Suicide Prevention Australia (SPA) is the national organisation for suicide prevention and works with organisations, agencies, communities and individuals to prevent suicide across Australia. SPA publishes position statements on priority areas of suicide prevention, intervention and postvention in Australia. These foundation documents provide a basis for understanding, dialogue, teaching, service delivery, strategy and policy development as well as research, and reflect the diversity of voices within the sector. Position statements are not intended to be specific to or limited to policy makers alone, but are instead written with a general cross section of the educated lay public in mind (i.e. broader community, media, and other non-government organisations). Suicide Prevention Australia Position Statements therefore represent a starting point for policy and strategy development, while supporting ongoing collaborative programs and services.

These statements are developed in consultation with community and specialist reference groups and are ratified by the Suicide Prevention Australia Board. This current Discussion Paper has been designed as a catalyst for dialogue, to inspire and guide consultation and inform the development of a final Position Statement and policy document on the topic.

SPA Position Statements can be downloaded from the Suicide Prevention Australia website: www.suicidepreventionaust.org

Acknowledgments
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This paper is designed as a catalyst for dialogue, to inspire and guide consultation and to inform policy development.
Snapshot of the Key Findings

- Women have higher rates of suicidal behaviour, i.e. ideation, planning and suicide attempts compared to men and when suicide mortality and morbidity are combined it has a large impact on public health in Australia and internationally.

- In 2013, 637 women died by suicide, a rate of 5.5 per 100,000 accounting for 21,608 years of potential life lost.

- Suicide is a disproportionate cause of death among younger women. The proportion of 15-19 and 20-24 year old female suicides (25%) compared to older women (less than 5%). The majority of these 2013 adolescent suicides were by hanging.

- Hanging is the most commonly used method of suicide for women (as it is for men) with poisoning by drugs being second most common. The number of women using poisoning by drugs has remained relatively stable across the past 10 years, while hanging has increased by 10% for both men and women.

- Whereas young men’s suicides have reduced in number and rate since the 1997 global peak, young women’s have not.

- Women are more highly represented in non-fatal suicidal behaviours but are far less visible in suicide prevention programs and research.

- The number of women aged 15 - 24 years who injured themselves so severely that they require hospital treatment has increased by more than 50 per cent since 2000.

- Self-injury is not well understood across the community, even amongst health professionals, which can lead to stigmatisation and social exclusion. Considering the strong association between self-injury and suicidality for women, it is imperative that the issue of self-injury in women is addressed, especially for younger women.

Risk Factors

- Women with a history of mental illness diagnoses, in particular depression, and anxiety disorders have a greater risk of suicidal behaviours. However not all women experiencing mental illness become suicidal, in fact the greater majority do not.

- Depression is a major issue for a significant number of middle-aged and older women; peri menopause is a complex time of life for women with a 16 fold increase in diagnoses of depression. This age group of women also have a higher rate and numbers of suicides than women of all other ages, including youth.

- One in 10 women develop depression during pregnancy and 1 in 7 women develop postnatal depression; roughly 30% of pregnant women with depression experience suicidal ideation.

- Alcohol was detected in nearly 28% of women and 36% of men who suicided.

- A review of 664 relevant studies demonstrated a strong, unequivocal relationship between intimate partner violence and suicidality.

- There is a complex relationship between bullying and risk of suicidal behaviours. Bullying and peer victimisation puts adolescents at increased
risk of suicidal ideation and behaviour, especially when other psychopathology is present (e.g. depression). It is not necessarily the bullying per se; there are many important mediating variables. Suicidal ideation and behaviour is usually not attributed to just one event or factor.

- Overall, adolescents are at greater risk for suicidal thoughts and behaviours if they have been both bullies and victims. For women, any involvement in bullying is associated with adverse outcomes. For males it is frequent involvement that is associated with adverse outcomes. Women are less likely to be bullies but when they are, they have a more severe impairment than their male counterparts.

### Population Groups at Increased Risk

- In a national survey 38% of same-gender attracted women aged 22-27 years had experienced depression compared to 19% of heterosexual women respondents.

- Non-heterosexual women of various sexualities were almost four times more likely to have tried to harm or kill themselves in the previous six months.

- The relationship between bullying and suicide risk was stronger for lesbian and bisexual youth than for heterosexual youth. Nineteen studies showed links between suicidal behaviour in lesbian and bisexual adolescents and bullying at school, especially among young people with cross-gender appearance, traits, or behaviours.

- ABS data for 2013 showed the suicide rate for Aboriginal and Torres Strait Islander women has increased to 12.9 per 100,000 compared with 5.4 for non-Indigenous women.

- Suicide rates (per 100,000) in 2013 for young Aboriginal and Torres Strait Islander women aged 15-24 years was 22.7 compared to 5.0 for non-Indigenous women.

- From 2004-05 to 2012-13, the hospitalisation rate for intentional self-harm increased for Aboriginal and Torres Strait Islander people by 48.1 per cent, while the rate for non-Indigenous people remained relatively stable.

- Evidence shows us that of all the relationships to the deceased, partners and mothers of people who die by suicide are the groups most at increased risk of suicide.

### Recommendations

SPA endorses and amplifies many of the recommendations developed by Women’s Health Victoria (2011).

**Recommendation 1:**
Increase accuracy in the recording of suicidal behaviour by developing standardised data classification and recording systems nationally.

**Recommendation 2:**
Increase consistent and systematic reporting of gender-disaggregated data on suicide and suicidal behaviour.

**Recommendation 3:**
Increase consistent and systematic demographic categories to include sexuality, relationships, gender experience / identity / expression, and intersex characteristics in suicide and suicidal behaviour.

**Recommendation 4:**
Develop well-articulated policies and strategies to address the risk factors for suicide and suicidal behaviour in women.

**Recommendation 5:**
Introduce mental health literacy programs and resources which are gender and culturally sensitive.

**Recommendation 6:**
Increase gender sensitive service provision to meet the needs of women at risk.

**Recommendation 7:**
Mandatory procedures for the treatment of women seeking medical care following attempted suicide.

**Recommendation 8:**
Work in collaboration with key Australian Women’s Health organisations to host a Roundtable dialogue on women’s suicide and suicidal behaviour to develop sustainable prevention, intervention and postvention strategies and policy.
Suicide research consistently demonstrates that women have higher rates of suicidal behaviour, i.e. ideation, planning and suicide attempts compared to men; however men are more likely to die by suicide (WHO 2014). This is referred to as the “Gender Paradox in Suicide” (Canetto & Sakinofsky 1998).

Gender plays a significant role in suicide and suicidal behaviours. Gender differences have been reported in relation to suicide methods, risk and protective factors, causal factors, the very nature of suicidal behaviour and how it is manifested. However, our knowledge of these differences remains incomplete, particularly so for reported gender differences in those who attempt suicide, and also within different age groups. The relevant knowledge already acquired from research to date (e.g. Stefanello et al 2010; Freitas 2008; Pietro & Tavares 2005; Qin et al 2000; Roy & Janal 2006) has rarely been used to inform gender specific suicide prevention and treatment responses.

Further, despite growth and advancements in the suicide prevention field over the past twenty years, more of the focus has been on understanding and preventing suicide mortality rather than non-fatal suicidal behaviours. Research has not contributed much to our understanding of suicide and suicidal behaviour in women nor consciously informed prevention of suicide in this population. There is also very limited research on suicidal behaviour among women of trans experience, women with intersex characteristics, feminine spectrum people who do not identify as women or men, and those with culturally specific genders beyond the woman/man binary.

The substantial attention on suicide prevention for men reflects the high importance of this pressing global issue. However, given the large swing in the size of the health burden towards women when suicide mortality and morbidity are combined (Chaudron & Caine 2004), it would seem both reasonable and sensible to focus also on understanding and preventing women’s suicidal behaviour. Taken together, the numbers of women who think about suicide, plan their suicide, attempt suicide and die by suicide is considerable and has a large impact on public health in Australia and internationally.

There are many theories and explanations for differences in suicide and suicidal behaviour between women and men and (Schrijvers et al., 2012; Hawton 2000; Canetto 2008; Jaworski 2007). Some of these include: gender equality/inclusion issues, differences in socially acceptable methods for dealing with stress and conflict for women and men, differences in vulnerability to psychopathology, biological and neurobiological differences, availability of and preference for different means of suicide, cultural role differences, availability and patterns of alcohol/drug consumption, and differences in help-seeking and help-acceptance rates for distress and mental illness between women and men (Stack 2000; Smalley et al 2005; McKay et al 2014). In addition, some of these reported differences may vary across cultural contexts rather than functioning as universal constants.

