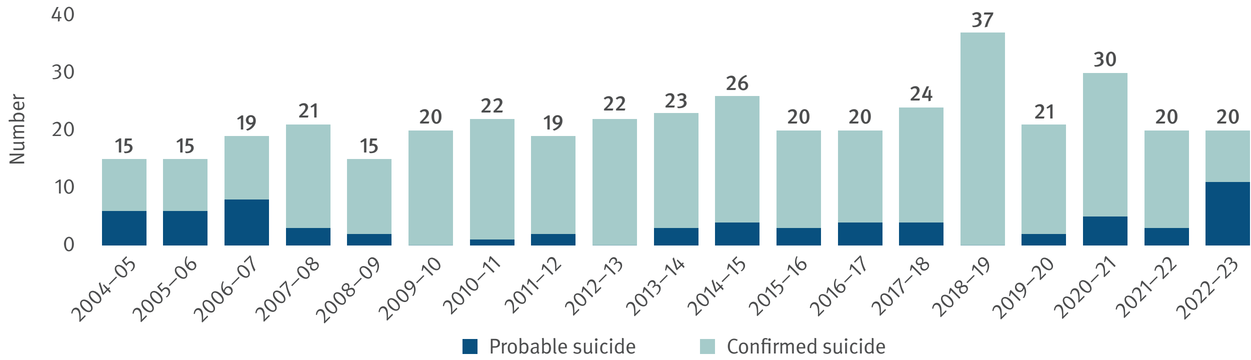
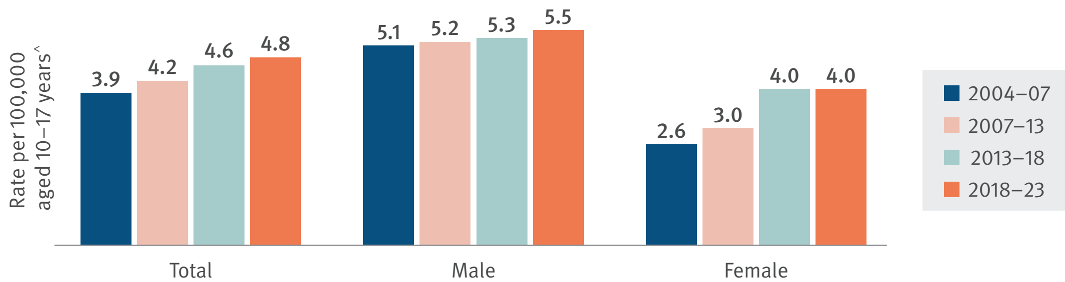
6 Suicide

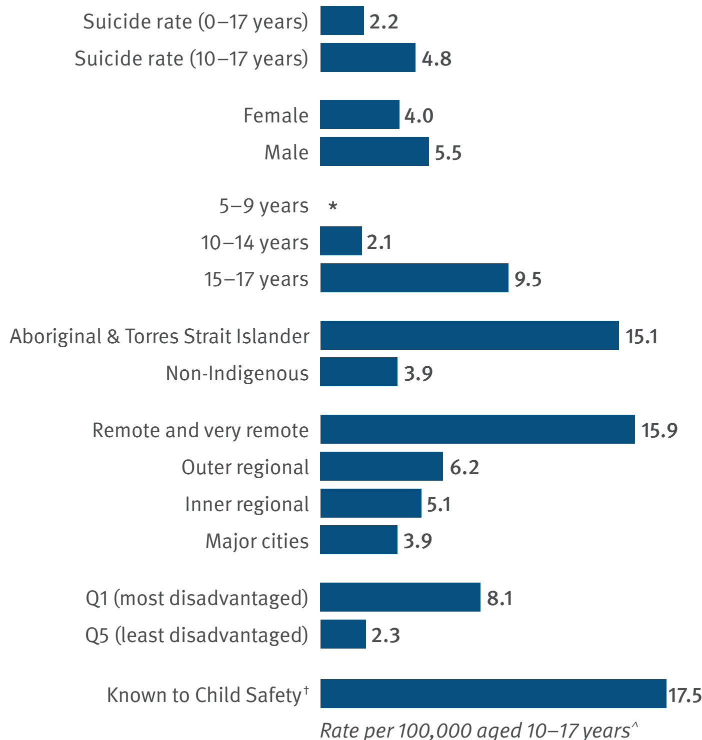
2004 to 2023



5-year summary (2018–23) | Sex



Demographics



Risk factors

38% adverse childhood experiences

41% diagnosed mental health condition

80% self-harm and suicidal behaviours

48% history of alcohol and/or substance misuse

39% history of behaviour problems and/or offending

Notes: Counting is by date of death registration.
** rate not calculated for numbers less than 4.*
^ deaths in 5–9 age group are included in 10–17 year rates, with exception of age group rates.
† in the 12 months prior to death.

