Suicide in Queensland

Annual Report 2025

DELIVERING FOR QUEENSLAND

Queensland Government

Queensland
Mental Health Commission

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Suicide in Queensland Annual Report 2025

Published by the Queensland Mental Health Commission, September 2026

ISSN 2982-1703 (Online)
ISSN 2982-169X (Print)

Content from this annual report should be attributed as:

Queensland Mental Health Commission 2026, *Suicide in Queensland Annual Report 2025.* Brisbane.

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In essence, you are free to copy, communicate and adapt this report, providing you attribute the work to the Queensland Mental Health Commission.

Acknowledgement of First Nations peoples

The Commission respectfully acknowledges First Nations peoples in Queensland as the Traditional Owners and Custodians of the lands, waters and seas. We acknowledge those of the past, who have imparted their wisdom and whose strength has nurtured this land. We acknowledge Elders for their leadership and ongoing efforts to protect and promote First Nations peoples and cultures.

The Commission recognises that it is our collective effort and responsibility as individuals, communities and governments to ensure equity, recognition and advancement of First Nations Queenslanders across all aspects of society and everyday life. We walk together in our shared journey of Reconciliation.

Acknowledgement of contribution

The Commission recognises those who have contributed to this report, including those working in the coronial system. We thank the Queensland Police Service and the Coroners Court of Queensland for sharing police reports with the Commission to support the interim Queensland Suicide Register (iQSR).

The Commission acknowledges the Victorian Department of Justice and Community Safety as the source organisation for data in the National Coronial Information System (NCIS) which informs the Queensland Suicide Register (QSR) and, to some extent, the iQSR. We acknowledge the NCIS as the database source of that data.

Warning

Aboriginal and Torres Strait Islander people should be aware that this report contains information about Aboriginal deceased persons and Torres Strait Islander deceased persons.

Recognition of lived experience

The Commission recognises people with lived experience of suicide. People with lived experience of suicide are those who have experienced suicidal thoughts, survived a suicide attempt, cared for someone through a suicidal crisis, or been bereaved by suicide. The Commission also acknowledges that lived experience of suicide can vary significantly and we must also consider Aboriginal and Torres Strait Islander people's ways of understanding social and emotional wellbeing.

The Commission acknowledges the lives we have lost to suicide, those who are living with suicidality and those who support them. People with lived experience have a critical role in informing how we understand and reduce suicide. Each death by suspected suicide in this report is more than a number. Each is a person with a unique story. Collectively, their experiences help us quantify commonalities and differences among those we have lost to suicide, so we can effectively reduce suicides in the future.

The Commission's role

The Queensland Mental Health Commission (the Commission) is an independent statutory body established under the *Queensland Mental Health Commission Act 2013*. Its role is to drive reform towards a more integrated, evidence-based and recovery-oriented mental health, alcohol and other drugs system in Queensland.

Support services

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

Thinking and reading about mental health challenges, harm from alcohol and other drug use, and suicide can be distressing. Some of the information captured in this report may also be distressing and we encourage you to reach out to a support person or service if needed.

Support services

Lifeline	13 11 14	www.lifeline.org.au/gethelp
Suicide Call Back Service	1300 659 467	www.suicidecallbackservice.org.au
MensLine Australia	1300 78 99 78	www.mensline.org.au
Beyond Blue Support Service	1300 22 4636	www.beyondblue.org.au
13YARN	13 92 76	www.13yarn.org.au
SANE Australia Helpline	1800 187 263	www.sane.org
QLife (LGBTQIA+)	1800 184 527	www.qlife.org.au
Kids Helpline	1800 55 1800	www.kidshelpline.com.au
Defence Member and Family Helpline	1800 624 608	www.defence.gov.au/adf-members-families
Gambler's Help	1800 858 858	www.gamblershelp.com.au
PANDA Perinatal Mental Health	1300 726 306	www.panda.org.au
Arafmi Carer Support Line	1300 554 660	www.arafmi.com.au

Alcohol and other drugs support services

National Alcohol and Other Drugs Hotline	1800 250 015	www.health.gov.au/contacts/national-alcohol-and-other-drug-hotline
adis	1800 177 833	www.adis.health.qld.gov.au
Family Drug Support	1300 368 186	www.fds.org.au

Suicide support services

StandBy Response Service	1300 727 247	www.standbysupport.com.au
Thirrili – National Indigenous After Suicide Support	1800 805 801	www.thirrili.com.au
Peer CARE Companion Warmline	1800 777 337	www.rosesintheocean.com.au/peer-care-companion-warmline/

Telephone Interpreter Service

If you require help with translation, please ask the relevant telephone support service to use the Translating and Interpreting Service by phoning **131 450**.

Hearing impaired callers

Dial **106** by TTY or in an emergency use National Relay Services TTY number **133 677**.