This discussion paper focuses on women’s suicidality because it is an important public health issue. The paper will discuss the available data and statistics relating to suicide and suicidal behaviour in women, the most relevant risk factors for women, the sub-population groups more at-risk, the impact of cultural beliefs and attitudes about gender, and the policy environment. The paper will conclude with recommendations for dialogue and change for the prevention of suicide and suicidal behaviour in women.

“One reason for the lack of investment in female suicidal behaviour may be that there has been a tendency to view suicidal behaviour in women as manipulative and non-serious (despite evidence of intent, lethality, and hospitalization), to describe their attempts as “unsuccessful,” “failed,” or attention-seeking, and generally to imply that women’s suicidal behaviour is inept or incompetent” (Beautrais 2006)
Background

Suicide in Australia

The impact of suicide and suicidal behaviours has far reaching effects on Australian families and communities. Official Australian Bureau of Statistics (ABS) figures put the lives lost from suicide at about 2,500 people in Australia each year (ABS 2014), however this is believed to be an under-estimate of the true numbers (De Leo 2007, 2010). The preliminary ABS data for 2013 states men’s suicides numbered 1,885 (rate of 16.4 per 100,000) and women’s suicides at 637 (5.5 per 100,000). Each death has a devastating impact on biological and chosen families, friends, colleagues and communities.

‘Suicidal behaviour’ or ‘suicidality’ is a broad term that includes suicide attempts (non-fatal, self-injurious acts done with an intention to die), suicide planning (taking action in preparation for suicide) and suicide ideation (thoughts about taking one’s own life). People who experience suicidal ideation and make suicide plans are at increased risk of suicide attempts, and people who experience all forms of suicidality are at greater risk of death by suicide, though a suicide attempt is the most significant predictor of future suicide.

Non-suicidal self-injury (NSSI), i.e. injury to oneself without intent to die, is prevalent amongst women and can be extremely distressing and complex. For most people, this behaviour is not about ending their life, however those who deliberately injure themselves are more likely than the general population to also experience suicidality. For this reason NSSI will be discussed in the Risk Factors section of this paper.

Suicide data has been under scrutiny for the past seven years in Australia following notification of the discrepancies between Australian Bureau of Statistics (ABS) data and the data obtained from the Queensland Suicide Register (QSR) (De Leo, 2007; Williams et al., 2010). In 2009 the ABS acknowledged the possibility of poor suicide data ‘quality’, which they reported may have been a consequence of increased numbers of open coroners’ cases at the time of releasing their statistics (ABS, 2009). Consequently, the ABS instigated a revision process of their data in 2009 whereby retrospective reconciliation of suicide cases from 2007 onwards would take place. The revision process, which is currently completed for data up until 2011, involves re-examination of all coroner certified deaths at 12 and 24 months after the original data entry and processing, resulting in “three sets of suicide data for each reference year: Preliminary, revised and final” (Kõlves et al, 2013:11). This revision process and reform to improve suicide data is welcomed by researchers and suicide preventionists alike, and is supported particularly by the National Committee for Standardised Reporting on Suicide (see SPA website).

At a global level, in response to difficulties in capturing the full extent and accurate calculation of non-fatal suicidal behaviour, the World Health Organisation recently published a resource booklet “Preventing suicide: A resource for non-fatal suicidal behaviour case registration” (WHO, 2014).

The purpose of the booklet is to guide national governments and policy makers in defining the topic and establishing national registries or surveillance systems for non-fatal suicidal behaviour. The current lack of national data registration and classification systems for suicidal behaviours creates a massive gap in our knowledge about suicidality and in particular women’s non-fatal suicidal behaviour. Nevertheless, and in light of the constraints of variability in data collection and classification systems of non-fatal suicidal behaviour, some existing data may provide estimated prevalence (albeit conservative) information on this phenomena in Australia.
Evidence across many decades reveals that for many so-called ‘developed’ countries of the world the suicide rate of men exceeds that of women between three to fourfold, with the exception only of China where (up until just recently) women’s suicide rates exceeded men’s rates (Kõlves, Kumpula & De Leo, 2013). Recent research has shown that the rate of men’s suicide in China has surpassed the women’s rate (Chen et al., 2012). In countries like India, Singapore, Hong Kong, Kuwait and Japan, men’s and women’s suicide rates are relatively the same (Cheng & Lee, 2000).

As portrayed in Figure 1, globally women’s suicides have been much more stable across the past 65 years and across age groups than men’s, though there is considerable variation by region, and some age groups of women have higher numbers, rates or proportion of total deaths (Callanan & Davis, 2012). More recently however, in the period from 2000 to 2012, the global age-standardised suicide rate for women has fallen by 32% (with variations by region) (WHO 2014).

Globally men’s suicide rates predominate over women’s suicide rates with a ratio of 3.2:1 in 1950, 3.6:1 in 1995 and 3.9:1 in 2020; with only one exception (China), where suicide rates in women are consistently higher than suicide rates in men, particularly in rural areas (Phillips, Li & Zhang 2002). This cross-cultural variability is important to consider, as the comparative findings suggest that suicide rates are influenced by local gender ideology.

**Figure 1: Global suicide rates since 1950 and projected trends until 2020**

Source: Bertolote & Fleischmann (2002)
There were an estimated 804,000 suicide deaths worldwide in 2012, which equates to a global suicide rate of 11.4 per 100,000 population (8.0 for women and 15.0 for men).

A method of assessing the importance of suicide as a public health problem is to assess its relative contribution to all intentional deaths, which include deaths from interpersonal violence, armed conflict and suicide [i.e. violent deaths].

Globally, suicides account for 56% of all violent deaths [50% in men and 71% in women] (WHO 2014).

A point of consideration is that many people of trans experience are misclassified in a way that does not reflect how they live and identify their own gender. A recent New Zealand study (Clark et al 2014) found 1.2% of a nationally representative adolescent population sample reported identifying as transgender and 2.5% were not sure of their gender. This means 3.7% or more of that population could be misclassified. It is therefore important to be aware of the proportion of culturally specific non-binary gender groups and the potential impact on our understanding of gender based analysis; consider, for example, the ‘sistagirls’ in Aboriginal communities and fa’affafine in Samoa.

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National

Similar to global trends, Australian women’s suicide rates have been relatively stable and constant across the past thirty years, at approximately 5 deaths per 100,000 [see Figure 2 below]. According to the 2013 preliminary ABS data, 637 women died by suicide, a rate of 5.5 per 100,000, though rates fluctuate across age groups [see Figure 3, next page]; accounting for 21,608 years of potential life lost (ABS 2015).

Figure 2: ABS suicide rates 1989 – 2013 by sex (incl. revision process)
In 2013, suicide accounted for 0.9% of all women’s deaths. Of note, suicide is a disproportionate cause of death among younger women, compared to older women, as shown in Figure 4, next page. Of particular concern is the proportion of 15-19 and 20-24 year old girls’ suicides compared to older women. The majority of these 2013 adolescent suicides were by hanging.

Whereas young men’s suicides have reduced in number and rate since the 1997 global peak, young women’s have not.

Hanging is the most commonly used method of suicide for women (as it is for men) with poisoning by drugs being second most common. Whereas the number of women using poisoning by drugs has remained relatively stable across the past 10 years, hanging has increased by 10% for both men and women (in 2003 hanging represented 37% of all women’s suicides; in 2012 it was 47%). Hanging is an increasing and predominant method of suicide. Only a small proportion, 10% of hangings occur in controlled environments (such as prisons, hospitals), the remainder occur in the community (Gunnell et al 2005).

Hanging is potentially lethal and the means (rope, belt, cord etc.) highly accessible, yet prevention within the community environment is a challenge. The prevention of hanging deaths is in fact a global challenge because of the difficulties attending to adjustments within the broader community environment and more research is needed to better understand the recent rise in the choice of this method (Biddle et al 2012).
2. Non-fatal suicidal behaviour

Evidence suggests that people who engage in non-fatal suicidal behaviour and attempt suicide are likely to do so again unless they receive appropriate help (Australian Government Department of Health & Ageing 2007). The Australian Bureau of Statistics (ABS) categorises suicide attempts under ‘intentional self-harm’. The ABS defines ‘intentional self-harm’ as ‘a range of behaviours including cutting, poisoning and attempted suicide (ABS 2008). The numbers of people who injure themselves without the intention of suicide and those who engage in non-fatal suicidal behaviour cannot be separated within the existing data collection systems, making it impossible to identify an accurate number of suicide attempts in Australia.