Key findings

Defining and classifying suicide

Suspected suicide cases are assessed and categorised using a suicide classification model that considers factors such as: whether the incident was more consistent with death by suicide than any other cause; whether intent was communicated; any prior suicide attempts; and mental health history. Further information on the classification model can be found in Appendix F (available at www.qfcc.qld.gov.au/sector/child-death/child-death-reports-and-data).

Twenty children and young people died by suicide in 2022–23, consistent with the 20 deaths in the previous reporting period.

Nine deaths in the 2022–23 period were classified as confirmed suicides and 11 deaths were probable suicides (i.e. more consistent with suicide than any other means).[53]

A total of 128 young people have died by suicide over the last 5 years, with an average of 26 deaths per year.[54] A slowly increasing trend in youth suicide rates is evident over time. Between 2004–07 and 2018–23 the rate of suicide increased from 4.2 to 4.8 per 100,000 young people aged 10–17 years.[55] As reported in Chapter 1, the increase in suicide rates may have slowed as the 20 suicides in 2021–22 and 2022–23 were below the high numbers recorded in 2018–19 and 2020–21 (37 and 30 respectively).

Suicide was the leading overall cause of death for both young people aged 10–14 years and 15–17 years over the 5-year period.

Table A.8 in Appendix A provides summary data and key characteristics for suicide deaths in the last 5 years.

Coronial findings

At the time of reporting, coronial findings had been finalised for 6 of the 20 suicides from 2022–23. Coroners made clear statements that suicide was the cause of death in 4 of these cases. In the remaining deaths, the coroner either made no findings in relation to intent or were unable to make a final determination on intent.

Intent stated or implied (orally or written)

There was evidence of suicidal intent in 12 of the 20 suicide deaths during 2022–23. Nine young people stated or implied their intent to a friend, intimate partner, family member, healthcare professional or support worker. Intent was stated or implied either during a phone call, by text or instant message or in person.[56] Suicide notes were left by 4 young people.

Age

Of the 20 suicide deaths during 2022–23, 11 were aged 10–14 years and 9 were young people aged 15–17 years.

The 5-year suicide rate for young people aged 15–17 years was 4.5 times the rate for young people aged 10–14 years (9.5 deaths per 100,000 aged 15–17 years, compared with 2.1 deaths per 100,000 aged 10–14 years).

As illustrated in Figure 6.1, youth suicide deaths increase with each year of age. Young people aged 9–11 years made up 1% of suicides, with the proportions increasing with age. Seventeen-year-olds comprised 35% of youth suicides over the past 5 years. Two-thirds of youth suicides were among young people aged 15–17 years.

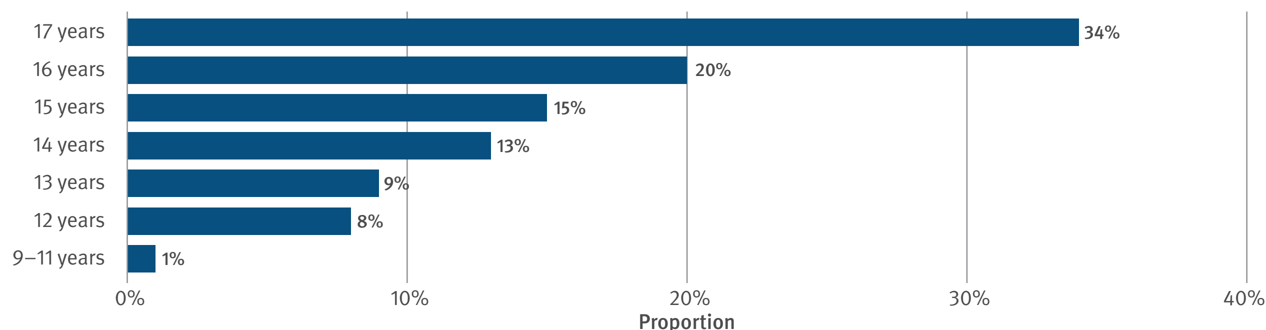
53 Suicide classifications are made based on information held by the QFCC at the time of reporting. Deaths are classified as possible suicides where there is insufficient information to determine fatal intent. Where the fatal outcome was most likely not intended, such as the consequences of risk-taking behaviour, these deaths will be classified as 'other non-intentional injury'. Where the coroner has not been able to determine whether death was the intended outcome, these cases are reported in the category 'unexplained'.

