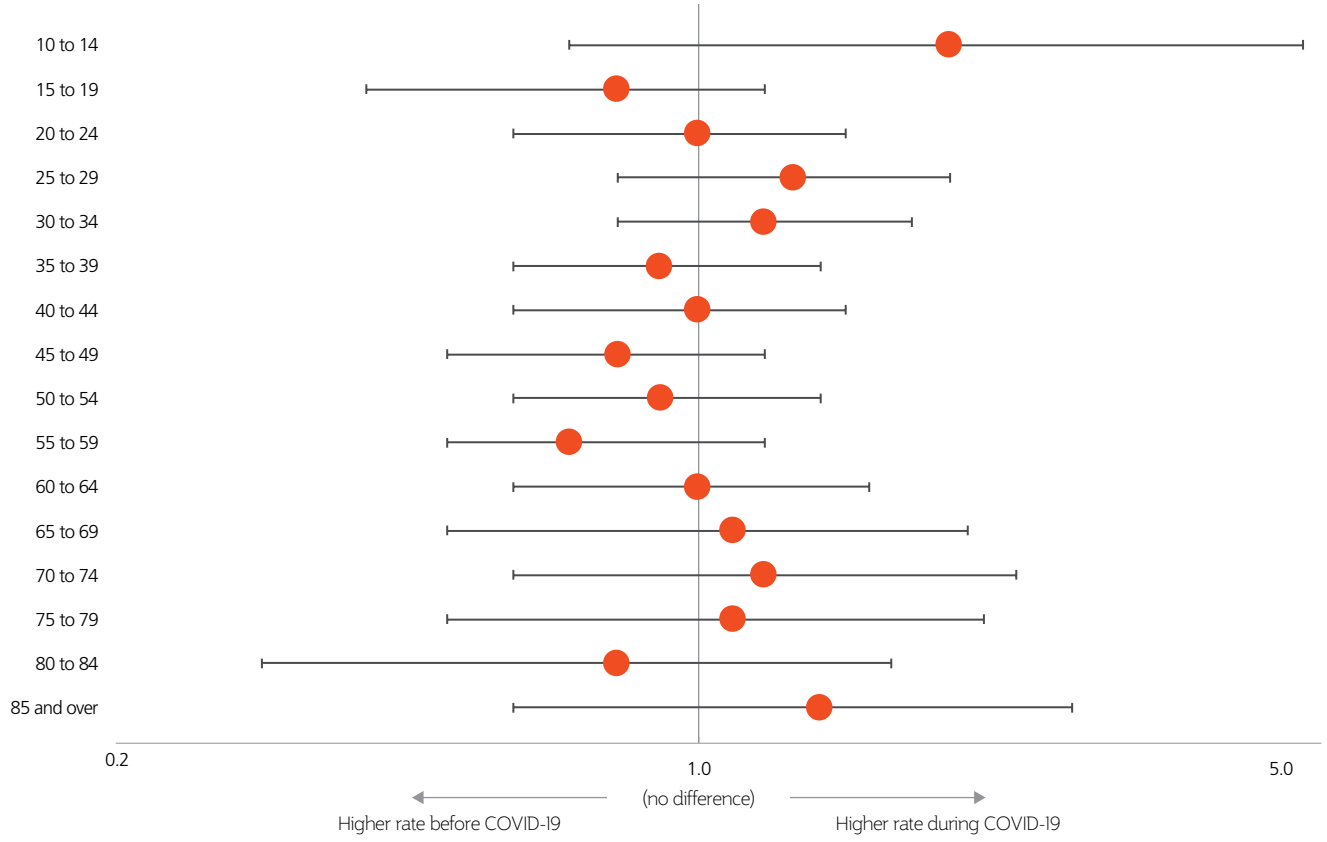
For females (**Figure 3.5**), the highest age-specific suspected suicide rates in the COVID-19 period, relative to the pre-COVID-19 period, differed from males. The highest rate was 2.0 times (100%) higher in females aged 10 to 14, although there was a lot of uncertainty in this estimate, reflected in wide confidence intervals.

Other increases in estimated age-specific suspected suicide rates during the COVID-19 period were observed for females aged 85 and over (1.4 times higher, or 40% higher), 25 to 29 (1.3 times higher, or 30% higher), 30 to 34 and 70 to 74 (1.2 times higher, or 20% higher), and females aged 65 to 69 and 75 to 79 (1.1 times higher, or 10% higher).

Female age groups with lower estimated age-specific suspected suicide rates during COVID-19 included females aged 55 to 59 (0.7 times lower, or 30% lower), females aged 15 to 19, 45 to 49 and 80 to 84 (0.8 times lower, or 20% lower), and females aged 35 to 39 and 50 to 54 (0.9 times lower, or 10% lower).

For both males and females, this preliminary analysis shows that some older and younger age groups, for both males and females, may have had higher estimated suspected suicide rates during COVID-19, although considerable uncertainty in these estimates remains. Not all younger or older age groups among males or females had higher suspected suicide rates, as some were actually under 1.0 (the same rate before and during COVID-19). **Tables A.5** and **A.6** in the appendix provide all numbers, rates, rate ratios and their 95% confidence intervals, and rate differences and their 95% confidence intervals underlying these figures.

Figure 3.5: Age-specific suspected suicide rates in the COVID-19 period (Feb 2020 to Dec 2021), compared to the pre-COVID-19 period (Jan 2015 to Jan 2020), Queensland females



Note: Bars represent 95% confidence intervals.

Source: interim Queensland Suicide Register (2015 to 2021).

The analysis does not provide evidence that there has been an increase in suspected suicide rates since the COVID-19 pandemic restrictions have been implemented. Some changes observed may have also occurred without the pandemic. However, this analysis does not consider time trends in age-specific suspected suicide rates in the years before the COVID-19 pandemic.

Further analysis of qualitative data from the iQSR by QSR staff shows that the COVID-19 pandemic contributed to some suicides. Police officers mentioned COVID-19 in 106 of 1,539 (6.9%) police reports of suspected suicides from 29 January 2020 to 31 December 2021. There were 20 instances where the police mentioned COVID-19, but the effect or context of the COVID-19 discussion on the suspected suicide was unclear or unrelated. Thus, the COVID-19 pandemic appeared to impact 86 of the 1,539 suspected suicides (5.6%) in Queensland from 29 January 2020 to 31 December 2021. Reported effects, which often overlapped and aligned broadly with known risk factors for suicide, included:

- **Employment**: there were 35 suspected suicides where people had their employment or business affected by the COVID-19 pandemic or related public health measures. These individuals were impacted in this context due to loss of hours of employment, jobs falling through or losing their job completely.
- **Psychological**: information from 24 suspected suicides mentioned that the COVID-19 pandemic and related public health measures reportedly affected a person's mood, coping, stress or anxiety. This included new mental health conditions due to COVID-19 restrictions, or more severe effects of pre-existing mental health conditions due to the COVID-19 pandemic.
- **Isolation**: 23 suspected suicides reported social isolation arising from the COVID-19 pandemic and related public health measures as a factor. Effects linked to social isolation included loneliness and limited socialisation due to the COVID-19 pandemic and related public health measures.
- **Healthcare**: there were nine suspected suicides where limited or changed access to healthcare support and healthcare items due to the COVID-19 pandemic and related public health measures reportedly affected the individual. This included where people could not attend medical appointments or obtain medications due to COVID-19 restrictions.
- **Finances**: there were under five suspected suicides where the COVID-19 pandemic reportedly affected finances, involving broader financial issues not directly related to employment.
- **Personal impacts**: under five suspected suicides occurred in the context of a breakdown in a relationship or an interruption to usual activities due to the COVID-19 pandemic and related public health measures.

2016 to 2018

This section reports the demographic and health characteristics of 2,367 people who died by suicide in Queensland (2,331 were Queensland residents) between 2016 and 2018. These years cover the most recent information about suicides from the QSR. This section identifies factors that may contribute to a person's death by suicide. It also helps to indicate target groups for Queensland's suicide prevention strategy.

The police report and the National Coronial Information System (NCIS) provide information on employment status and marital status in the QSR. If discrepancies between these sources exist, QSR coders rely on the police report.

Marital status and related life events

Over a third of people who died by suicide in Queensland were reportedly married or in a de facto relationship (841, 35.5%; **Table 3.4**). The proportions of individuals who were married or in a de facto relationship who died by suicide were similar between males (650, 35.8%) and females (191, 34.8%). Males who died by suicide were more often separated (265, 14.6%) than females (43, 7.8%).

Relationship separation (with or without conflict) was reportedly a life event for one in every four people (207, 25.6%) dying by suicide from 2016 to 2018 (**Table 3.5**). Relationship conflict (with or without separation) was a life event reported for every fifth (477, 20.2%) person who died by suicide from 2016 to 2018. While relationship separation was more likely to precede suicide for males (19.9%) than females (13.5%) from 2016 to 2018, relationship conflict was more likely to precede suicide for females (13.8%) than males (12.6%).