Accessing accurate, valid and reliable data on suicide attempts is problematic; however there are some sources that provide an approximate picture. A comparison between two data collection points of Australia’s National Survey of Mental Health and Wellbeing (NSMHW), 1997 and 2007, showed an increase in the 12 month prevalence rates of women’s suicide attempts from 0.4% to 0.5% respectively for the age group 16 – 85 years (ABS 2008). From another source, the estimate of lifetime prevalence of a suicide attempt in a large population study conducted in Queensland revealed women’s numbers were higher than those of men, 5.0 compared to 3.3 (De Leo et al 2005).

Researchers, policy makers and clinicians are confronted by many challenges when trying to define and classify suicidal behaviours, including adopting a standard vocabulary, dealing with the issue of data reliability, data linkage, and service usage versus self-reporting of non-fatal suicidal behaviour. Most data on the prevalence of suicide attempts is derived from hospital data, which unfortunately...
suffers from a myriad of case classification issues. Further, there are no standardised terms used across jurisdictions (states/territories) or health facilities and institutions, with ‘intentional self-harm’ (ISH) being the terminology most commonly used in the hospital setting. However there are variable behaviours which can be registered as ISH, including suicide attempts as well as non-suicidal self-injury, without an intention to die (WHO 2014).

One international example of achieving improvements to the classification of non-fatal suicidal behaviour can be observed in the United Kingdom where the Republic of Ireland has developed a National Register of Deliberate Self-Harm, operating since 2006 (Perry et al 2012). The focus here has been on the design of standardised data collection procedures for documenting, observing, measuring and analysing non-fatal behaviour across time to subsequently inform prevention and intervention strategies. Another example comes from the Multicentre Study of Self-Harm in England which is a large collaboration between Derbyshire, Oxford and Manchester health trusts (Kapur et al 2013). It involves use of shared standard protocols for investigating the epidemiology, causes, clinical management, outcome and prevention of self-harm behaviour. According to the 2007 National Survey of Mental Health and Wellbeing (NSMHW), approximately 2.1 million adults in Australia have had serious thoughts about killing themselves. According to the same survey 600,000 adults have made a plan to suicide and 500,000 adults have made a suicide attempt during their lifetime (Slade et al 2008). Table 1 below presents 12-month prevalence of men and women’s suicidality obtained from the NSMHW survey, plus ABS suicide data.

The proportion of women who experienced some form of suicidality [being ideation, plans and/or attempts] is nearly 1% higher than their men counterparts. This is a public health problem in an order of magnitude far greater than just suicide mortality numbers. Presentation to a hospital after a suicidal attempt is low, with less than 30% of a large Queensland survey acknowledging attendance after their attempt (De Leo et al

Table 1: Prevalence, 12-month suicidality by gender, Australia, 2007 & 2013 suicides

<table>
<thead>
<tr>
<th></th>
<th>Women %</th>
<th>Women No.</th>
<th>Men %</th>
<th>Men No.</th>
<th>All Persons %</th>
<th>All Persons No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicidal ideation</td>
<td>2.7</td>
<td>221,300</td>
<td>1.9</td>
<td>146,700</td>
<td>2.3</td>
<td>370,000</td>
</tr>
<tr>
<td>Suicide plans</td>
<td>0.7</td>
<td>57,500</td>
<td>0.4</td>
<td>33,500</td>
<td>0.6</td>
<td>91,000</td>
</tr>
<tr>
<td>Suicide attempts</td>
<td>0.5</td>
<td>42,700</td>
<td>0.3</td>
<td>22,600</td>
<td>0.4</td>
<td>65,000</td>
</tr>
<tr>
<td>Any suicidality</td>
<td>2.8</td>
<td>N/A</td>
<td>1.9</td>
<td>N/A</td>
<td>2.4</td>
<td>380,000</td>
</tr>
<tr>
<td>Suicides (ABS 2013 data)</td>
<td>25</td>
<td>637</td>
<td>75</td>
<td>1,885</td>
<td>100</td>
<td>2,522</td>
</tr>
</tbody>
</table>

I Note: Any suicidality is lower than the sum as people may have reported more than one type of suicidality.

II Note: Using most recently available suicide data 2013

N/A Note: Not easily derived from the ABS data spreadsheet

“Population-based data on hospital-treated intentional self-harm represents an important index of the burden of mental illness and suicide risk in the community.”
(Perry et al 2012)

Women were 2.3 times more likely than men to attend hospital after a suicidal act with each of these presentations creating an opportunity for compassionate care, psycho-education, treatment, and linkage to ongoing support in the community. Increased accuracy in the recording of reported non-fatal suicidal behaviour is vital to suicide prevention efforts and can be used to determine the prevalence and correlates of non-fatal suicidal behaviour, the efficacy of interventions and informs government funding allocations for suicide prevention and mental health support programs to meet the needs of women and at risk people.

As previously mentioned, hospital data gives us only an approximate picture of non-fatal suicidal behaviour since the term “intentional self-harm” (ISH) clusters together suicide attempts and non-suicidal self-injury”. Be that as it may, hospital attendance trends are useful to further illuminate the picture.

The rates for women hospitalised as a result of ISH were at least 40% higher than men’s rates over the period from 1999–00 to 2011–12, with the number of women’s cases exceeding men’s cases most noticeably in the adolescent years (AIHW 2014).

Poisons (including prescription and non-prescription, but excluding gas) accounted for almost 82% of all hospitalisations due to ISH over the period from 1999–00 to 2011–12. Contact with sharp objects and hanging accounted for a further 12% and 2% respectively (AIHW 2014). The number of women aged 15–24 years who injured themselves so severely that they require hospital treatment has increased by more than 50 per cent since 2000 [see Figure 5 below]. In 2010–11, more than 26,000 people were hospitalised for “intentional self-harm”; nearly one in five were women aged 15–24 years (AIHW 2013).

While it cannot be determined how many of these cases were non-fatal suicidal behaviours or self-injury without intention to die, the dramatic increase is concerning.

Figure 6 (next page) indicates the recent age distribution by sex of those hospitalised for “intentional self-harm”. Clearly the prevalence of this behaviour in younger women requires urgent attention.

The suicide methods used by women and men have contributed [amongst other

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**Figure 5: Trends in hospitalised injury, Australia 1999–00 to 2010–11**

<table>
<thead>
<tr>
<th>Cases of self-harm among women aged 15 to 24</th>
</tr>
</thead>
<tbody>
<tr>
<td>3407</td>
</tr>
</tbody>
</table>

Source: AIHW (2013)
factors) to the difference in suicide rates (Callanan & Davis, 2012). Historically, it has been debated that women have chosen methods of variable effectiveness e.g. poisoning (overdose) whereas men have chosen more violent methods e.g. firearms, hanging. Nevertheless, research shows that women and men with equal intent to die use methods for suicide which differ in lethality, with men typically choosing more lethal methods (Denning et al 2000).

Trends have been changing, however, and women are adopting more lethal methods (Byard et al 2004; Austin et al 2011). It has been posited that the changing ideas of femininity and masculinity and gender roles in Australian society have affected method choices, however more research is required to fully understand, and address the change to more lethal methods and how this varies within minority groups (Women’s Health Victoria 2011).

Women may have the same intent to die, however the resulting suicide attempt status is less recognised as a social issue, and is not well recorded in data collection and reporting. As a result, while women are more highly represented in non-fatal suicidal behaviours they are far less visible in suicide prevention dialogue and research.

Figure 6: Age-specific rates of hospitalisation as a result of intentional self-harm, by sex, Australia, 2010–11

Note: Rates for ages 0–4 and 5–9 not reported.
Attitudes and beliefs about women’s suicide and suicidal behaviours

“The gender differential in suicide has been one of the most perplexing and controversial issues in the study of suicidal behaviour, largely because of gender biases, which have influenced both theory and research.”

There are ubiquitous cultural stereotypes that impede the level and kind of support provided to women exhibiting suicidal behaviours. While stigmatisation of suicide exists for both genders, women’s suicidal behaviours are often viewed differently (Canetto 1997).

Suicidal behaviour, in particular, suicide attempts and NSSI, is more common in women, and these behaviours are regarded as more ‘feminine’ than acts of suicide by men. Women who attempt suicide are often portrayed in classic literature and popular culture as engaging in a form of ‘manipulative femininity’ (Dyson et al. 2003; Canetto 2008; Scurfield 2011). The view of men’s suicide however is seen as masculine, decisive, lethal, violent, aggressive and serious. Women’s suicide is often conceptualised as non-lethal, non-violent and passive and women who attempt suicide are often described as ‘attention-seeking’, aiming to manipulate their loved ones into feeling guilty or responsible (Canetto & Sakinofsky, 1998; Jaworski, 2003). This portrayal is implicit, pervasive and subtle and can insidiously influence the way in which women’s suicidal behaviours are misunderstood and unsupported by families, the community and service providers.