54 Tables with data for 2004–23 are available online at www.qfcc.qld.gov.au/about-us/publications/child-death-reports-and-data

55 Suicide rates in this chapter are per 100,000 population aged 10–17 years and, with the exception of age specific rates, include the small number of suicides of children aged 5–9 years.

56 Each young person may have stated or implied their intent using more than one communication method.

Figure 6.1: Suicide deaths by single year of age (proportion), 2018–19 to 2022–23



Notes: Percentages may not add to 100 due to rounding.

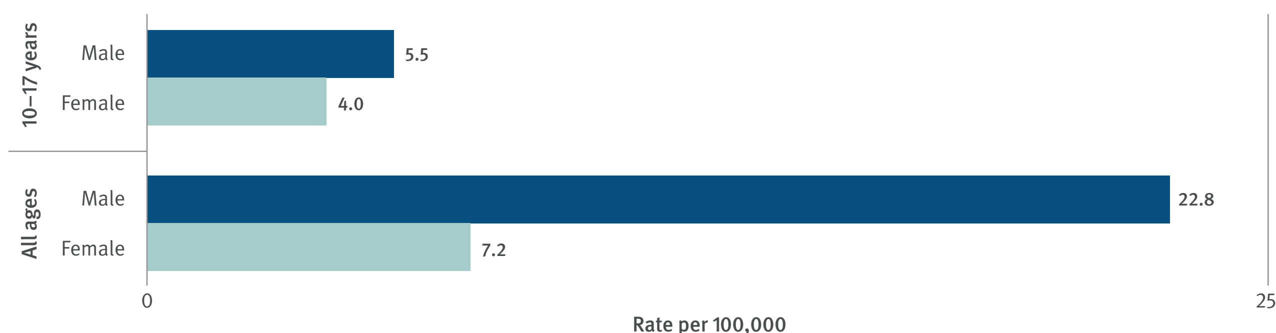
Sex

Of the 20 young people who died by suicide in 2022–23, 11 were male and 9 were female.

Over the last 5 years, 59% of young people who suicided were male and 41% were female. The average suicide rate for males was 1.4 times the rate for females (5.5 deaths per 100,000 males aged 10–17 years, compared with 4.0 deaths per 100,000 females aged 10–17 years). While the latest youth suicide rates are similar for males and females, during the first 10 years of the Child Death Register, males suicided at almost twice the rate of females.

Figure 6.2 presents the male and female suicide rates in the youth population in contrast to the population level suicide rates by sex (age-standardised). It illustrates the much higher rate of male suicide in the 'all ages' data compared with the much closer male and female rates for 10–17-year-olds.

Figure 6.2: Male and female youth suicide rates (2018–23) and Queensland total suicide rates (2021, age-standardised)



*Sources: QFCC Queensland Child Death Register; ABS (2022) **Causes of Death, Queensland**, 2021, 'Table 4.1: Underlying cause of death, All causes, Queensland, 2021'. **www.abs.gov.au/statistics/health/causes-death/causes-death-australia/latest-release#data-downloads***

Adverse childhood experiences and child maltreatment

Australian child maltreatment study

In 2023, the National Health and Medical Research Council released their report, *The prevalence and impact of child maltreatment in Australia: Findings from the Australian child maltreatment study*. The study collected data from 8,500 randomly selected Australians and examined the incidence of child maltreatment (physical abuse, emotional abuse, sexual abuse, neglect and exposure to domestic violence) as well as their history of mental health disorders and health risk behaviours. One in 4 16–24 year olds reported experiencing child maltreatment and that the abuse often occurred over a number of years. It was identified that young people aged 16–24 years who had experienced child maltreatment were at increased risk of:

- developing cannabis dependence (6.5 times)
- attempting suicide (4.5 times)
- non-suicidal self injury (3.5 times)
- developing a mental disorder (including symptoms consistent with major depressive disorder, generalised anxiety disorder and/or post-traumatic stress disorder) (2.9 times).