Table 3.4: Marital status, people dying by suicide in Queensland, 2016 to 2018

	Sex				Persons	
	Males		Females			
Marital status	**Number**	**%**	**Number**	**%**	**Number**	**%**
Married/de facto	650	35.8	191	34.8	841	35.5
Single	308	16.9	101	18.4	409	17.3
Unknown	284	15.6	91	16.6	375	15.8
Separated	265	14.6	43	7.8	308	13.0
Never married	156	8.6	45	8.2	201	8.5
Divorced	112	6.2	35	6.4	147	6.2
Widowed	43	2.4	43	7.8	86	3.6
Total	**1,818**	**100.1**	**549**	**100.0**	**2,367**	**99.9**

Note: Percentages sum to 100.1 and 99.9 due to rounding.

Source: Queensland Suicide Register.

Table 3.5: Relationship problems as a recent life event, people dying by suicide in Queensland, 2016 to 2018

	Sex				Persons	
	Males		Females			
Relationship problems	**Number**	**%**	**Number**	**%**	**Number**	**%**
None known	1,085	59.7	370	67.4	1,455	61.5
Separation	361	19.9	74	13.5	435	18.4
Conflict	229	12.6	76	13.8	305	12.9
Both conflict and separation	143	7.9	29	5.3	172	7.3
Total	**1,818**	**100.1**	**549**	**100.0**	**2,367**	**100.1**

Note: Percentages sum to 100.1 for males and persons due to rounding.

Source: Queensland Suicide Register.

Employment status and related life events

In Queensland, a quarter (595, 25.1%) of people who died by suicide from 2016 to 2018 were reportedly unemployed (**Table 3.6**). In contrast, the unemployment rate in Australia in June 2017 was 5.6%.[54]

Table 3.8 shows that recent or pending unemployment was reportedly an adverse life event for one in every 10 (232, 9.8%) suicides between 2016 and 2018, being more frequent for males (11.3%) than females (4.9%). Over a quarter of people who died by suicide (654, 27.6%) were unemployed or reportedly experienced recent or pending unemployment near their death.

Financial problems were reportedly an adverse life event for around one in every five males dying by suicide (335, 18.4%) and a bit over one in every 10 female suicides (63, 11.5%) (**Table 3.8**). This suggests that reducing the impact of financial problems can be a target for suicide prevention policies, especially for males.

Table 3.6: Employment status by sex, people dying by suicide in Queensland, 2016 to 2018

	Sex				Persons	
	Males		Females			
Employment status	**Number**	**%**	**Number**	**%**	**Number**	**%**
Unemployed	465	25.6	125	22.8	590	24.9
Unknown	345	19.0	151	27.5	496	21.0
Full-time employment	394	21.7	51	9.3	445	18.8
Retired	246	13.5	93	16.9	339	14.3
Employed (unknown mode)	154	8.5	37	6.7	191	8.1
Part-time/casual employment	100	5.5	33	6.0	133	5.6
Student	63	3.5	41	7.5	104	4.4
On disability pension	49	2.7	17	3.1	66	2.8
Other not in labour force	np	np	np	np	7	0.3
Incarcerated	np	np	np	np	5	0.2
Total	**1,818**	**96.5**	**549**	**99.8**	**2,367**	**100.4**

Note: np = not provided (suicides less than five for one or both sexes). Totals do not sum to 100.0% as nine students were also in casual employment.

Source: Queensland Suicide Register.

Occupation

Occupational groups are exposed to different types of stressors that might influence an individual's risk of suicide. These stressors can involve work culture, workload, occupational risks and exposure to stressful or traumatic events that may impact personal health and wellbeing.

Occupational data were available for 646 (84.8%) people who were reportedly employed when they died by suicide. Table 3.7 lists the number and proportion of each major occupational group of people who died by suicide in Queensland from 2016 to 2018.[55] The largest major occupational group to die by suicide in Queensland from 2016 to 2018 was labourers and machine operators/drivers, which included 179 males (9.8%) and 15 females (2.7%). Technicians and trades workers (142, 6.0%) were the next most frequent occupational group. This data illustrates the importance of focusing occupation specific suicide prevention activities for trades workers.

Australian Defence Force personnel

It is a nationwide priority to reduce the suicides of current and ex-serving Australian Defence Force (ADF) people in Australia. The QSR recorded 30 suspected suicides of current or ex-ADF personnel in Queensland from 2016 to 2018. This report provides suicide numbers of current and veteran ADF personnel together for confidentiality reasons. This may be an under-reported figure because currently serving ADF or veteran status may not always be captured when investigating a suicide.

Table 3.7: Major occupational group by sex, people dying by suicide in Queensland, 2016 to 2018

	Sex				Persons	
	Males		Females			
Occupation group	Number	%	Number	%	Number	%
Not reportedly working	1,170	64.4	428	78.0	1,598	67.5
Labourers and	179	9.8	15	2.7	194	8.2
Machine operators/drivers	133	7.3	9	1.6	142	6.0
Technicians and trades	108	5.9	22	4.0	130	5.5
Unknown	85	4.7	7	1.3	92	3.9
Managers	65	3.6	21	3.8	86	3.6
Professionals	43	2.4	28	5.1	71	3.0
Community and personal service	21	1.2	9	1.6	30	1.3
Sales workers	14	0.8	10	1.8	24	1.0
Total	**1,818**	**100.1**	**549**	**99.9**	**2,367**	**100.0**

Note: np = not provided (suicides less than five for one or both sexes). Percentages sum to 100.1 and 99.9 due to rounding.

Source: Queensland Suicide Register.

Adverse life events

The QSR defines an adverse life event as any event before a suicide that may have negatively impacted the deceased person. The most frequent life events before deaths by suicide for males (in order of frequency) were financial problems (335, 18.4%), bereavement (272, 14.9%) and family conflict (249, 13.7%; **Table 3.8**). For females, the major life events before deaths by suicide were bereavement (123, 22.4%), family conflict (107, 19.5%) and financial problems (63, 11.5%; **Table 3.8**).

Pending legal matters were also a significant adverse life event, specifically for males (237, 13.0%). These findings demonstrate the need for sex-specific cross-sectoral suicide prevention policies to reflect the different adverse life events experienced by males and females dying by suicide.

Table 3.8: Adverse life events, people dying by suicide in Queensland, 2016 to 2018

	Sex				Persons	
	Males		Females			
Adverse life event	**Number**	**%**	**Number**	**%**	**Number**	**%**
Financial problems	335	18.4	63	11.5	398	16.8
Bereavement	272	14.9	123	22.4	395	16.5
Family conflict	249	13.7	107	19.5	356	15.0
Pending legal matters	237	13.0	33	6.0	270	11.4
Work/school problems (not financial)	209	11.5	58	10.6	267	11.3
Recent or pending unemployment	205	11.3	27	4.9	232	9.8
Child custody dispute	102	5.6	27	4.9	129	5.4
Interpersonal conflict	90	5.0	37	6.7	127	5.4
Childhood trauma	78	4.3	54	9.8	132	5.6
Sexual abuse	61	3.4	42	7.7	103	4.4

Note: One person can experience multiple life events, so the total percentages are not 100.0, and totals are not tallied here.

Source: Queensland Suicide Register.

Alcohol use

Acute and chronic alcohol use increase the risk of suicide. The QSR collects data on the blood alcohol concentration of those who died by suicide from toxicology reports. Blood alcohol concentration being detected means that the person consumed alcohol before their death. It does not mean that alcohol use contributed to their death, however, acute alcohol use may promote depressive thoughts and disinhibit the barriers including fear of death.[56]

From available data (finalised investigations into deaths with available toxicology reports), over a third (37.5%) of people dying by suicide from 2016 to 2018 were found to have a blood alcohol concentration of 10mg/100ml (0.10 in road traffic terms) or higher (**Table 3.9**). Alcohol policies targeting alcohol consumption, alcohol availability and pricing may reduce suicidal behaviour.[57]

Table 3.9: Blood alcohol concentration, people dying by suicide in Queensland, 2016 to 2018

		Persons	
Blood alcohol content	**Likely effect**	**Number**	**%**
Not detected (less than 10mg/100 mL)	Not applicable	1,287	54.4
Detected		888	37.5
0.01 to 0.05g%	Mild speech, memory, attention impairments; sleepiness can begin	247	10.4
0.06 to 0.15g%	Speech, memory, attention further impaired; increased risk of injury to self	381	16.1
0.16 to 0.30g%	Judgement and decision-making dangerously impaired	246	10.4
0.31 to 0.45g%	Loss of consciousness, risk of alcohol poisoning, suppression of vital life functions	14	0.6
Blood toxicology not performed or not available	Not applicable	192	8.1
Total		**2,367**	**100.0**

Source: Queensland Suicide Register.