At a global level, in response to difficulties in capturing the full extent and accurate calculation of non-fatal suicidal behaviour, the World Health Organisation recently published a resource booklet “Preventing suicide: A resource for non-fatal suicidal behaviour case registration” (WHO, 2014).

The purpose of the booklet is to guide national governments and policy makers in defining the topic and establishing national registries or surveillance systems for non-fatal suicidal behaviour. The current lack of national data registration and classification systems for suicidal behaviours creates a massive gap in our knowledge about suicidality and in particular women’s non-fatal suicidal behaviour. Nevertheless, and in light of the constraints of variability in data collection and classification systems of non-fatal suicidal behaviour, some existing data may provide estimated prevalence (albeit conservative) information on this phenomena in Australia.

One domain where judgemental beliefs and attitudes about women’s suicidal behaviours are highly visible and problematic is in healthcare settings. Some healthcare staff continue to lack understanding and compassion, and in their time-poor, stressful work environments, often deem suicidal behaviour as ‘attention-seeking’. This greatly compromises the quality of care provided to women and potentially adds to their risk (Scurfield et al. 2011).

Despite the development and implementation of guidelines and standards relating to the treatment of suicidal patients, staff may not always adhere to these guidelines (Dyson 2007). Women are generally more likely than men to come forward to share their personal experience of having been hospitalised for self-harm and report feeling dissatisfied with emergency and psychiatric services due to perceived negative attitudes directed towards them (Walker 2009; NMHC Report Card 2013).

A systems approach to compassionate and humanistic care for suicidal women is imperative if we are to encourage women to access support (Youngson 2012; US Suicide Care in Systems Framework, 2012; Ballat & Campling, 2010). Training of healthcare staff needs to address underlying, entrenched beliefs and attitudes not just suicide risk assessment.
Factors impacting and influencing suicidal behaviour in women

Suicide is complex and there is usually an interplay of multiple factors that contribute to someone taking their own life. Although the experience of suicidal behaviour is unique and individual in nature, a number of bio psychosocial and cultural factors have been found to influence the risk of suicide in women (though the level of research on differences in risk factors between genders is scant).

Risk factors can be defined as either distal or background factors, such as genetic factors, or proximal, more immediate factors, such as a recent life events. These factors interact with a confluence of social determinants, for example intimate partner violence, culture, geographic location, and discrimination, to influence patterns of women’s suicidality. Not having autonomy, choices and agency in one’s life adversely affects women’s experience. Constraints including financial, economic equity, health, marriage and relationship recognition, fertility and assisted reproduction options, geographic mobility, employment equality issues, societal stereotypes, cultural norms, and limited role definitions can also contribute to the wellbeing of women.

A wide range of risk factors have been recognised as influencing suicide and some are illustrated below. For simplicity, they have been grouped into areas reflective of the Ecological Model (Dahlberg & Krug 2002; WHO 2014) across systemic, societal, community, relationship (social connectedness to immediate family and friends) and individual risk factors.

**Individual factors:**
- mental health diagnoses and related symptoms (depression, eating disorders, schizophrenia, borderline personality disorder, post-traumatic stress responses, NSSI)
- harmful use of alcohol and substance use
- post-natal depression, unwanted pregnancy
- chronic illness/pain
- previous non-fatal suicidal behaviour
- genetic and biological factors
- access to lethal means
- feelings of hopelessness

**Life experience and relationships:**
- current relationship/marital turmoil
- intimate partner violence and domestic violence
- childhood sexual abuse
- exposure to poor parenting or violent parental conflict; fractured family structures
- family of origin history of violence or suicide
- financial, work stress, under or unemployed

**Community level:**
- social or geographical isolation
- bullying and hate crimes
- high unemployment
- poverty and low income
- cultural scripts about women’s suicidal behaviour
Risk Factors

Discussed below are risk factors that have some research evidence documenting their specific influence on women’s suicidal behaviour and suicide.

Mental illness

Research reveals that women with a history of mental illness diagnoses, in particular depression, and anxiety disorders have a greater risk of suicidal behaviours (Chaudron & Caine 2004; Cougle et al 2009). Depression appears to have a higher prevalence among women with an earlier age of first onset (Ferguson et al, 2000; Kessler 2003), and depression diagnoses are ubiquitous among women who die by suicide (Chaudron & Caine 2006). Co-occurring conditions, e.g. affective disorders, anxiety disorders and substance use disorders, are particularly common among those who take their own life. One study revealed that 74% of women, who had attempted suicide at some stage in their life, had also received a prior diagnosis of depression or PTSD (Cougle et al 2009). While having a mental health diagnosis is strongly associated with suicidality, an acute situational crisis of deep despair, hopelessness and unbearable suffering can also precipitate suicidality. It is also true that not all women experiencing mental illness become suicidal, in fact the greater majority do not.

There is also an important body of literature on the medicalisation of women’s misery and the problem of women receiving a diagnosis of depression (Ussher 2010).

Mental health symptoms experienced more by women that carry increased suicide risk include depression, particularly during the perinatal period, and eating disorders (both bulimia and anorexia nervosa). Borderline personality disorder (BPD) is a severe and persistent mental illness, prevalent amongst women. Among patients with BPD, 69% - 80% engage in suicidal behaviour, with a suicide mortality rate of up to 9% (Linehan et al 2006).

Women’s greater vulnerability to non-fatal suicidal behaviour can also be associated with gender-related vulnerability to psychopathology and to psychosocial stresses (Beautrais 2006). Biological factors may include: personality traits, genetic susceptibility, and family history, while social determinants include: lack of access to resources, resilience, connectedness, freedom from interpersonal violence, reproductive rights, freedom from discrimination and racism, gender equality, and access to education, healthcare. A positive social environment can support wellbeing through protective factors that mitigate risk.

Depression remains a major issue for a significant number of middle-aged and older women; peri menopause is a complex time of life for women with a 16 fold increase in diagnoses of depression (Cohen et al 2006). This age group of women also have a higher rate and numbers of suicides than women of all other ages, including youth (Lawrence et al 2000). In Australia approximately 100,000 women over 50 years of age will be diagnosed with a major affective disorder during any one year (ABS 2007-2008).

One contributing factor for worsening depression in vulnerable women appears to be menopause (Freeman et al 2006). There is debate amongst health professionals whether this is new depression because of the menopause or is pre-existing depression exacerbated at this time. Nevertheless, women in their middle years have increased rates and numbers of suicides and the management of increased depression at this time in life will improve their quality of life and wellbeing.
The relationship between pregnancy and suicidality is complex, with motherhood generally providing a protective effect. However, there has been significant difficulty collecting accurate data about the prevalence of suicide and suicidal behaviour among mothers in Australia.

Despite pregnancy and parenthood being a protective factor for women against suicide and suicidal behaviour, suicide is a leading cause of death for women during pregnancy and in the year after giving birth (Austin et al., 2007). Contributing factors include that 1 in 10 women develop depression during pregnancy and 1 in 7 women develop postnatal depression; roughly 30% of pregnant women with depression experience suicidal ideation (Gold et al., 2012; Melville et al., 2010). Factors associated with suicidal ideation during the antenatal period include depression, perceived stress, smoking, and common mental disorders (Gavin et al., 2011; Huang et al., 2012). Austin et al. (2007) identified a risk profile that is unique to childbearing women — women with previous psychiatric hospitalisation without their baby and severe mental illness with early onset following childbirth (postpartum psychosis). In women with postpartum psychosis, the suicide risk increased 7-fold in the year after childbirth and 17-fold over the long term (Appleby et al., 1998).

Intimate partner violence (IPV) also peaks during pregnancy for a wide range of psychosocial reasons (Martin et al., 2004), strengthening the combined risk of pregnancy (particularly unplanned), IPV, and suicidality. The protective effect of pregnancy may be lessened in mothers aged less than twenty years or in cases where the pregnancy ends in stillbirth, miscarriage, the loss of a child, or is unwanted (Qin et al., 2000; Qin & Mortenson, 2003). There is a long-standing association between depression/suicidal behaviour and unwanted pregnancy (Bunevicius et al., 2009; Newport et al., 2007). Despite common myth, there is no concrete evidence linking abortion to mental health problems (Charles et al., 2008). The likelihood of a woman experiencing poorer mental health after an abortion is more dependent on factors such as pre-existing mental health status (Robinson et al., 2009), ambivalence toward the pregnancy (Kero, Hogberg & Lalos, 2004), and exposure to IPV (Taft & Watson, 2008).