Other literature on suicide provides a relatively consistent account of the factors and life circumstances that are associated with youth suicide.[57] The *Adverse childhood experiences study* has led research showing strong relationships between adverse experiences in childhood and health and social problems across the lifespan, with a link to depressive disorders.[58]

Adverse childhood experiences include childhood abuse, neglect and household dysfunction (substance abuse, parent mental illness, exposure to domestic violence and parent criminal behaviour).

Information available indicated 8 of the 20 young people who suicided in 2022–23 had a history of alleged childhood abuse and neglect. Emotional abuse and physical abuse were the most common types of abuse reported.

Household dysfunction was identified in 7 of the 20 suicide deaths of young people in 2022–23, with exposure to domestic violence identified as the most common.

Complex behaviours

Young people can engage in risk-taking behaviours beyond that which is developmentally appropriate. These complex behaviours may interfere with development and daily functioning, pose serious risks to the young person's health and safety, and impair healthy functioning.

The behaviours often include substance dependency, self-harm and suicidal behaviours, verbal and physical assaults on others, destruction of property, engaging with adults who are considered exploitative, criminal behaviour, high-risk sexual behaviour and engaging in dangerous physical activities.[59]

Alcohol and substance misuse

Six of the 20 young people who suicided during 2022–23 were reported as having a history of alcohol, tobacco and/or substance use; with cannabis and alcohol the most frequently cited substances used.[60]

57 McDermott B (2021) ***Highly vulnerable infants, children and young people***: *A joint child protection mental health response to prevent suicide*, Queensland Child Death Review Board. **www.cdrb.qld.gov.au/reports-and-publications/**

58 Chapman DP, Whitfield CL, Felitti VJ, Dube SR, Edwards VJ, Anda RF (2004) 'Adverse childhood experiences and the risk of depressive disorders in adulthood', *Journal of Affective Disorders*, 82(2):217–225, **https://doi.org/10.1016/j.jad.2003.12.013**

59 QFCC *Beyond behaviours discussion paper* (pending publication).

60 Previous or current use of alcohol or drugs identified by friends, family members or in toxicology findings.

Self-harm and suicidal behaviour

Research into youth suicide shows that a history of self-harming behaviour, suicidal ideation and previous suicide attempts are associated with future suicidality. In relation to the 20 young people who died by suicide in 2022–23:

- At least one risk factor was present for 16 of the 20 young people who suicided.
- Ten had previously attempted suicide, with 3 young people attempting suicide on more than one occasion.
- Nine young people had previously engaged in self-harming behaviour, such as cutting.
- Thirteen had previously expressed suicidal thoughts (ideation).[61]
- There was no evidence of previous self-harm or suicidal behaviour for 4 young people.

Behavioural problems and offending

Eight of the young people who suicided in 2022–23 were identified as having exhibited behavioural problems and offending, with risk taking and aggression identified the most frequently.

Mental health

A high proportion of mental illness has been found among young people who die by suicide. While mental health issues are prevalent among young people who suicide, many young people are treated for these conditions and only a very small number may go on to suicide.

Eight of the 20 young people who suicided during 2022–23 had a diagnosed mental health condition before their death. Seven young people were known to have engaged with a healthcare professional and 8 had been prescribed medication for their condition/s.

The range of mental health diagnoses included depressive disorders, anxiety disorders (including obsessive compulsive disorder), eating disorders, trauma disorders and functional neurological disorder. The most common diagnosed conditions were depressive and anxiety disorders. Six of the 8 young people were identified to have multiple mental health conditions (co-morbid conditions).

Four young people were suspected to have a mental health issue. Three of those young people had engaged with a healthcare professional.

Cohorts in youth suicide

The *Adverse childhood experiences study* and the *Australian child maltreatment study* both highlight the risks to future health outcomes for those who have a history of adverse childhood experiences, including the increased risk of suicidal behaviour. While the cohort of young people who experience these adversities account for a significant proportion (45%), it appears that there are a number of other distinct groups within youth suicides.

Figure 6.3 provides a summary of the adverse childhood experiences, mental health diagnoses and complex behaviours identified for the 128 young people who suicided in Queensland in the last 5 years. This overview is based on information available to the QFCC and may therefore under-represent the actual circumstances for the children and young people.