Other drug use

Drug use is a suicide risk factor. This section on drug use refers to current use (i.e. regular users, occasional/social users, users [unknown regularity] and those who consumed a substance before their suicide). Individuals might have used multiple drugs and presented information should not be interpreted as indicating using the drug contributed to or caused the person to take their own life.

Table 3.10 shows current usage of illicit drugs by people who took their own lives. Cannabis was the most common substance used for both males (368, 20.2%) and females (83, 15.1%) who took their own lives. Amphetamines or methamphetamines were the second most common substances used for both males (284, 15.6%) and females (55, 10.0%).

Table 3.10: Current drug use or misuse, people dying by suicide in Queensland, 2016 to 2018

	Sex				Persons	
	Males		Females			
Current drug use	**Number**	**%**	**Number**	**%**	**Number**	**%**
Cannabis use	368	20.2	83	15.1	451	19.1
Amphetamines or methamphetamines	284	15.6	55	10.0	339	14.3
Use of other or unspecified illicit substances	31	1.7	7	1.3	38	1.6
Cocaine	np	np	np	np	27	1.1
Heroin	np	np	np	np	26	1.1
Hallucinogenics	np	np	np	np	17	0.7

Note: np = not provided (suicides less than five for one or both sexes). One person could have reported multiple conditions, so the total percentages are not 100.0, and totals are not tallied here.

Source: Queensland Suicide Register.

Mental health conditions

Some mental health conditions heighten the risk of suicide. The QSR records mental health conditions of the person reportedly diagnosed during their lifetime. This recording uses information from police reports and coroner's findings. Limitations of this data is that it includes reported diagnoses according to friends and family of the person who took their own life. It is also not cross-checked with any public or private mental health data that would hold further information on any mental health conditions that people dying by suicide had.

The QSR only records if the person reportedly had a diagnosis, and not who reported this to police or coroners. Thus, numbers and proportions would underestimate true numbers of mental health conditions. A person may not have been experiencing symptoms of their mental health condition at the time of death, and these conditions did not necessarily contribute to the person's death.

Of all people who died by suicide from 2016 to 2018, 1,262 (53.3%) reportedly had a mental health condition (**Table 3.11**). A greater proportion of females who died by suicide had a reported mental health condition (66.3% females versus 49.4% males), especially depression (46.8% females versus 34.8% males) and anxiety (28.4% females versus 13.4% males; **Table 3.12**). Females had a higher proportion for most conditions. However, males had a higher proportion of reported psychotic disorders and developmental disorders.

Suicide prevention policies need to consider that not all people who die by suicide will be diagnosed with a mental health condition. Also, a diagnosis may not mean the symptoms of the condition contributed to the death. Even where the symptoms do contribute to the death, there may still be multiple contributing causes.

Table 3.11: Reported mental health condition, people dying by suicide in Queensland, 2016 to 2018

	Sex				Persons	
	Males		Females			
	Number	%	Number	%	Number	%
Yes – any mental health condition	898	49.4	364	66.3	1,262	53.3
Yes – common mental health condition	857	47.1	351	63.9	1,208	51.0
No	920	50.6	185	33.7	1,105	46.7
Total	**1,818**	**100.0**	**549**	**100.0**	**2,367**	**100.0**

Note. Common mental health conditions included depression, anxiety, bipolar, substance use disorders and personality disorders.

Source: Queensland Suicide Register.

Table 3.12: Lifetime diagnosed mental health conditions, people dying by suicide in Queensland, 2016 to 2018

	Sex				Persons	
	Males		Females			
	Number	%	Number	%	Number	%
Depression	632	34.8	257	46.8	889	37.6
Anxiety	250	13.8	156	28.4	406	17.2
Substance use disorder	206	11.3	68	12.4	274	11.6
Psychotic conditions	152	8.4	44	8.0	196	8.3
Bipolar	85	4.7	58	10.6	143	6.0
Developmental disorder	69	3.8	19	3.5	88	3.7
Personality disorder	33	1.8	52	9.5	85	3.6
Dementia	41	2.3	19	3.5	60	2.5
Adjustment disorder	19	1.0	8	1.5	27	1.1
Eating disorder	6	0.3	11	2.0	17	0.7
Conduct disorder	np	np	np	np	7	0.3

Note: np = not provided (suicides less than five for one or both sexes). One person could have reported multiple conditions, so the total percentages are not 100.0, and totals are not tallied here.

Source: Queensland Suicide Register.

History of suicidal behaviour

Opportunities to avert suicides emerge during situations where people express their intent to take their own life or after they attempt to take their own life. These opportunities also depend on these events being reported to health services or professionals, who can subsequently deliver evidence-based interventions to at-risk individuals with previous suicidality. Table 3.13 shows that over one in two males (1,042, 57.3%) and almost two in three females (342, 62.3%) who took their own lives between 2016 and 2018 expressed their intent to take their own life in their lifetime. In the 12 months before they took their own life, around four in 10 males (754, 41.4%) and females (237, 43.2%) expressed their intention to take their own life.

Over one in three people (832, 35.2%) who took their own life made an attempt at any point in their past. Around three in every 10 males (575, 31.7%) and almost half of all females (257, 46.7%) dying by suicide had reportedly tried to take their own life at any point in their past. During the year prior to taking their own life, about one in every six males (272, 15.1%) and almost a quarter of females (129, 23.5%) had attempted suicide.

Table 3.13: Prior suicidality, people dying by suicide in Queensland, 2016 to 2018

	Sex				Persons	
	Males		Females			
	Number	%	Number	%	Number	%
Communication of intent in lifetime						
Once or twice	749	41.2	226	41.2	975	41.2
Several times	293	16.1	116	21.1	409	17.3
No	355	19.5	83	15.1	438	18.5
Unknown	421	23.2	124	22.6	545	23.0
Total	**1,818**	**100.0**	**549**	**100.0**	**2,367**	**100.0**
Communication of intent in past 12 months						
Once or twice	626	34.4	191	34.8	817	34.5
Several times	128	7.0	46	8.4	174	7.4
No	415	22.8	102	18.6	517	21.8
Unknown	649	35.7	210	38.3	859	36.3
Total	**1,818**	**99.9**	**549**	**100.1**	**2,367**	**100.0**
Lifetime suicide attempts						
Once or twice	448	24.6	188	34.2	636	26.9
Several times (3 or more)	85	4.7	52	9.4	137	5.8
Yes (unknown times)	30	1.7	11	2.0	41	1.7
Yes (multiple but unknown times)	12	0.7	6	1.1	18	0.8
No	629	34.6	144	26.2	773	32.7
Unknown	614	33.8	148	27.0	762	32.2
Total	**1,818**	**100.1**	**549**	**99.9**	**2,367**	**100.1**
Suicide attempt in the past 12 months						
Once or twice	261	14.4	119	21.7	380	16.1
Several times (3 or more)	11	0.6	10	1.8	21	0.9
No	741	40.8	212	38.6	953	40.3
Unknown	805	44.3	208	37.9	1,013	42.8
Total	**1,818**	**100.1**	**549**	**100.0**	**2,367**	**100.1**

Note: A person may have had multiple types of suicidal behaviour, which this table does not reflect. Percentages sum to 100.1 and 99.9 due to rounding.

Source: Queensland Suicide Register.

Contact with health services

This part considers the contact with health services of people who died by suicide in Queensland from 2016 to 2018. These contacts included general practitioners, inpatient or outpatient hospital services, and other services (e.g. psychologists). These contacts refer to seeing a health professional or service for a mental health condition. Health service contact offers opportunities for suicide prevention interventions, particularly when consultations are for mental health conditions.

Table 3.14 indicates that over a quarter of people (646, 27.3%) reportedly consulted with a general practitioner about a mental health condition in their lifetime. These consultations were more common for females (192, 35.0%) than males (454, 25.0%) who died by suicide.

One of every five people (523, 22.1%) had been an inpatient at some point in their life. This proportion differed by sex.

Two in 10 males (356, 19.6%) and three in 10 females (167, 30.5%) had a history of inpatient treatment for a mental health condition. From 2016 to 2018, one in six people (375, 16.9%) dying by suicide had reportedly received outpatient treatment for a mental health condition in their lifetime. This proportion was again lower for males (253, 13.9%) than females (122, 22.2%).

Lastly, the QSR recorded treatment from another service for a mental health condition (e.g. treatment with a private psychologist). Across both sexes, around one in 10 (276, 11.6%) of all people dying by suicide from 2016 to 2018 had reportedly received treatment from another service for a mental health condition. The proportion was again slightly lower for males (192, 10.5%) than females (84, 15.4%).