The menstrual cycle implications for women are that non-fatal suicidal behaviour occurs most often when oestrogen and serotonin levels are lowest (Villeneuve et al., 2006).

“...it has been argued that if all women were given the right to self-determination and were able to control their own fertility, there would be fewer unwanted pregnancies and therefore fewer suicides.”

(Boama & Arulkumaran, 2009; WHO, 2008)

Alcohol and substance abuse

See SPA’s 2011 Position Statement “Alcohol, drugs & Suicide Prevention” for further information on this topic.

Substance abuse appears to be a strong identifier for detecting women at risk for suicide. Alcohol abuse is considered a distal risk factor for suicide, with individuals with alcohol abuse having higher rates of suicide than the general population (Rossow et al., 2007; Potash et al., 2000). Alcohol use is also considered a proximal risk factor, in that alcohol use lowers inhibitions that may...
normally prevent suicidal behaviour in individuals who are not alcoholics (Moscicki, 1995). A review of studies found alcohol involved in 10% to 69% of suicides (Cherpitel et al., 2004). According to a recent study, alcohol was detected in nearly 28% of women and 36% of men who suicided (Kaplan et al., 2014).

Less is known about alcohol involvement in nonfatal suicidal behaviour. Some studies suggest that perhaps 30% to 50% of hospital-admitted suicide acts involved alcohol (Borges et al., 2004; Cherpitel et al., 2004).

Women's self-inflicted injuries involved alcohol significantly less often than men's however men also drink more than women. Although women more frequently attempt suicide, European emergency department data suggest that women are less likely to have used alcohol immediately prior to a poisoning or other suicidal act then men (Prkacin et al., 2001).

Women’s nonfatal poisoning suicidal behaviour involved alcohol 21.9% of the time, compared to 34.3% for men. Alcohol and substance use by women increases their likelihood of dying by suicide (Conner et al., 2007).

**Intimate partner violence (IPV) and sexual abuse**

Reducing violence against women and children is a burgeoning issue in Australia, as it is around the world. According to the Australian Longitudinal Study on Women’s Health, 1 in 5 women report having experienced domestic violence in the past year. In 2012, more than 130,000 women were abused by their partners (ABS 2014).

Women constitute the majority of victims of sexual abuse and IPV and these experiences are linked to suicidal behaviours (Oquendo et al. 2007; Curtis 2006). Women who are severely injured in incidents of domestic violence are more likely to report depression, anxiety, alcohol abuse, eating disorders and suicide ideation (Curtis 2006).

Women who have been abused by their intimate partners are almost four times more likely to have suicidal ideation compared to non-abused women (Taft 2006), and are at increased risk of suicide attempts (Coker et al., 2002). A recent systematic review of 664 relevant studies (McLaughlin et al., 2012) demonstrated a strong, unequivocal relationship between intimate partner violence and suicidality.

For women who have experienced IPV, suicide is elevated (Guggisberg 2006 & 2008). A VicHealth report stated that IPV was a leading contributor to the death of Victorian women aged between 15-44 years, accounting for 10% of deaths, with more than half being suicides (VicHealth 2005).

Exposure to childhood sexual abuse can result in increased vulnerability to subsequent psychopathology and adverse life events. The risk of suicide ideation and attempts increases with the extent of the abuse.

Suicidal ideation is more common among women who have been sexually assaulted than the general population (Stepakoff 1998). Younger survivors may be at particular risk of attempting suicide following rape (Petrak 2002).

**Bullying**

Bullying is defined as the ongoing physical or emotional victimisation of a person. The emerging problem of cyberbullying occurs when people use new communication technologies, such as social media and texting, to harass and cause emotional harm to others. Much of the research on this issue has involved adolescents in the school setting, however bullying can occur across all ages and social environments.

There is a complex relationship between bullying and risk of suicidal behaviours [Gould et al. 2003]. Bullying and peer victimisation puts adolescents at increased risk of suicidal ideation and behaviour, especially when other psychopathology is present e.g. depression [Van Geel 2014]. It is not necessarily the bullying per se; there are many important mediating variables [Arseneault et al., 2010; Wang et al., 2011].

Suicidal ideation and behaviour is usually not attributed to just one event or factor.

Bullying others, and not only being victimised, is associated with depression, suicidal ideation and attempts [Kaltiala-Heino et al. 2000; Roland 2002]. The strongest association between involvement in bullying and depression/suicidal ideation/attempt is found among those who are both bullies and victims [bully-victims] (Kim & Leventhal, 2008; Klomek et al., 2007).
Overall, adolescents are at greater risk for suicidal thoughts and behaviours if they have been both bullies and victims. There appears to be gender differences associated with frequency of involvement in bullying, either as a bully or a victim, and adverse psychological outcomes. For women, any involvement in bullying is associated with adverse outcomes. For males it is frequent involvement that is associated with adverse outcomes. Women are less likely to be bullies but when they are, they have a more severe impairment than their male counterparts (Kim et al., 2006; Wasserman et al., 2005).

Girls are particularly at risk if they are suffering depression and are self-medicating with alcohol, drugs, or other substances (Lieberman et al., 2008).

Frequent victimisation is associated with later suicide attempts and suicides, even after controlling for conduct and depression symptoms. Frequent childhood victimisation puts girls at risk for later suicidal behaviour, regardless of childhood psychopathology (Sourander et al., 2005; Klomke et al., 2007, 2008, 2009, 2011).

Despite its recent prevalence in the media and society in general, cyberbullying is a relatively new concept in the domain of research. Some recent empirical studies have demonstrated an association between cyberbullying with psychopathology and suicide (Kломк et al. 2008; Sourander et al. 2010). A recent meta-analysis by Van Geels (2014) states that “the effects of cyberbullying are more severe because wider audiences can be reached through the internet and material can be stored online, resulting in victims reliving denigrating experiences more often”. Public dialogue in Australia has been influenced by media coverage of the 2013 adolescent girl’s suicide Chloe Fergusson, and pursuant campaign to raise awareness of the impacts of cyberbullying. Further longitudinal studies are necessary to examine the association between cyberbullying and suicidality.

Research is growing on this issue and strongly supports the view that all forms of bullying and peer victimisation are clear risk factors for depression and suicidality and need to be addressed in all settings.

**Non-suicidal self-injury (NSSI)**

Non-suicidal self-injury is the deliberate damaging of the body without suicidal intent. This behaviour can be extremely complex, not well understood and highly distressing for individuals, family, friends and the community (Lindgren et al 2004). It is a risk factor for suicidal behaviours and eventual suicide (RANZCP 2004), and like suicidal behaviours, is more prevalent amongst women, especially younger women.

A large Australian study by Martin et al (2010a) revealed the population prevalence to be 1.1%, in the month previous to the survey period, and a lifetime prevalence of 8.1%. This was highest for girls 15–19 years old (4% in the previous month, 16.6% lifetime prevalence) and 20-24 year olds (3.6% in previous month, 24.4% lifetime prevalence). The comparative numbers for males in the 15–19 years group are: 2.2% in previous month, 11.6% for lifetime prevalence and in the 20-24 year old age group 18.1% for lifetime prevalence.

The study confirmed that self-injury co-occurs with suicidal thoughts in 48.1% of those surveyed and revealed a lifetime history of suicide attempts for 26.3% (Martin et al 2010).

Self-injury is often used as a coping mechanism with common motivations being: to manage emotions, feeling the need to punish oneself and to feel alive (Favarro et al 2007; Martin et al 2010b). Self-injury is not well understood across the community, even amongst health professionals, which can lead to stigmatisation and social exclusion. Considering the strong association between self-injury and suicidality for women, it is imperative that the issue of self-injury in women is addressed, especially for younger women.
Population Groups at Higher Risk

Lesbian and bisexual women, women of trans experience, feminine spectrum people with non-binary genders, and women with intersex characteristics.

See SPA Position Statement 2009 “Suicide and self-harm among Gay, Lesbian, Bisexual and Transgender communities” for further information on this topic.

“Human sexuality is a complex construct. It involves not only the label we may choose to attach to our sexuality but also the gender of people to whom we experience attraction and the gender of people with whom we engage in sexual activity. Thus, categorising an individual’s sexuality is not a simple matter of asking a single question.” (Smith et al 2003)

Given this complexity, obtaining accurate information and population data is limited.