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Glossary

Age-specific rate	Age-specific rates are the crude rates in a specific age group. Rates are calculated as the number of suspected suicide deaths in that age group for a period, divided by the estimated population for that age group. The rate is then converted to a standard population unit by multiplying the rate by 100,000.
Age-standardised suicide rate	Age-standardisation is a method that removes the influence of age when comparing populations with different age structures. This is necessary because the rates of many health conditions vary with age, making it difficult to compare populations with different age distributions. For example, if one population has a much older age structure than another, it is likely to have higher crude death rates, even if the underlying health of the populations is similar.
Crude rate	Crude rate is the number of suspected suicides in a given time period divided by the estimated resident population for the same year, usually expressed per 100,000 population.
Form 1	Formally called the *Form 1 Police Report of Death to a Coroner*. A Queensland Police Service officer completes this form to provide details on reportable deaths to support the coroner in their investigation, including deciding whether to order an autopsy. The form also helps the pathologist performing an autopsy to establish a cause of death. This document is the source of information in the iQSR.
Geocoding	Geocoding takes an address or place name and turns that information into an exact geographical location using latitude and longitude coordinates. This enables data to be mapped, sorted and grouped into geographical areas for analysis.
Hospital and Health Service	The statutory bodies providing public health services across Queensland, each with its own geographic region.
Mental illness	A clinically diagnosable disorder that significantly affects how a person feels, thinks, behaves, and interacts with other people. The experience of mental illness is often characterised as mild, moderate or severe.
Numbers	The number of people who died by suspected suicide. This report does not provide numbers less than 5.
Primary Health Network	Independent organisations funded by the Australian Government to manage health regions. These regions differ from state Hospital and Health Service regions.
Public health surveillance	Using data to monitor health matters to inform and support suicide prevention responses.
Real-time	Real-time refers to information on suspected suicides received and collated as soon as possible after an event occurs, using police reports of deaths to coroners.
Sex	Sex refers to a person's biological sex.[1] The interim Queensland Suicide Register does not sufficiently capture the breadth of gender and sexual diversity in the Queensland community for 2025.
Suspected suicide	A person's death that appears to be by suicide, but the coronial investigation and determination of the type of death is still ongoing. Coroners are responsible for determining whether a person's death is formally recorded as suicide, after investigating and considering all available evidence. Until a coroner finalises their investigation, deaths are referred to as 'suspected suicides'. This term is not intended to take away from the tragedy of each person's death. Deaths in the interim Queensland Suicide Register with a probability code of 'probable' or 'confirmed' are termed 'suspected suicides' to acknowledge the ongoing coronial processes.

1 The interim Queensland Suicide Register only records a person's biological sex, as the Form 1 currently does not account for gender diversity. The Commission acknowledges and respects that there are many gender identities outside of cisgender male and female.

Acronyms

ABS	Australian Bureau of Statistics
AISRAP	Australian Institute for Suicide Research and Prevention
HHS	Hospital and Health Service
iQSR	interim Queensland Suicide Register
PHN	Primary Health Network
QSR	Queensland Suicide Register

How to share suicide statistics with others

This report discusses suicide. It is important to discuss suicide with sensitivity, care and consideration of the potential impact on others. The language we use when discussing suicide and suicide data is important as it shapes our perceptions, approaches, and responses to suicide. Language has the ability to carry hope, possibility and encourage help-seeking, but it can also inadvertently perpetuate harm and stigma.

Mindframe is a national program supporting safer media reporting, portrayal and communication about suicide, mental health concerns and alcohol and other drugs. Mindframe has developed recommendations and guidelines on how to discuss suicide data and statistics that are available on their website. These guidelines also highlight problematic and preferred language to use when talking and writing about suicide.

Preferred language when discussing suicide

Issue	Problematic	Preferred
Presenting suicide as a desired outcome	✗ • Successful suicide • Unsuccessful suicide	✓ • Died by suicide • Took their own life
Associating suicide with crime or sin	✗ • Committed suicide • Commit suicide	✓ • Took their own life • Suicide death
Sensationalising suicide	✗ • Suicide epidemic	✓ • Increasing rates • Higher rates
Language glamorising a suicide attempt	✗ • Failed suicide • Suicide bid	✓ • Suicide attempt • Non-fatal attempt
Gratuitous use of the term 'suicide'	✗ • Political suicide • Suicide mission	✓ • Refrain from using the term 'suicide' out of context

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

Introduction

Suicide is complex and influenced by a combination of life experiences and circumstances, rarely a single factor. Effective suicide prevention requires strong collaboration and leadership across government, the suicide prevention sector and the broader community, and needs to be informed by contemporary evidence and timely data.

Every life: The Queensland Suicide Prevention Plan 2019–2029[2] *(Every life)* is Queensland's whole-of-government and whole-of-community suicide prevention plan. It is delivered in three phases, with each phase building on the one before. This approach allows each phase to respond to new challenges and changes in the community, and lets evidence and data build over time.

Phase One of the *Every life* plan spanned from 2019–2022 and laid the foundation for a whole-of-government approach to suicide prevention. **Phase Two** ran from 2023 to 2026 and strengthened the focus on priority populations and risk factors.