Table 3.14: Contact with health services for a mental health condition, people dying by suicide in Queensland, 2016 to 2018

	Sex				Persons	
	Males		Females			
	Number	%	Number	%	Number	%
Lifetime treatment from a general practitioner						
Yes	454	25.0	192	35.0	646	27.3
Unknown	444	24.4	172	31.3	616	26.0
Not applicable	920	50.6	185	33.7	1,105	46.7
Total	**1,818**	**100.0**	**549**	**100.0**	**2,367**	**100.0**
Lifetime treatment as an inpatient						
Yes, current	38	2.1	12	2.2	50	2.1
Yes, past	318	17.5	155	28.3	473	20.0
No/unknown	542	29.8	197	35.9	739	31.2
Not applicable	920	50.6	185	33.7	1,105	46.7
Total	**1,818**	**100.0**	**549**	**100.1**	**2,367**	**100.0**
Lifetime treatment as an outpatient						
Yes, current	135	7.4	66	12	201	8.5
Yes, past	109	6.0	49	8.9	158	6.7
Yes, unknown when	9	0.5	7	1.3	16	0.7
No/unknown	645	35.5	242	44.1	887	37.5
Not applicable	920	50.6	185	33.7	1,105	46.7
Total	**1,818**	**100.0**	**549**	**100.0**	**2,367**	**100.1**
Lifetime treatment from another service						
Yes, current	98	5.4	42	7.7	140	5.9
Yes, past	79	4.3	35	6.4	114	4.8
Yes, unknown when	15	0.8	7	1.3	22	0.9
No/unknown	706	38.8	280	51.0	986	41.7
Not applicable	920	50.6	185	33.7	1,105	46.7
Total	**1,818**	**99.9**	**549**	**100.1**	**2,367**	**100.0**

Note: People may have been receiving or have received multiple types of treatment, which this table does not reflect. Percentages sum to 100.1 and 99.9 due to rounding.

Source: Queensland Suicide Register.

Implications for suicide prevention

Section 4

Key findings and their implications for policy and practice

The Queensland Government is taking action at multiple levels to reduce suicide and inform cross-sectoral prevention and policy through *Every life: The Queensland Suicide Prevention Plan 2019–2029* (*Every life*), a strategy to reduce suicide over 10 years.

Every life includes the Queensland Government's commitment to enhancing the model of surveillance of suicide deaths, as a crucial part of reducing suicides in Queensland. The review of the Queensland surveillance system coincides with renewed efforts by the Australian Government to reducing suicides and their impact in the *National Mental Health and Suicide Prevention Plan*.[58] The *National Suicide Prevention Adviser's* final report informed this plan and includes more focus on cross-government and cross-sectoral suicide reduction initiatives.[59] Essential parts of this approach are suicide registers, which the National Suicide Prevention Adviser's Office acknowledged in December 2020. They recommended as a priority action that "*All jurisdictions maintain or, where not already in place, establish a suicide register and mechanisms for the routine collection and timely sharing of data on suicide*".[60] Opportunities to better align and coordinate state and national activity are being examined to achieve an optimal approach to surveillance of suicide deaths and behaviours to support suicide prevention.

Across Queensland in 2021, **813 Queensland residents** were lost to suicide. This equates to 15 deaths by suicide per 100,000 people. **Males continue to be overrepresented in suicide deaths at a rate of more than three to one**. This continues the existing trend of increasing male age-standardised suicide rates across the years since 2006. Reducing the male suicide rate in Queensland continues to present a significant challenge to suicide prevention efforts – a challenge not unique to Queensland, nor Australia,[61] but one that must be met if reductions in the overall suicide rate in Queensland will occur.

Every life acknowledges this particular challenge, with specific focus on reducing the male suicide rate in Queensland. The pathways to suicide for males differ from those of females, and remain less than fully understood by researchers, making it difficult to develop and implement targeted suicide prevention initiatives amongst Queensland males.

What is known, however, is that middle-aged males, particularly those aged 50 to 54, accounted for the most deaths by suicide in 2021. Major risk factors for suicide in this age group have been shown to include work-related factors and factors related to family relationships. While the pursuit of more evidence must continue through further research, better quality surveillance, and the building of a better picture of male suicidal pathways, these known risk factors for middle-aged males need to be considered by existing suicide prevention strategies.

Queensland young males aged 20 to 24 are another group experiencing high suicide rates, with these rates also showing an increasing trend over time since 2011. Many mental health problems (e.g. psychosis and bipolar disorder) have peak onset periods in this age group, which should be considered when planning and implementing suicide prevention initiatives designed to target this group.

While the suicide rate in males has remained higher, the findings of this report outline that suicide rates of females are increasing. It is important to note that a relatively low male to female suicide rate ratio (3.1) was measured in 2021; this can be attributed to the female rate slowly increasing over time compared to the male rate. Increasing suicide rates among females are attributable to an increasing proportion of females using more lethal methods, including hanging, strangulation or suffocation. It is also important to consider that females have higher rates of hospitalisations for intentional self-harm compared to the males, and for Queensland females these rates have increased in last decade.[62] Females also had higher numbers and crude rates of ambulance attendances for self-injury, suicidal ideation and suicide attempts in Queensland in 2020.[63] This further highlights the need for gender specific suicide prevention strategies.

Queensland is a large state with a scattered population. Increasing **remoteness** of location is associated with higher suicide rates for both males and females. Some of this phenomenon may, however, be attributable to the fact that many rural and remote locations are populated by greater numbers of people who are identified as being at higher risk of suicidality or vulnerable to suicide. These vulnerable groups include farmers and Aboriginal and Torres Strait Islander peoples. Any suicide prevention activities planned for and implemented in these remote areas will need to consider this.

Aboriginal and Torres Strait Islander peoples, especially young First Nations people, have been identified as experiencing greater vulnerability to suicide than non-Indigenous Queenslanders. Strategies that aim to increase cultural connection and engagement, and reduce discrimination, should be included in any initiatives developed to reduce the number of deaths by suicide amongst First Nations young people.[64] *Every life* highlights and addresses this issue through multiple pathways and actions, such as enhancing Aboriginal and Torres Strait Islander leadership in mental health and suicide prevention.[65]

Unemployment continues to appear as a significant factor related to suicide deaths in Queensland. Conversely, initiatives designed to ameliorate the effects or levels of unemployment, such as unemployment support benefits, and legislation targeting employment protections appear to be protective against suicide.[66] Type of employment also appears to impact the risk of suicide, with suicide rates found to be much higher in certain occupations, such as the construction sector.[67] Initiatives such at MATES in Construction, Mining and Energy have evidence of effectiveness in these areas.[68]

A reported **mental health condition** was found to be present in about half of those who died by suicide in Queensland. This finding is not necessarily indicative of a causal relationship, but certainly a contributory relationship must be considered. A reported mental health condition may exacerbate other risk factors for suicide that are relevant to an individual. This finding does, however, perhaps present us with opportunity for surveillance and identification of those at risk of suicide, through contact with mental health services.

The involvement of **alcohol and other substance use** is frequently found in suicide deaths in Queensland. As with the involvement with mental health conditions, this knowledge presents us with multiple points of contact in which to identify and intervene in cases before they have the opportunity to progress to suicidal behaviour. In addition, multiple levels of suicide prevention can be utilised in attempting to reduce the rate of these suicide deaths, starting at whole-of-population education and awareness campaigns aimed at raising awareness of the effects of alcohol and substance use, through to intervention and postvention strategies.

Despite now being more than two years into the **COVID-19 pandemic**, Queensland's suicide rates have not seen notable impacts from this event. As the pandemic continues, however, there is a need to continue monitoring for changes in circumstances, as Queensland communities continue to experience ongoing disruptions and changes to their usual lifestyles and business.

Those **bereaved by suicide** are also sadly subsequently more vulnerable to suicide following the loss of a loved one. Support must not end at the death of an individual. The government and local communities must recognise and accept that the support required goes beyond the death of an individual to suicide and put in place responses aimed at supporting those left behind. Through the continued development and implementation of postvention initiatives and responses, there may be a way to mitigate further losses to suicide. Postvention development may be enhanced by collaboration with those with lived experience to design responses that meet the needs of those bereaved by suicide.

Suicide in Queensland: Annual Report 2022 contains the critical findings around suicide in Queensland. It outlines the multifaceted and complex nature of suicide and the importance of a multidisciplinary and cross-sectoral approach to prevention. The QSR and iQSR are important components of the all-important stage of surveillance in the efforts in suicide prevention. But these are just anchors—starting points in the complex process of suicide prevention. Surveillance must be followed on by other strategies such as data linkage. These data linkages have the potential to enhance further surveillance efforts, by enabling researchers to recognise patterns and trends in suicide in Queensland. Early identification and recognition pave the way for early intervention. Early intervention paves the way for a reduction in the suicide rates of Queensland.

Appendix

Queensland Suicide Register and interim Queensland Suicide Register methods

The QSR includes information on suspected suicides occurring between 1990 and 2018. This information has several uses (**Table A.1**).