Same-gender attraction is common across the experience of human sexuality and relationships (beyondblue, 2011). Many women of trans experience and women with intersex characteristics live as and identify as heterosexual, and are often ‘invisible’ as an at-risk group. Though there is nothing intrinsically suicidal about these groups, the experiences of stigma, discrimination, harassment, homophobia, transphobia, abuse, bullying and alienation at family and societal levels (Blosnich & Bossarie, 2012; Fitzpatrick et al., 2005) can increase suicidal behaviours within lesbian/bisexual/transgender/intersex (LBTI) individuals, especially in adolescence (Shaffer et al., 1995).

A recent review found that people of lesbian, bisexual, and trans experience are at a higher risk for suicidal behaviours in the Australian context (Skerrett, Kölves & De Leo, 2015) and also constitute unique risk groups for suicide (Skerrett, Kölves & De Leo, 2014).

"People are expected to assume the gender typically associated with their assigned sex category, and to adopt the gender roles and expectations associated with this. Those who challenge these expectations experience "antagonistic, unwelcoming, and unsafe" environments.


The literature on suicidality in women who identify as lesbian, bisexual or of trans experience, shows a strong tendency toward their higher rates of suicidal behaviour when compared with people whose own understanding of their gender has been recognised in their assigned sex category. For example, results from the Longitudinal Study of the Health of Australian Women showed that 38% of same-gender attracted women respondents aged 22-27 years had experienced depression compared to 19% of heterosexual women respondents, and that non-heterosexual women of various sexualities were almost four times more likely to have tried to harm or kill themselves in the previous six months [12.6% compared with 2.7%] (Corboz et al., 2008).

Other research in Australia reveals that the prevalence of reported suicide attempts in heterosexual women is 4.1% while in lesbian/bisexual women it is 17.9% (Skerrett & Mars, 2014). The rates for bisexual women are even higher than lesbians. Other studies indicate over 30% of transgender people have attempted suicide, with rates almost double for women of trans experience who were assigned as ‘male’ in comparison to men of trans experience (Couch 2007).

International research has found that lesbian and bisexual (LB) individuals are at a higher risk for suicidal ideation (Marshal et al., 2012; Silenzio et al. 2007), and suicide attempts (Bolton & Sareen, 2011; Hatzenbuehler, 2011). King and colleagues (2008) revealed that non-heterosexual
people have at least twice the lifetime risk of suicide attempt than heterosexual individuals. Lesbian and bisexual adolescents appear to be at particularly high risk (Russell & Toomey, 2012). A USA study found them to be two to three times more likely to have attempted suicide than their heterosexual counterparts (Eisenberg & Resnick, 2006; Russell & Joyner, 2001), while bisexual adults have been shown to be three times more likely to attempt suicide (Bolton & Sareen, 2011).

A review of research has found that the relationship between bullying and suicide risk was stronger for lesbian and bisexual youth than for heterosexual youth (Kim & Leventhal, 2008). A recent review of the research identified nineteen studies linking suicidal behaviour in lesbian and bisexual adolescents to bullying at school, especially among young people with “cross-gender appearance, traits, or behaviours” (Haas et al., 2011).

Most people with intersex characteristics identify as either women or men, not as a ‘third gender’ and are often omitted from population surveys and research. Smith and colleagues (2003) found that most LGB people in Australian do not self-identify as LGB, but report these attractions and experiences.

**Aboriginal and Torres Strait Islander People**

See SPA Position Statement 2010 “Suicide Prevention and Capacity Building in Australian Indigenous Communities” for further information on this topic.

Over the past thirty years, there has been an escalating tragedy in Australia with increasing numbers of Aboriginal and Torres Strait Islander people, in particular youth, taking or attempting to take their own lives. Almost non-existent before the 1980s, youth suicide across the northern regions of Australia has reached crisis proportions (Tatz 1999, Elders Report 2014). Studies suggest that the suicide of Aboriginal and Torres Strait Islander people is influenced by a very complex set of factors (AIHW 2013). These factors can include: history of colonisation, dispossession of land and culture, trans-generational and inter-generational trauma, removal from family and community, relocation of people to missions and reserves, racism and discrimination; other factors include: resilience, social capital and socio-economic status (Productivity Commission, OID Report 2014).

The suicide rates for Aboriginal and Torres Strait Islander people is not accurately known due to quality issues with deaths data and population estimates, so the figures we have constitute our ‘best estimate’. Based on data collected over 10 years from 2001 to 2010 from NSW, Queensland, SA, WA and the NT, the ABS estimates that the suicide rate for Aboriginal and Torres Strait Islander women is approximately double the non-Indigenous rate. The rate for Aboriginal and Torres Strait Islander women was 8.7 per 100,000 compared with 4.5 for non-Indigenous women (ABS 2012). According to more recent ABS data for 2013, the rate for Aboriginal and Torres Strait Islander women has increased to 12.9 per 100,000 compared with 5.4 for non-Indigenous women (ABS 2014).

Suicide rates (per 100,000) for young Aboriginal and Torres Strait Islander women aged 15–19 years (18.7) and 20–24 years (21.8) were 5.9 and 5.4 times the corresponding rates for non-Indigenous women (ABS 2012). More recently, in 2013, the rate for 15–24 year olds was 22.7, compared to 5.0 for non-Indigenous women.

For the period from 2007–08 to 2010–12, rates of hospitalised intentional self-harm for Aboriginal and Torres Strait Islander women and men were around 2 times and 2.5 times as high as the rates for non-Indigenous women and men respectively (AIHW 2014). From 2004-05 to 2012-13, the hospitalisation rate for intentional self-harm increased for Aboriginal and Torres Strait
Islander people by 48.1 per cent, while the rate for non-Indigenous people remained relatively stable (Productivity Commission Report 2014).

Suicidal behaviours among Aboriginal and Torres Strait Islander young women are increasing. The compounding risk factors of: trauma, poor mental health, high alcohol and substance abuse, high rates of IPV, unemployment, and racism/discrimination are contributing to disconnection from family and community, hopelessness and suicidal behaviours. Aboriginal and Torres Strait Islander people’s suicide prevention calls on governments to take priority steps to address these mental health gaps and act on recommendations and policy advice already articulated (Dudgeon et al 2014; Productivity Commission Report 2014; Elders Report 2014; The National Empowerment Programme 2014; National Aboriginal and Torres Strait Islander Suicide Prevention Strategy 2013). There needs to be an increase in acknowledgement and support for community based suicide prevention programs, and dissemination of successful models.

Bereaved by suicide

Women are significantly impacted by the suicide of those in their familial/social/collegial networks, however they are often overlooked in suicide prevention and postvention strategies. Mothers, grandmothers, wives, partners, girlfriends, aunts, nieces and sisters constitute a large group of women who are devastatingly impacted by their predominantly male (and female) loved one’s suicides (Pitman et al 2014). Often unrecognised, with the more significant numbers of male suicides, there are inevitably a larger group of women who were in primary relationships (i.e. mother/daughter, spouse/partner/girlfriend) with the deceased who are left with the aftermath of suicide.

Evidence shows us that of all the relationships to the deceased, partners and mothers of people who die by suicide are the groups most at increased risk of suicide (Agerbo 2003, 2005). It is vital to apply a cultural lens when considering and addressing loss, grief and bereavement.
Protective factors reduce the likelihood of suicidal behaviour and contribute to a person’s ability to cope with difficult circumstances (Commonwealth of Australia 2007). Even though women may be more vulnerable to suicidal behaviours because of psychopathological and psychosocial issues, research indicates there are a number of gender-specific factors which may protect them from suicide, some of which are listed here:

Protective factors include (Beautrais 2006):

- Strong social connections with family, friends and community.
- Pregnancy (suicide rates in pregnancy are estimated to be half those of women who are not pregnant).
- Motherhood, especially when children are very young and at their most dependent. In relation to this protective factor, it has been speculated that the social community networks related to children’s activities create a safety net of interconnectedness for young mothers.
- A willingness to ask for, be offered, and accept help for emotional and mental health issues.
- A likelihood of using telephone/online help lines and visiting the family doctor.
- A likelihood of discussing their problems with others and more opportunities to access and accept other social and health services.
- A tendency to have good verbal and social skills which means they may respond better to psychological and cognitive behavioural therapies for depression.

Policy Context

There is currently a global dialogue underway to improve the lives of women and children including policy development to address the reduction of violence and improved mental health. Many international organisations are focusing on these issues and our own national Commonwealth Government of Australia has also emphasised this important topic with a number of national policy and strategy documents.