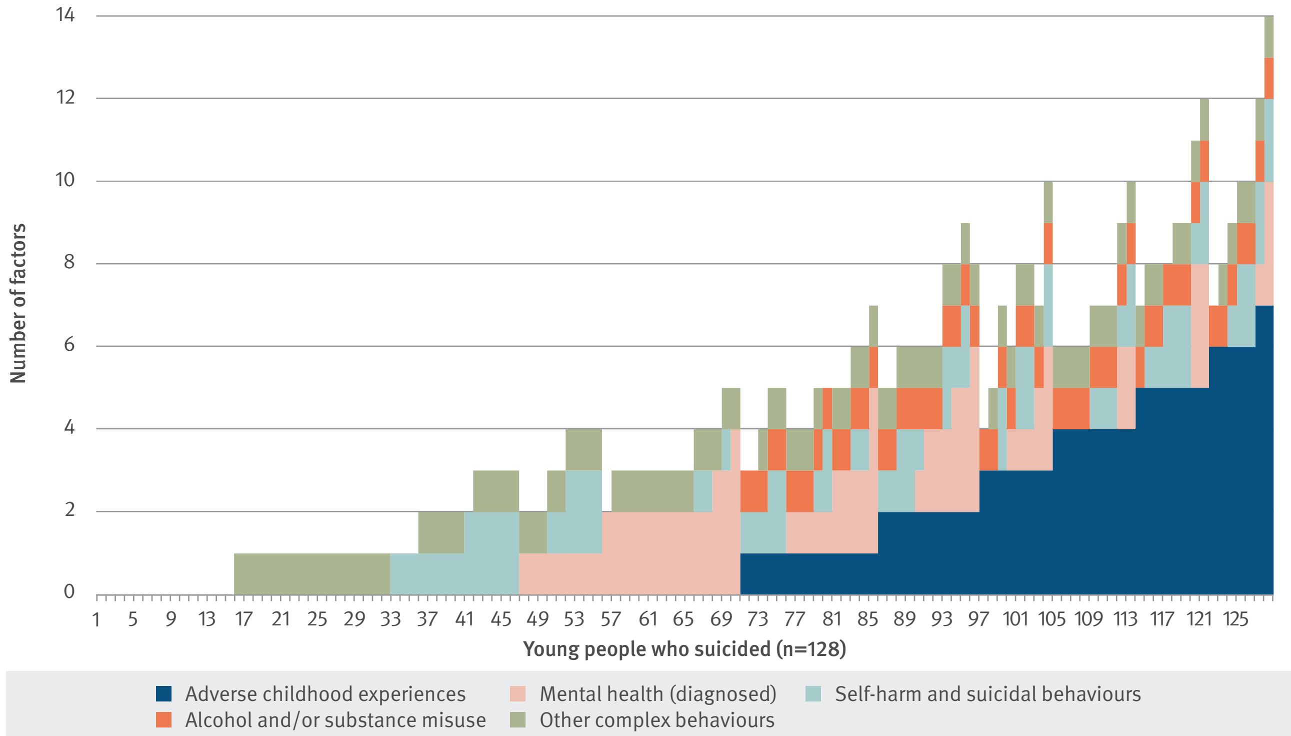
The data shows a number of groups, based on the experiences of those young people's lives:

- Young people who have a history of adverse childhood experiences with co-occurring diagnosed mental health conditions and/or complex behaviours (45%).
- Young people with diagnosed mental health conditions who display complex behaviours (19%).
- Young people who demonstrate complex behaviours (24%).
- Young people without any identified risk factors (12%).

61 Each young person with identified self-harm or suicidal behaviour may have exhibited more than one type of behaviour.

The data highlights the importance of intervention and prevention strategies tailored to the life experiences of children and young people.

Figure 6.3: Adverse childhood experiences, diagnosed mental health conditions and complex behaviours in youth suicides (number), 2018–19 to 2022–23



Other factors

Neurodiversity[62]

Five of the young people who suicided during 2022–23 were identified as neurodiverse. Neurodiversity is a term used to describe differences in how the brain works and can include autism, attention deficit hyperactivity disorder, Tourette's syndrome, dyspraxia, dyslexia, dyscalculia and other learning disabilities. The most common type of neurodiversity identified was autism. Three young people had co-occurring neurodiversities.

Stressful life events and precipitating incidents

Life stressors are events or experiences which produce significant strain on an individual; they can occur at any stage over the course of a person's lifetime and vary in severity and duration. Life stressors differ from precipitating incidents as they are more likely to occur in the background with strain accumulating over a period of time.