The Queensland Government implemented the iQSR in 2011 to enable real-time information on suicides in Queensland. The iQSR registers suspected suicides from police reports from the Queensland Police Service (QPS) as police email this information to the Coroners Court of Queensland.

The iQSR information is preliminary. Once coroners finalise their investigations, QSR staff reassess suspected suicides, enter and check their details into the QSR. Information in the iQSR on suspected suicides from 2011 to 2022, although QSR data is now available for most of those years (2011 to 2018). The iQSR can report real-time information about changes to suspected suicide numbers in Queensland. It can also look for trends, potential clusters and locations where suicides occur more frequently. **Table A.1** lists the uses of QSR and iQSR data.

Table A.1: Uses of Queensland Suicide Register (QSR) and interim Queensland Suicide Register data (iQSR)

Use	QSR	iQSR
Identify at-risk groups, individuals, places and situations	✓	✓
Estimate the magnitude of a health problem	✓	✓
Show long-term time trends	✓	
Detect and respond to clusters and contagion		✓
Document the burden and distribution of deaths by suicide	✓	✓
Enable epidemiological research (e.g. create and test hypotheses)	✓	✓
Evaluate prevention measures through analysing trends (e.g. large-scale aftercare interventions for people who have attempted suicide)	✓	✓
Monitor the impact of external, environmental exposures (e.g. COVID-19, recession)	✓	✓
Monitor emerging or changing patterns of motives for suicide		✓
Plan public health, prevention and postvention actions at local, state and national levels	✓	
Secure and allocate prevention and postvention resources	✓	
Identify emerging and preventable suicide methods		✓
Support tailored local, state and national suicide prevention efforts	✓	

Note: QSR = Queensland Suicide Register; iQSR = interim Queensland Suicide Register.

Source: Adapted from SB Thacker, 'Historical development', in LM Lee, SM Teutsch, SB Thacker and ME St Louis (eds), Principles and practice of public health surveillance, 3rd edn, Oxford University Press, New York, 2010; World Health Organization, Preventing suicide: a global imperative, World Health Organization, Geneva, 2014.

Data sources

iQSR information comes solely from the QPS's *Form 1 police report of death to a coroner*. Police reports enable police to report a death to a coroner. The police report has information that will help a coroner's investigation into the death, like socio-demographic data, the circumstances of the death and other information about the context (e.g. descriptions of the deceased's mental health or any adverse life stressors prior to death).

QSR data comes from police reports and other coronial investigation material accessed via the NCIS. This coronial investigation material includes:

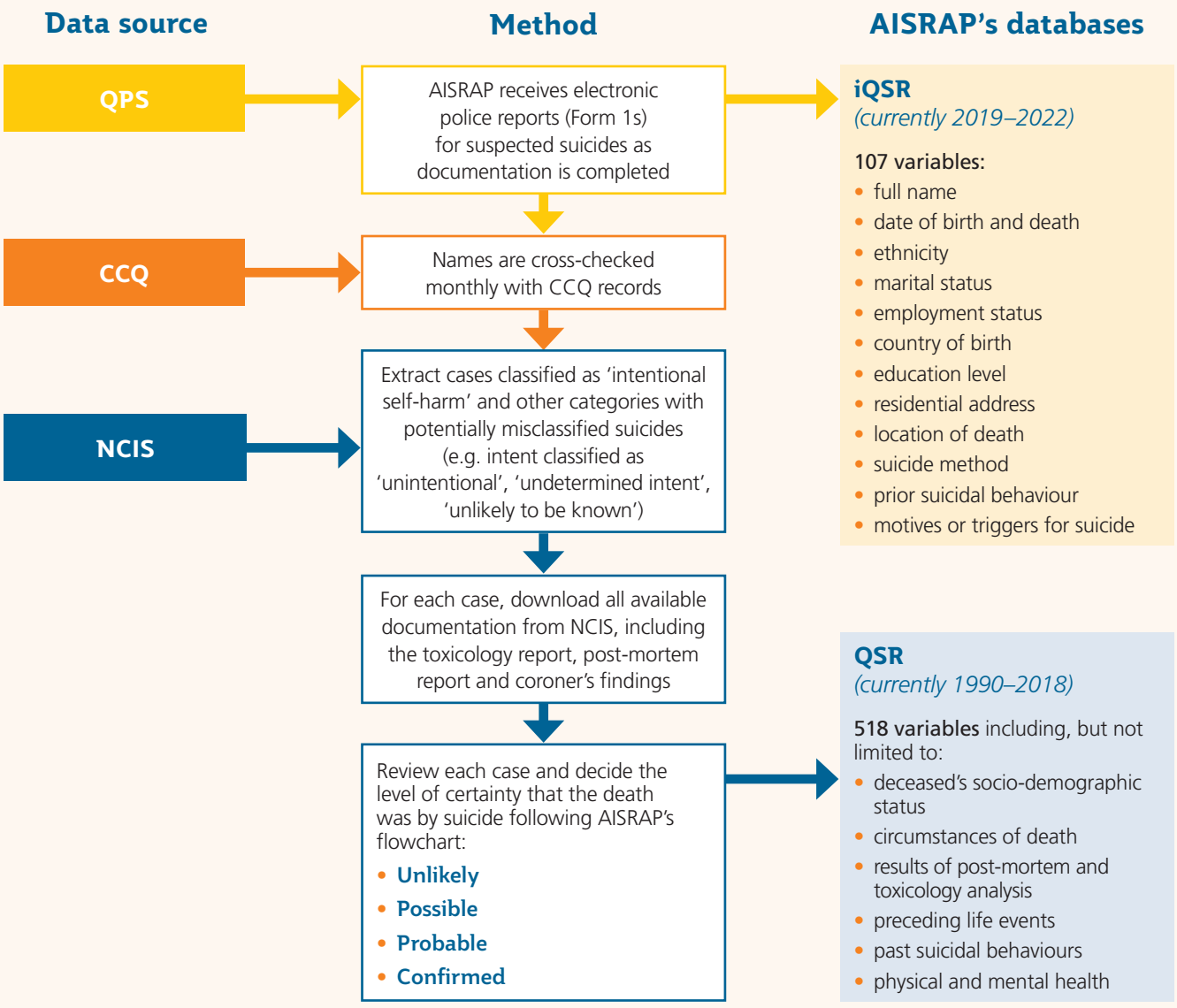
- a **toxicology** report from Queensland Health Forensic and Scientific Services. This report provides information about substances the person may have consumed before their death.
- a **post-mortem examination** from Queensland Health Forensic and Scientific Services. This report provides a detailed medical examination of a person's body and tries to determine the cause of death.
- the **coroner's findings and notice of completion of the coronial investigation**. This finding is a legal document summarising the coroner's findings about a death. The form includes a summary of the context and circumstances leading up to the death. It also summarises how the person died and the place, date and medical cause of the death.

More information comes from three organisations:

- Information on geographical areas, latitude and longitude for the deceased's residential address and the suicide site comes from an external geocoding provider. The NCIS provides more information on marital status, employment status, occupation, country of birth and Aboriginal and Torres Strait Islander origin. The NCIS is a purpose-built data platform established to facilitate access to coronial information. It reflects a commitment by all coroners and jurisdictions to improve the accessibility of coronial information for researchers.
- Information on the deceased's country of birth and Aboriginal and Torres Strait Islander status for recent years when this information is not yet available from the NCIS comes from the Queensland Registry of Births, Deaths and Marriages.

Each suicide death is first recorded in the iQSR, before being entered into the QSR later (**Figure A.1**).

Figure A.1 Flowchart depicting the processes of the interim Queensland Suicide Register (iQSR) and the Queensland Suicide Register (QSR)



Notes:

AISRAP = Australian Institute for Suicide Research and Prevention

iQSR = interim Queensland Suicide Register

NCIS = National Coronial Information System

QPS = Queensland Police Service

CCQ = Coroners Court of Queensland

QSR = Queensland Suicide Register.

Stage 1, iQSR: Information from the police report enters the iQSR. The iQSR includes administrative, demographic and geocoding data and information on the circumstances of suspected suicides. The iQSR is updated three times a week to include incoming data from forms on suspected suicides emailed from police, allowing real-time monitoring of suspected suicides in Queensland.