Listed below are some of the relevant current international and national developments pertinent to the topic of women’s health, including mental health and suicide prevention. Noteworthy is the loud silence on the prioritisation of suicide prevention for women. Mention is made below more by the absence than presence of focus on the current topic. There is a risk, since so little is known about women’s suicidality in and of itself, that current strategies, services and programs may not be effective for women since their development is mostly based on the greater body of knowledge of men’s experience of suicidality.

International

Within the United Nations Millennium Development Goals attention is focused on the need to include both the health of women and children and their mental health in the new Sustainable Development Goals, www.fundamentalsdg.org. Most development experts accept that women and children are central, not only to the future of health, but also to the future sustainability of our societies (Horton 2014).

Recently, the WHO enacted their “Global Mental Health Action Plan, 2013-2030”, and also released the “WHO - Preventing suicide: a global imperative” report [WHO 2014]. Neither of these important international documents devotes much attention to the issue of suicide and its prevention in women. This is remarkable since several countries of the world experience a women’s suicide rate higher than or approaching that of their male counterparts (e.g. China, India, Singapore, Hong Kong, Kuwait and Japan).
"Finally, what is a strategy for women’s and children’s health really about? It cannot only be about survival, or even physical and mental health. It must be about wellbeing, an idea that is much misunderstood. Wellbeing is not only “happiness”. As Andrew Steptoe has recently explained, wellbeing also means life satisfaction and our sense of meaning or purpose. Our ambition for women and children should be nothing less than to define health in terms of improvements to the satisfaction, meaning, and purpose of their lives—to offer the opportunities to women, adolescents, and children to live the lives they desire, wish, and dream to live."

(p 1732 Horton 2014)

National Women’s Health Policy

Since 2007 the Commonwealth government has specifically committed to improving the health and wellbeing of all women in Australia, and implemented policies to encourage the health system to be more responsive to the needs of women.

The “Development of a New National Women’s Health Policy: Consultation Discussion Paper” was used to launch national consultations which occurred in 2009, followed by the launch of the National Women’s Health Policy 2010.

The second of four priority areas within this policy is: Mental health and wellbeing; targeting anxiety, depression and suicide. However the document does not provide strong leadership for action and change on the issue of suicide prevention in women.

In the Women’s Health Policy arena the federal Department of Health also funds the Australian Longitudinal Study on Women’s Health (ALSWH) - www.alswh.org.au. It is a valuable resource and consists of longitudinal survey of over 40,000 women in 3 cohorts aged 18-23, 45-50 and 70-75 years when the surveys began in 1996. In 2012/13 more than 10,000 young women were recruited for a new cohort of 18-23 year olds. ALSWH assesses women’s physical and mental health and provides invaluable data about the health of women across the lifespan, however information relating to suicide specifically is scant.

Mental Health Policy

The backdrop for mental health policy in Australia includes the following developments:

- COAG’s 10 year Roadmap for National Mental Health Reform (2012)

Neither of the aforementioned report cards from the NMHC focuses on women and suicide; however the 2013 “A Contributing Life” Report card proposed future work in the area of suicide attempt behaviour. This is promising given the high proportion of women versus men who attempt suicide, and thus the likelihood of enhanced understanding derived from investigations or focus on this behaviour.

The Black Dog Institute was commissioned to develop a report on ‘Care After A Suicide Attempt’ (CAASA), for the National Commission. It is anticipated that this report should provide policy lead to improve surveillance, standardised data collection and linkage, agreed nomenclature, improved training for health professionals, more compassionate / humanistic response to suicidal women, improved treatment and access to care, amongst other issues.

As mentioned earlier, the recent World Health Organisation document “Preventing suicide: A resource for non-fatal suicidal behaviour case registration” (WHO, 2014) was developed in an effort to highlight the need for policy makers to seriously attend to the issue of non-fatal suicidal behaviour, which has been somewhat neglected due to the predominant focus on suicide. This document captures the essence of the complexity of non-fatal suicidal behaviour, the need for standardised or uniform national registration systems and, the need for its inclusion in government health care planning efforts due to its critical weighting as a risk factor for suicide. While a specific focus on women’s non-fatal suicidal behaviour is not apparent, the significance of improving accuracy in data reporting to enhance understanding and our responses to prevent this behaviour can only contribute to knowledge and awareness of women’s suicidal behaviour.
Suicide Prevention Policy

Australia has had a National Suicide Prevention Strategy for almost 20 years. The current Living Is For Everyone (LiFE) Framework, developed in 2007, provides national direction in suicide prevention priorities. However, there is little mention of women in any of the Framework documents. In fact, within this strategic response there exists a Fact Sheet on Suicide and Men (see Fact Sheet number 17) but there is no such equivalent women’s fact sheet.

Further, in 2010, the report from the Senate Inquiry into Suicide in Australia – “The Hidden Toll” was released with scant attention to the issue of women’s suicide or suicidal behaviour. An absence of attention to the topic is reflected in the deficiency of consequent project funding and service and program development directly informed by the recommendations from this Inquiry.

Reduction of Violence against Women and Children


Australia’s National Research Organisation for Women’s Safety (ANROWS) represents one of the commitments derived from the ‘National Plan to Reduce Violence against Women and their Children’ with their ‘National Research Agenda’ report released in May 2014.

Recommendations Framework

“Experience indicates that for effective suicide prevention, the appropriate treatment of people with mental disorders is just one of the main components. Actually, biological and psychological characteristics, and factors pertaining to the cultural, social and physical environment, although more difficult to approach in quantitative ways, should receive much more attention...”

Bertolote et al, 2004

This Discussion Paper on the prevention of suicide and suicidal behaviours in women has been developed to inspire dialogue and generate change in this very important yet traditionally overlooked domain. Listed below are recommendations derived from the paper to guide discussion amongst individuals, communities, organisations, and government bodies to increase their focus on the suicidality of women and the issues that impact on their wellbeing.

Women constitute 51% of the population and their health and wellbeing impacts across the whole of the community. Women are often the lynchpins of families, with carer responsibilities often in two generations [children and aging parents], and they also constitute a large majority of the health care workforce. Though often sidelined from the ‘wheels of industry’ women’s contribution to society has a tangible and vital influence on productivity and wellbeing. When calculated cumulatively, the numbers of women who think about suicide, plan to kill themselves, attempt suicide and die by suicide is a sizeable group and has an enormous impact on public health in Australia. The lives of women matter, but they have to be alive and healthy to contribute.
Women are less likely to die from suicide on their initial attempt, which creates a powerful and unique opportunity for prevention. If women’s suicidal behaviour is recognised and respected, compassionately responded to, with appropriate and timely interventions provided, then real reductions in suicidal behaviours and death by suicide are possible. Women engage in help-seeking and help-accepting behaviours as part of their gender make up. Capitalising on this, and the reduced likelihood of death from initial suicidal behaviour, provides a real opportunity to lower the burden of suicidality in Australia.

With regards to preventing suicidal behaviours in women, the following recommendations are set out to stimulate dialogue and promote change:

**Data**

- Improved national real time surveillance and data collection for suicidal ideation, suicide attempts and hospitalisations for suicidal behaviours would provide more accurate information about prevalence and enable more accurate measurement for service planning, research and evaluation of interventions (see “Preventing suicide: A resource for non-fatal suicidal behaviour case registration” WHO, 2014).

**Public Health Policy**

- Suicide Prevention Australia recommends that women’s suicide and suicidal behaviour be recognised in national health policy as an issue requiring targeted investment for prevention, intervention, treatment and research.

- The Commonwealth Government’s LiFE Framework, released in 2007, needs revision and should include explicit mention of women and related issues and recommendations for gender specific prevention, intervention and postvention.

- National and State/Territory suicide prevention efforts should invest both in programs/services that try to reduce deaths by suicide, and in programs/services that seek to reduce morbidity and the significant personal, social, psychological and economic costs associated with nonfatal suicidal behaviour.

- Given the higher prevalence of suicidal behaviour in women across communities, the general public need awareness and education about identification of suicidality, resources to facilitate having a conversation about suicide, and awareness of appropriate helping appropriate sources.

**System changes**

- Both fatal and non-fatal suicidal behaviour needs to be taken seriously; all suicidal behaviour warrants attention.

- Take a life span approach to women’s health and wellbeing as life transitions appear to increase vulnerability to suicidality (adolescence, perinatal period, partnering/relationship recognition, parenthood, menopause, divorce/relationship dissolution, retrenchment, retirement).

- Ensure the integration of information on risk factors more pertinent to women e.g. intimate partner violence, sexual abuse, bullying, into the development of suicide prevention education, training and awareness.

- Increase focus, quality standards, and policy on screening for Intimate Partner Violence and suicidality in all healthcare settings, including maternity and maternal and child health services (beyondblue, 2011); including issues related to intersex genital mutilation and involuntary and coerced medical interventions routinely imposed on people with intersex characteristics in Australia today.