Precipitating incidents refer to events or stressors which occur prior to a suicide and which appear to have influenced the decision for a person to end their life. Most precipitating incidents will occur in the hours, days or weeks prior to death. Bereavement can be considered a precipitating incident, with an arbitrary timeframe of up to 6 months between the death of the family member or friend and the suicide of the young person.

Outside of adverse childhood experiences, the most common stressors and precipitating incidents evident for young people who suicided in 2022–23 were transitions in education (8), transitions in residence (6), transitions to/from out-of-home care (6), arguments with family members, intimate partners or friends (6), poor intra-familial relationships (6), bereavement (5) and relationship breakdowns (4).

62 Conditions recorded in neurodiversity were previously included in mental health and behavioural problems in earlier reports.

Contagion

Contagion refers to the process by which a prior suicide or attempted suicide of a family member or friend facilitates or influences suicidal behaviour in another person. Contagion was not identified in any youth suicides during 2022–23.

COVID-19

COVID-19 was not identified as a direct stressor for any suicide deaths in 2022–23. There continues to be no evidence of a significant change in youth suicide deaths in Queensland attributable to COVID-19.

Queensland Ambulance Service data

Queensland Ambulance Service (QAS) data indicates in the last year almost 9,400 ambulance callouts occurred for suicidal behaviour and self-harm-related incidents involving children, including both fatal and non-fatal injuries (see Table 6.1). Female patients accounted for 68% of callouts.

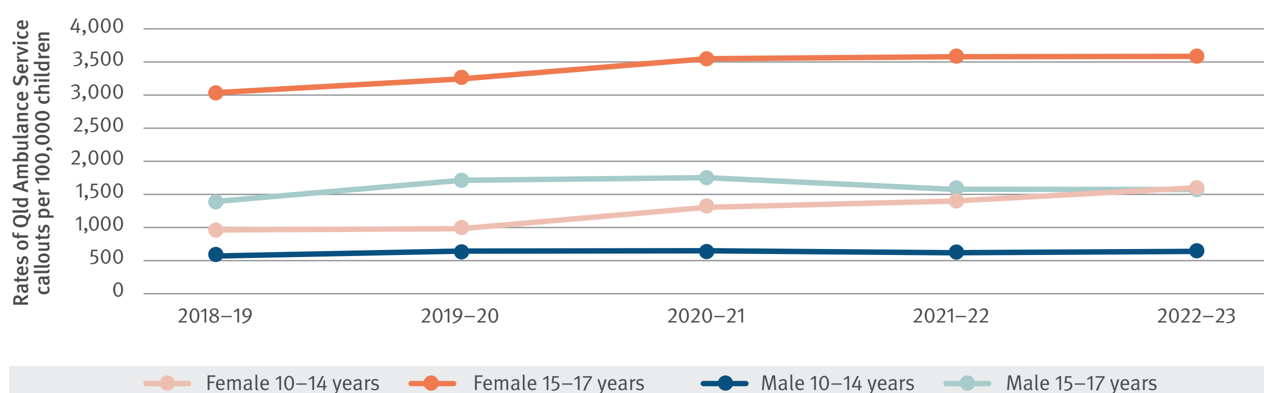
Table 6.1: Queensland Ambulance Service responses to self-harm and suicidal behaviour incidents (number), 2022–23

Age	Female	Male	Not specified	Total
5–9 years	82	80	*	162
10–14 years	2,761	1,157	45	3,963
15–17 years	3,529	1,654	75	5,258
Total	6,372	2,891	120	9,383

Source: Queensland Ambulance Service (Aug 2023).
Notes: Not specified includes cases where gender was recorded as indeterminate or missing.
** Not reported for total less than 5 and removed from totals.*

Analysis of the rate of QAS callouts for self-harm and suicidal behaviours over the last 5 years are shown in Figure 6.4.[63] The rate of callouts for 15–17 year old females was considerably higher than the other groups. While rates over time remained relatively stable for males, rates increased over time for females (both 10–14 year olds, and 15–17 year olds). The greatest increase was identified for 10–14 year old females (67% increase over the 5-year period).

Figure 6.4: Queensland Ambulance Services responses to self-harm and suicidal behaviour incidents (rate per 100,000), 2018–19 to 2022–23



Source: Queensland Ambulance Service.
Notes: Excludes cases where gender was recorded as indeterminate or missing.

63 Data for the past years is published in previous editions of this report, from data originally provided by the QAS.