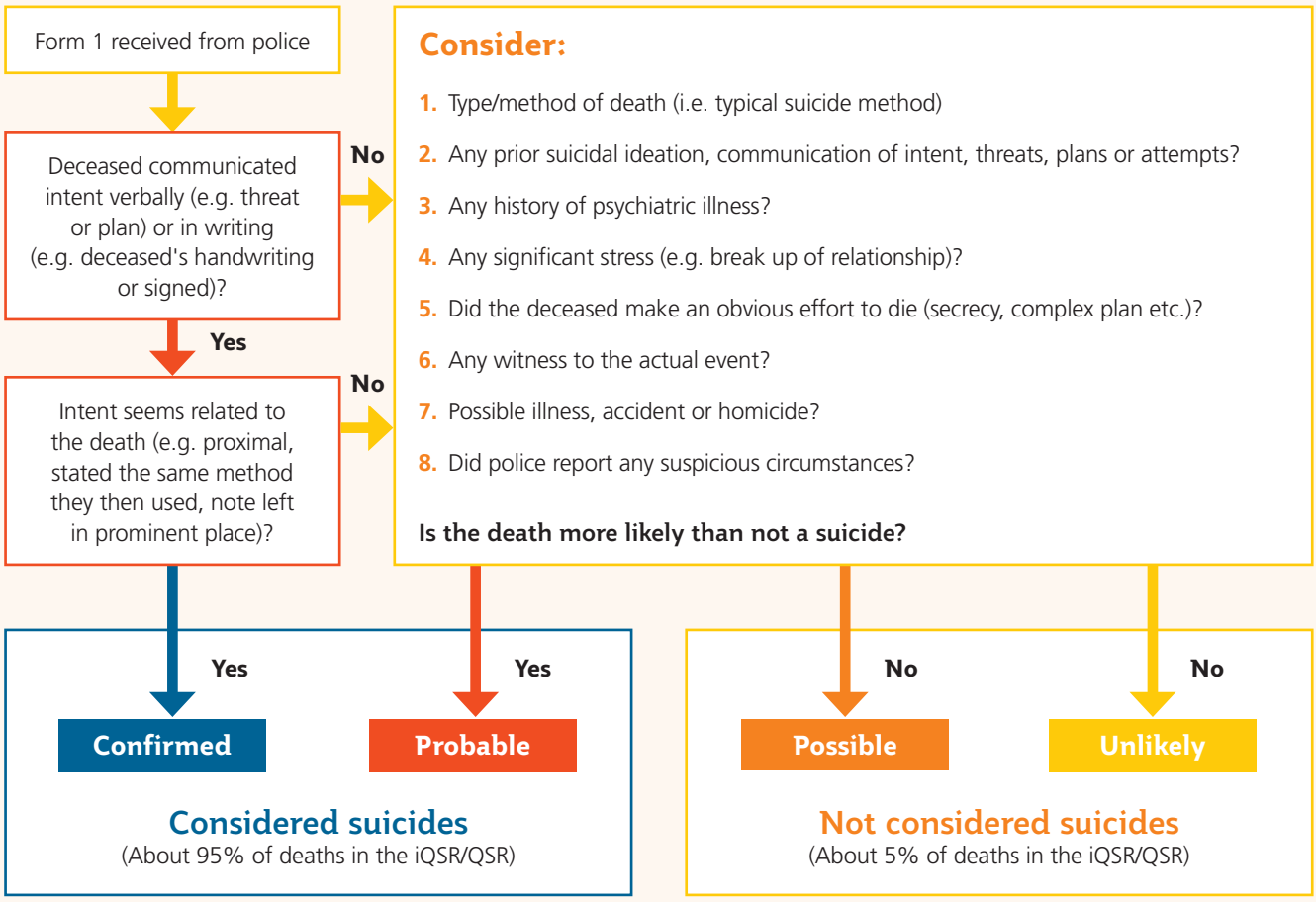
Stage 2, QSR: In the second stage, as coronial investigations close and all coronial information becomes available in the NCIS, suspected suicides in the iQSR are reassessed and then recorded in the QSR. All available information from the NCIS is downloaded, entered, reviewed and added to the QSR.

QSR staff use a decision tree (**Figure A.2**) to code deaths into one of four probabilities of suicide, based on health research criteria:

- **Unlikely**: the available information indicates that death by suicide was unlikely (e.g. heart attack).
- **Possible**: the available information suggests a suicide, but there remains a substantial possibility that the death may be from other internal or external causes of death (e.g. accident, illness or homicide).
- **Probable**: the available information does not allow for a 'confirmed' judgement of suicide but is still more consistent with a death by suicide than any other cause.
- **Confirmed**: the available information suggests that the deceased had written or stated their intent to die by suicide before their death.

Analyses of QSR data exclude the first two groups ('unlikely' and 'possible' suicides), but consider 'probable' and 'confirmed' to be suicides (**Figure A.2**).

Figure A.2: Decision tree for coding the probability of the death being a suicide



Note: iQSR = interim Queensland Suicide Register; QSR = Queensland Suicide Register.

Other data sources

Comparing the Australian Bureau of Statistics (ABS) and the Australian Institute for Suicide Research and Prevention

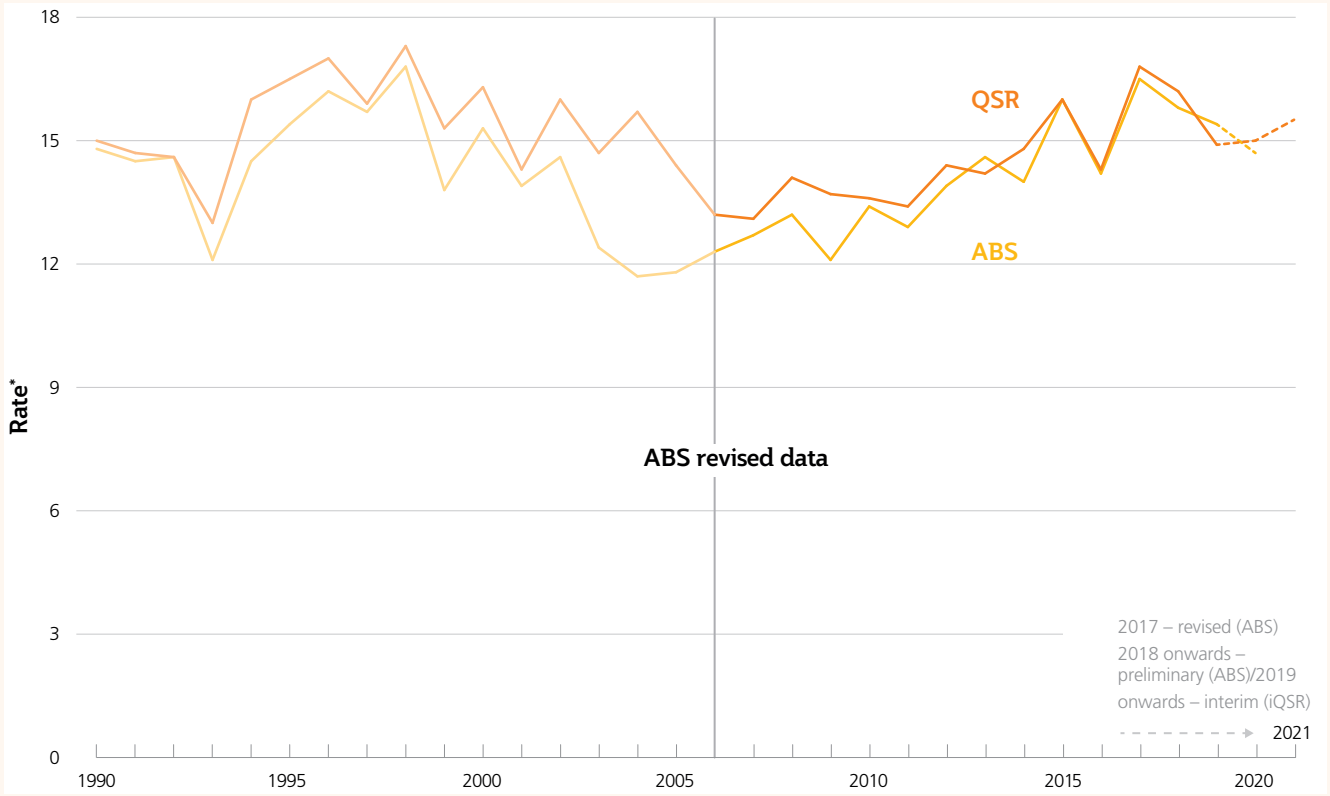
Both the ABS and the QSR and iQSR publish annual numbers and rates of suicide for Queensland each year. However, differences exist in the number of suicides recorded. The ABS mostly reports suicides by the year they were registered with a state-based registry of births, deaths and marriages. The QSR and iQSR report suicides by the year they occurred, which is a small aspect of what the ABS report.

The ABS and the iQSR both include suspected suicides where the death is still under investigation. However, the ABS has nationwide NCIS access to identifiable information on open cases. This better access means that the ABS can access police reports of suspected suicides still being investigated by coroners in all states and territories. In contrast, the iQSR would not identify these deaths until they are closed in the NCIS.

This consideration is relevant for Queensland residents dying by suspected suicide in other states in Australia, and also the suspected suicides not received by AISRAP from the QPS (see **Figure A.4** below).

Figure A.3 compares the ABS to QSR and iQSR statistics over time. The ABS began revising all suspected suicides registered after 1 January 2007 in 2009, to improve the quality of mortality data. They extended this revisions process to suicide mortality data dating back to 1 January 2006 in 2012. **Figure A.3** has a vertical line indicating data that the ABS's revisions process occurred on. Figures from this point show that, from 1990 to 20021, both organisations published similar figures.