- All levels of government need to respond with systemic and integrated broad reaching reform in partnership with aboriginal elders and community leaders in order to address increasingly high levels of suicidal behaviours and suicide in Aboriginal and Torres Strait Islander women and girls.

**Service improvements**

- Improved integration and linkages between services/programs across sectors (health, housing, employment) including a focus on improving pathways to and continuity of care for women (e.g. referral systems such as post discharge services from hospitals to community mental health follow-up and other services).

- Recognition and management of increased reported rates of depression for women in their middle years (peri menopausal) may reduce the higher rates and numbers of suicides at this stage of life.
and will improve their quality of life and wellbeing.

- Immediate hospital treatment for suicidality needs to address psychological distress as well as the physical injury.

- Support for women who have made a suicide attempt and their families must be enhanced, with particular attention directed to the emotional, social and psychiatric needs of the person concerned (including importantly, public and personal stigma and other survivor experiences such as guilt, shame etc.). This includes not assuming that biological relatives automatically constitute ‘family’, nor automatically excluding non-biological relationships as ‘family’.

- Always include the voice of lived experience of women and feminine spectrum people with non-binary genders who have experienced suicidality when developing inclusive women’s suicide prevention services and programs.

- Identify high-risk women groups (such as Aboriginal and Torres Strait Islander women, those experiencing intimate partner violence, etc.) and develop targeted prevention, intervention and postvention programs and services.

**Workforce development**

- When suicidal women present at a health care institution, all staff need to provide a compassionate/humanistic response to address their psychological distress as well as their physical and mental health needs. Support for women who are suicidal and their families must be improved, with specific attention to the emotional, social, spiritual, and cultural as well as psychiatric needs of the person concerned.

- Training, supervision and quality assurance measures need to be developed and implemented to improve attitudes and behaviour of all staff in contact with suicidal women. This change in attitudes and behaviour needs to be driven by a systems approach to improving care and aftercare.

- Ensure people employed as domestic violence workers all receive suicide risk assessment, suicide prevention and safety planning training.

**Community awareness and education**

- Media and communications relating to suicide should be educated about more appropriate ways to depict the problem of suicide such that suicide is not portrayed as a predominantly men’s problem, and acknowledging that, in terms of the total burden of morbidity and mortality, suicidal behaviour is more common in women.

- A Fact Sheet on ‘Suicide, suicidal behaviour and Women’ should be developed and used to complement the existing collection of fact sheets housed on the LiFE website to inform the general public of the pertinent issues and strategies.

- When developing targeted information strategies, the Hunter Institute for Mental Health and Mindframe will play a key role in working with the media.

**Research Agenda**

- Increase research into women’s suicide and suicidality: epidemiology, risk and protective factors across the lifespan, and effective prevention, intervention, and postvention initiatives across different cultural settings.

- Invest in preventing access to means [a well-recognised evidence based prevention initiative resulting in reduced suicide rates, Mann et al, 2005]. For example, address access to pharmacological/treatment medications via either GP prescription assertiveness regarding amount and frequency of dispensing and, carer assistance in regulating availability of supply.
SPA endorses and amplifies many of the recommendations developed by Women’s Health Victoria (2011).

Recommendation 1:
Increase accuracy in the recording of suicidal behaviour by developing standardised data classification and recording systems nationally

Knowledge in suicide prevention relies on data quality available to both researchers and policy makers alike. A major problem in addressing suicide effectively is the difficulty in obtaining reliable and timely data to inform service and policy development. Improvements to data reporting, recording and management can be achieved with standardised data collection and classification systems nationally. Awareness of the problem of misgendering in data collection also needs to be considered. Once all these improvements have been achieved a more accurate knowledge base on suicidal behaviour in women can be ascertained to inform gender specific suicide prevention, intervention and postvention.

An additional problem for addressing non-fatal suicidal behaviour is the lack of registries; moreover nationally standardised registries, to capture the accurate number as well as the extent of non-fatal suicidal behaviour. While acknowledged as a difficult and complex task to achieve, efforts to register non-fatals suicidal behaviour cases in a standardised manner is critical (WHO, 2014).

Recommendation 2:
Increase consistent and systematic reporting of gender-disaggregated data on suicide and suicidal behaviour

Data that shows gender-disaggregated information for women and men makes visible the differing trends and patterns in mental health experiences as well as across sectors including maternal morbidity and mortality. Therefore collection of gender-disaggregated data on risk and protective factors for suicide and attempted suicide, and data on access to services for those who attempt suicide is needed. Further, consistent and systematic use of gender-disaggregated data across a broad range of indicators including mental health, would facilitate identification of the needs of women and men, to inform gender sensitive suicide prevention strategies. Women of trans experience and women with intersex characteristics need to be counted as women, with separate items to collect data about their gender experience and/or physical characteristics.

Recommendation 3:
Increase consistent and systematic demographic categories to include sexuality, relationships, gender experience/identity/expression, and intersex characteristics in suicide and suicidal behaviour

Australia lacks systemic data collection methods for accurate classification of sexual orientation, gender identity, and intersex characteristics including of lesbian, gay, bisexual people, people of trans experience, and people with intersex characteristics who are at a higher risk for suicidal behaviours and suicide. The accurate and appropriate collection of such data is needed to shed light on numbers and patterns of suicide and suicidal behaviour, and access to services for same-gender-attracted women, women of trans experience, women with intersex characteristics, feminine spectrum people with non-binary genders in Australia. The consistent and systemic use of demographics identifying sexual orientation, gender identity, and intersex status would provide a greater understanding of the prevalence of suicidal behaviours in these population groups and support the development and provision of appropriate strategies to improve access to services and health outcomes.

Recommendation 4:
Develop well-articulated policies and strategies to address the risk factors for suicide and suicidal behaviour in women

Gender sensitive approaches that recognise the specific differences (including cultural and social determinants of suicide and mental health) can contribute to effective suicide prevention. Initiatives that focus on reducing risk factors and increasing protective factors are
vital in reducing vulnerability to suicidal behaviour and promoting women’s mental health and wellbeing.

**Recommendation 5:**
**Introduce mental health literacy programs and resources which are gender and culturally sensitive**

Publicly funded mental health literacy and health promotion programs can contribute to suicide prevention. These mental health literacy programs should consider gender and the deeply ingrained gender scripts pervasive across Australian communities, together with the protective and risk factors particular to women.

**Recommendation 6:**
**Increase gender sensitive service provision to meet the needs of women at risk**

Gender sensitivity training (knowledge, skills and attitudes) should be developed and incorporated into general suicide prevention training and be delivered to treatment services of women who are suicidal. Such training should also be incorporated into workforce development programs for staff whose roles intersect with women potentially at risk of suicide. Specific settings such as youth, social welfare services, maternity and maternal and child health services, correctional services, and refuges are some examples for targeted training of this nature. Further, service providers addressing the needs of population groups such as Aboriginal and Torres Strait Islander, lesbian, and bisexual women, women of trans experience, feminine spectrum non-binary people, women with intersex characteristics, migrant and CALD communities should also be targeted.

**Recommendation 7:**
**Mandatory procedures for the treatment of women seeking medical care following attempted suicide**

Service providers need to recognise that women who have attempted suicide require and are entitled to appropriate, compassionate/humanistic and continued care. Guidelines on treating patients who have attempted suicide must be established and implemented in a mandatory way. There should also be an immediately end to non-consensual ‘normalising’ interventions routinely imposed on women and girls with intersex characteristics in Australia and pathologising approaches to women, girls, and feminine spectrum people with non-binary genders seeking medical services for gender affirmation.

**Recommendation 8:**
**Work in collaboration with key Australian Women’s Health organisations to host a Roundtable dialogue on women’s suicide and suicidal behaviour to develop sustainable prevention, intervention and postvention strategies and policy**

Provide an opportunity for governments, service providers, key organisations and individual champions to come together and further dialogue on issues relevant to women’s suicide and suicidal behaviour. Roundtable discussions can create a collaborative setting to develop possible strategies and actions to address suicide and suicidal behaviour in women and can provide a platform for future opportunities to address this issue and elevate its importance in the public health domain.


Australian Longitudinal Study on Women’s Health [ALSWH] www.alswh.org.au


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Hunter Institute for Mental Health. Downloaded from http://himh.clients.squiz.net/mindframe/for-media/reporting-suicide-facts-and-stats


Multicentre Study of Self-Harm in England http://cebmh.warne.ox.ac.uk/csr/mcm/