Figure A.3: Age-standardised suicide rates, Australian Bureau of Statistics and Queensland Suicide Register/interim Queensland Suicide Register data, Queensland residents, 1990 to 2021



Notes: QSR = Queensland Suicide Register; ABS = Australian Bureau of Statistics.

*Age-standardised suicide rate per 100,000 estimated resident population as at 30 June (mid-year) each year.

Sources: Queensland Suicide Register; interim Queensland Suicide Register; Australian Bureau of Statistics, Causes of death, Australia, 2020, ABS website, 29 Septembers 2021, accessed 1 October 2021.
https://www.abs.gov.au/statistics/health/causes-death/causes-death-australia/latest-release

The Australian Institute of Health and Welfare National Suicide and Self-Harm Monitoring System and the interim Queensland Suicide Register

The Australian Institute of Health and Welfare launched the National Suicide and Self-Harm Monitoring System online in 2020. This system collates and reports data on suicide deaths from the ABS and the state-based suicide registers. The system includes information on the demographics, trends, methods and risk factors for suicide in Australia. The Australian Institute of Health and Welfare works closely with multiple state-based suicide registers to enable more timely data on suspected suicides. This information informs the decision-making of state and federal governments during COVID-19.

Comparing the Coroners Court of Queensland and the Queensland Suicide Register

Coroners need to establish that a death was a suicide using a legal standard of proof— the balance of probabilities. This standard is a higher and more onerous standard of proof than the health research criteria the QSR and iQSR use. When making their findings, they do not need to explicitly determine a person's intent. They consider all evidence available to them before deciding on intent, to the necessary legal standard.

Revisions to the interim Queensland Suicide Register

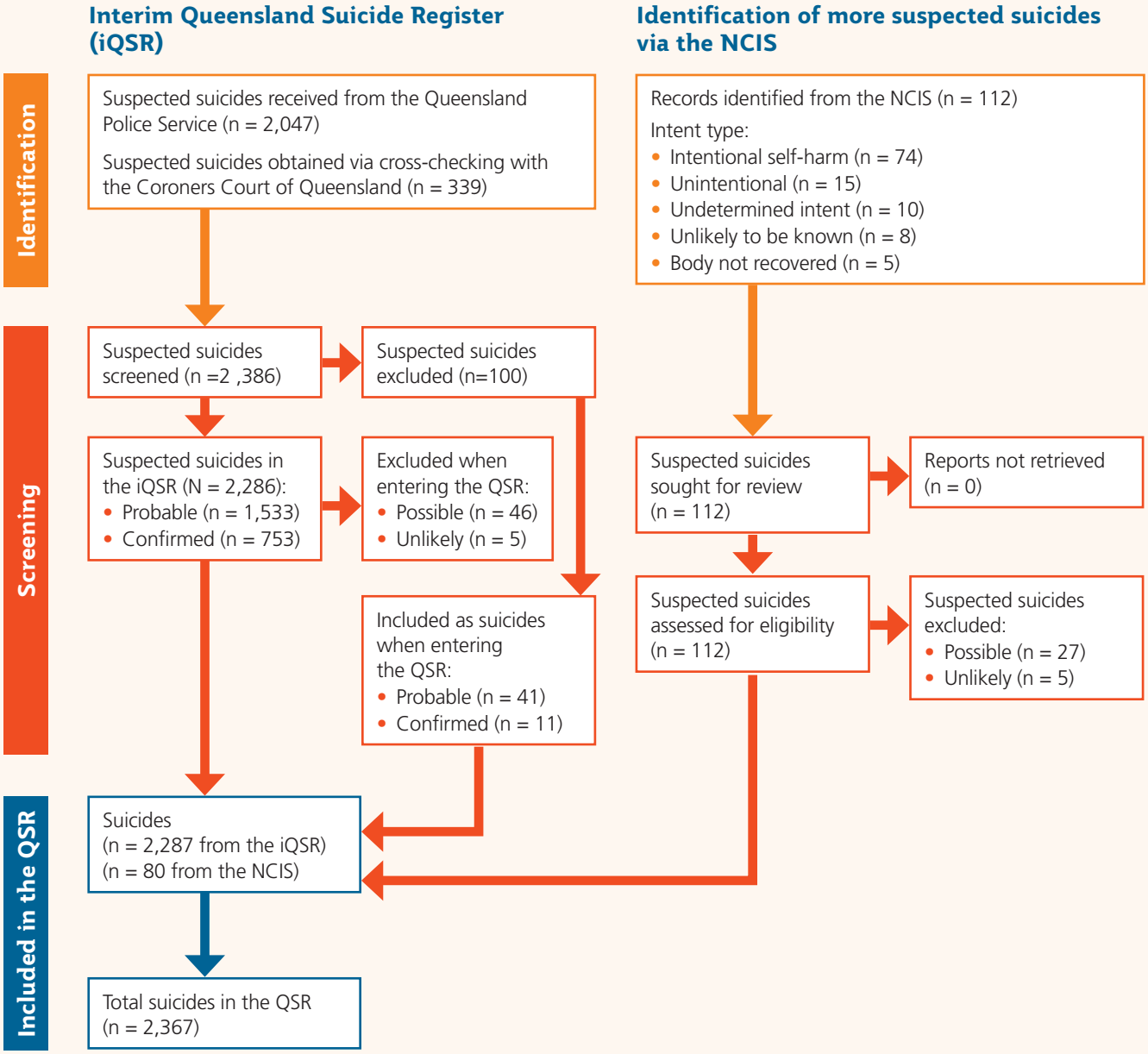
Once coronial investigations end, QSR coders independently reassess the probability of each death in the iQSR being a suicide. This revision occurs without revisiting the original coding in the iQSR. **Figure A.4** shows the revisions process for suspected suicides, from the iQSR and the NCIS to the QSR, from 2016 to 2018.

Of the 2,386 deaths occurring between this time reported to AISRAP, coding between the iQSR and the QSR remained unchanged 95.7% of the time. The net increase in suicides between the iQSR and QSR for 2016 to 2018 for the suspected suicides received from the Queensland Police Service and Coroners Court of Queensland was one (0.0004%) of the 2,386 suspected suicides examined.

Across the three years, NCIS searches found 112 extra deaths of interest from the intent categories of 'intentional self-harm', 'undetermined intent', 'unlikely to be known', 'unintentional' and the other non-intent category of 'body not recovered' that AISRAP considered might be suspected suicides. QSR staff coded 80 (71.4%) of these deaths as suicides. NCIS searches therefore added another 3.5% of suicides to the QSR above those received from the Queensland Police Service and the Coroners Court of Queensland.

The total increase from the iQSR to the QSR for 2016 to 2018 was 81 suicides (3.42%). Over the three years, this was 27 more suicides a year. These suicides may not have been not reported earlier because the initial circumstances may not have suggested that it was a suspected or apparent suicide. Routine monitoring of other sudden and unexpected deaths reported to the Coroners Court of Queensland does not occur. These deaths are therefore not identified earlier for incorporating into the iQSR.

Figure A.4: Flowchart depicting the coding of suicides into the Queensland Suicide Register (QSR), 2016 to 2018



Note: iQSR = interim Queensland Suicide Register; QSR = Queensland Suicide Register; NCIS = National Coronial Information System.

Supplementary tables

Table A.2: Age-standardised suicide rates by sex, rate ratio and rate difference, Queensland residents, 1990 to 2021

Year	Males	Females	Rate ratio*	Rate difference**	Persons
1990	24.7	5.7	4.3	19.0	15.0
1991	23.7	6.0	4.0	17.8	14.7
1992	22.7	6.9	3.3	15.8	14.6
1993	21.7	4.9	4.4	16.8	13.0
1994	25.6	6.7	3.8	18.9	16.0
1995	26.2	7.0	3.7	19.2	16.5
1996	26.6	5.9	4.5	20.8	17.0
1997	25.9	6.2	4.2	19.7	15.9
1998	27.1	7.8	3.5	19.3	17.3
1999	24.8	6.2	4.0	18.6	15.3
2000	26.2	6.7	3.9	19.6	16.3
2001	22.1	6.2	3.6	15.9	14.3
2002	25.5	6.8	3.7	18.7	16.0
2003	22.3	6.3	3.6	16.0	14.7
2004	24.1	6.1	3.9	18.0	15.7
2005	22.0	6.2	3.6	15.8	14.4
2006	19.7	5.9	3.4	13.8	13.2
2007	20.2	6.3	3.2	13.9	13.1
2008	22.3	6.2	3.6	16.1	14.1
2009	20.7	6.8	3.0	13.9	13.7
2010	20.7	6.9	3.0	13.9	13.6
2011	20.0	7.0	2.8	13.0	13.4
2012	22.0	7.1	3.1	15.0	14.4
2013	22.0	6.7	3.3	15.3	14.2
2014	22.6	7.2	3.1	15.4	14.8
2015	24.8	7.1	3.5	17.7	16.0
2016	22.6	6.3	3.6	16.4	14.3
2017	25.7	8.2	3.1	17.5	16.8
2018	25.6	7.1	3.6	18.4	16.2
2019	22.9	7.3	3.1	15.6	14.9
2020	24.0	6.5	3.7	17.5	15.0
2021	23.7	7.6	3.1	16.1	15.5

Note: Age-standardised suicide rate per 100,000 estimated resident population as at 30 June (mid-year) each year. This table includes the rate difference because people perceive ratios (a relative measure) and differences (an absolute measure) differently.

* The rate ratio is the male rate divided by the female rate.

** The rate difference is the male rate minus the female rate.

Sources: Queensland Suicide Register (1990 to 2018); interim Queensland Suicide Register (2019 to 2021).

Table A.3: Age-specific suicide rates by sex, 15- to 19-year and 20- to 24-year age groups, rate ratio and rate difference, Queensland residents, 1990 to 2021

Year	15 to 19			20 to 24		
	Males	Females	Persons	Males	Females	Persons
1990	22.8	np	13.2	41.8	np	22.9
1991	21.5	np	11.8	34.6	8.4	21.7
1992	21.9	6.8	14.5	45.8	8.1	27.2
1993	14.8	5.2	10.1	36.5	4.7	20.8
1994	19.8	4.3	12.2	44.6	8.4	26.8
1995	23.9	5.2	14.8	42.8	9.1	26.2
1996	29.3	np	16.7	48.9	5.4	27.5
1997	23.5	5.9	14.9	48.1	12.7	30.6
1998	22.4	12.5	17.5	40.0	5.7	23.0
1999	20.4	4.1	12.4	41.8	7.5	24.7
2000	21.7	6.4	14.2	37.2	5.0	21.2
2001	22.8	4.0	13.6	36.9	7.4	22.2
2002	17.3	8.6	13.0	36.2	8.1	22.4
2003	16.4	8.5	12.5	31.1	3.9	17.7
2004	8.1	5.4	6.8	31.3	10.6	21.1
2005	12.3	np	7.7	28.9	8.0	18.6
2006	19.1	5.9	12.7	24.7	5.6	15.3
2007	18.5	6.4	12.6	24.7	5.5	15.2
2008	12.7	5.6	9.2	28.0	7.4	17.8
2009	9.8	6.8	8.3	20.1	9.7	15.0
2010	11.7	8.1	9.9	19.8	10.8	15.4
2011	15.5	6.8	11.2	23.3	12.6	18.0
2012	15.4	5.4	10.5	24.7	8.6	16.8
2013	16.5	5.3	11.1	21.4	5.5	13.5
2014	16.6	6.6	11.7	26.2	6.0	16.3
2015	14.7	9.3	12.1	37.7	9.5	23.8
2016	14.7	6.0	10.4	29.5	13.0	21.4
2017	11.3	10.6	11.0	37.5	6.5	22.1
2018	25.6	11.1	18.5	35.3	10.0	22.7
2019	12.3	8.4	10.4	29.6	9.4	19.5
2020	21.4	7.1	14.4	37.0	8.9	23.0
2021	15.2	6.4	10.9	34.8	9.8	22.4

Note: Age specific suicide rate per 100,000 estimated resident population as at 30 June (mid-year) each year.
np = not provided (under five suspected suicides).

Sources: Queensland Suicide Register (1990 to 2018); interim Queensland Suicide Register (2019 to 2021).

Table A.4: Suicides and suspected suicides of lesbian, gay, bisexual and transgender persons, Queensland, 2016 to 2021

2017	2018	2019	2020	2021
20	12	12	18	24

Sources: Queensland Suicide Register (2017 to 2018); interim Queensland Suicide Register (2019 to 2021).

Table A.5: Age-specific suspected suicide rates of Queensland males, before COVID-19 (Jan 2015 to Jan 2020) and during COVID-19 (Feb 2020 to Dec 2021)

	Before COVID-19		During COVID-19				
Age group	**Number**	**Rate per 100,000**	**Number**	**Rate per 100,000**	**Rate difference (95% CIs)**	**Rate ratio (95% CIs)**	**Two-sided p-value**
10 to 14	16	1.9	9	2.6	0.7 (-1.3–2.67)	1.4 (0.5–3.3)	0.45
15 to 19	128	15.8	60	19.0	3.2 (-2.3–8.8)	1.2 (0.9–1.6)	0.24
20 to 24	295	33.6	114	35.4	1.7 (-5.8–9.3)	1.1 (0.8–1.3)	0.64
25 to 29	243	31.2	109	27.0	4.2 (-2.5–11.0)	1.2 (0.9–1.5)	0.21
30 to 34	288	33.2	108	31.7	-1.5 (-8.6–5.6)	1.0 (0.8–1.2)	0.68
35 to 39	300	35.9	120	36.9	-0.9 (-8.6–6.7)	1.0 (0.8–1.2)	0.82
40 to 44	322	39.3	93	30.2	-9.1 (-16.6– -1.6)	0.8 (.61–.97)	0.02
45 to 49	291	35.0	99	30.6	-4.5 (-11.7–2.8)	0.9 (.69–1.1)	0.24
50 to 54	235	30.2	109	35.7	5.5 (-2.2–13.2)	1.2 (.93–1.5)	0.15
55 to 59	236	31.3	88	29.8	-1.6 (-9.0–5.8)	1.0 (0.7–1.2)	0.69
60 to 64	175	26.3	74	27.0	0.7 (-6.6–8.0)	1.0 (0.8–1.4)	0.84
65 to 69	125	20.5	45	18.8	-1.7 (-8.3–4.8)	0.9 (0.6–1.3)	0.62
70 to 74	96	19.5	47	21.6	2.1 (-5.2–9.4)	1.1 (0.8–1.6)	0.57
75 to 79	76	23.2	28	18.4	-4.8 (-13.4–3.8)	0.8 (0.5–1.2)	0.30
80 to 84	58	28.7	38	41.1	12.4 (-2.6–27.4)	1.4 (0.9–2.2)	0.09
85 and over	56	810.0	25	660	-150 (-484.8–184.3)	0.8 (0.5–1.3)	0.40

Source: interim Queensland Suicide Register.

Table A.6: Age-specific suspected suicide rates of Queensland females, by age, before COVID-19 (Jan 2015 to Jan 2020) and during COVID-19 (Feb 2020 to Dec 2021)

	Before COVID-19		During COVID-19				
Age group	**Number**	**Rate per 100,000**	**Number**	**Rate per 100,000**	**Rate difference (95% CIs)**	**Rate ratio (95% CIs)**	**Two-sided p-value**
10 to 14	20	1.4	9	2.8	-1.4 (0.6–3.4)	2.0 (0.7–5.3)	0.14
15 to 19	93	9.3	21	7.0	-2.3 (-6.0–1.4)	0.8 (0.4–1.2)	0.25
20 to 24	114	9.7	30	9.5	-0.3 (-4.2–3.7)	1.0 (0.6–1.5)	0.91
25 to 29	99	7.3	33	9.4	2.1 (-1.5–5.8)	1.3 (0.8–2.0)	0.24
30 to 34	106	8.0	34	9.5	1.5 (-2.2–5.2)	1.2 (0.8–1.8)	0.41
35 to 39	106	9.2	29	8.3	-0.9 (-4.5–2.7)	0.9 (0.6–1.4)	0.64
40 to 44	109	9.3	30	9.3	0.0 (-3.9–3.9)	1.0 (0.6–1.5)	1.00
45 to 49	135	11.7	33	9.8	-1.9 (-6.0–2.1)	0.8 (0.5–1.2)	0.38
50 to 54	118	10.7	31	9.6	-1.1 (-5.2–2.9)	0.9 (0.6–1.4)	0.61
55 to 59	114	11.2	26	8.4	-2.9 (-6.9–1.1)	0.7 (0.5–1.2)	0.18
60 to 64	73	7.5	21	7.3	-0.2 (-3.9–3.5)	1.0 (0.6–1.6)	0.92
65 to 69	46	5.1	14	5.5	0.4 (-3.0–3.8)	1.1 (0.5–2.1)	0.81
70 to 74	42	5.4	15	6.7	1.3 (-2.7–5.2)	1.2 (0.6–2.4)	0.51
75 to 79	37	8.0	14	8.7	0.7 (-4.9–6.3)	1.1 (0.5–2.2)	0.79
80 to 84	35	10.8	9	8.5	-2.3 (-9.2–4.6)	0.8 (0.3–1.7)	0.55
85 and over	34	108.6	14	148.3	39.7 (-51.4–130.8)	1.4 (0.6–2.8)	0.37

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