2 https://www.qmhc.qld.gov.au/every-life-suicide-prevention-plan

The Queensland Government has been recording suicides in Queensland for the last three decades. The Queensland surveillance system consists of two registers: the Queensland Suicide Register (QSR) and the interim Queensland Suicide Register (iQSR).

The QSR includes data since 1990 and records all suicides in Queensland after a coronial investigation is finalised. In Queensland, only an investigating coroner can determine whether a person's death is a suicide, after considering all available evidence gathered as part of their investigation. Until a coroner has made their findings, these deaths are referred to as suspected suicides. This term is not intended to take away from the tragedy of each person's death. Each death referred to as a suspected suicide represents a life lost and a life that was valued and will be missed. The impact of this loss is widespread and, for many of those left behind, lifelong.

The iQSR was established in 2011 to provide real-time information on suspected suicide deaths. The primary source of data in this report is the iQSR. Further information about data sources and collection methods is included in the Appendix.

Data Revision Notice

July 2026

Revision to First Nations identification

Following additional data quality assurance work undertaken in collaboration with the Queensland Registry of Births, Deaths and Marriages, the identification of Aboriginal and Torres Strait Islander status in historical suicide mortality records has been reviewed and updated. As a result, previously published First Nations suicide counts for 2023 and 2024 have been revised.

Revised counts:

2023: 82 deaths *(previously published as 61)*

2024: 82 deaths *(previously published as 61)*

These revised figures should be used when comparing First Nations suicide mortality data across years, including comparisons with the 2025 results. The figures published in the *Suicide in Queensland Annual Report 2023* and *Suicide in Queensland Annual Report 2024* have not been updated and may differ from the revised figures presented here.

Suicide surveillance reform

In mid-2023, the Queensland Government assumed custodianship of Queensland's suicide surveillance systems, following recommendations from an independent review. As part of this reform, responsibility for both the QSR and iQSR transitioned to the Queensland Mental Health Commission (the Commission), which is leading the Reforming Suicide Surveillance Project. This project includes a three-year work plan through to 30 June 2027, focused on modernising and enhancing Queensland's suicide data systems.

Key achievements to date include:

Establishing and maintaining public monthly suicide data reporting on the Commission's website, improving the transparency and accessibility of information.

Completing outstanding data entry in the QSR, improving accuracy and depth of information available to inform suicide prevention in Queensland.

Redesigning the data models for both the QSR and iQSR, strengthening the structure and usability of suicide surveillance data.

Developing interim custom interfaces for the iQSR, streamlining data entry, minimising errors and improving the speed and quality of reporting.

Introducing geospatial mapping, enhancing the ability to identify and monitor suspected suicide clusters across the state.

Responding to suicide data requests, supporting service planning and addressing community-specific needs.

Establishing improved data access processes for key stakeholders, particularly Primary Health Networks (PHNs) and Hospital and Health Services (HHSs), enabling more informed local suicide prevention responses.

Data products from these efforts have been used to inform the design and delivery of programs aimed at responding to suicide and addressing the needs of local populations.

Informing policy

Geospatial mapping has been introduced to inform means restriction strategies.

This involved using mapping to analyse the distribution of suicides across Queensland. This approach helped identify specific geographic areas with higher need, supporting the development of targeted interventions and tailored support services. The initiative involved direct collaboration with local councils, Primary Health Networks (PHNs) and various government departments.

Information from geospatial mapping has supported the Commission to:

Work with other government agencies to identify opportunities for incorporating suicide prevention considerations into the design of public spaces and infrastructure, including integrated means restriction measures.

Partner with local councils to improve access to support services at high-risk locations.

Collaborate with other government agencies and health providers to develop targeted responses in regions or locations with higher suicide rates.

Going forward, the Commission will continue to enhance its capacity to analyse and apply information from the suicide registers to drive evidence-informed policy development. This includes using the data to identify emerging issues, inform priorities for suicide prevention research, and guide strategic policy and investment decisions.

Summary

The *Suicide in Queensland Annual Report 2025* uses data from the iQSR. Information in the iQSR, draws primarily on the Queensland Police Service's *Form 1 Police Report of Death to a Coroner* (Form 1).

This report provides a summary of data from the iQSR on suspected suicides in the 2025 calendar year. It also provides some limited comparison of suspected suicide data across other years.

In total,

781 **people died by suspected suicide**

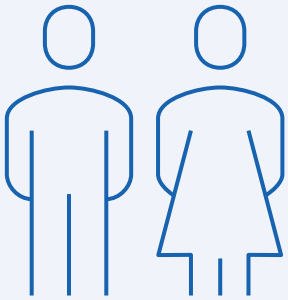
in Queensland in 2025.

The preliminary age-standardised suspected suicide rate for 2025, which considers growth and changes in the population's age structure, is

13.5 per 100,000 people.[3]

Male suspected suicide deaths are disproportionately higher than female suspected suicide deaths.

3 This figure has been calculated using data from the iQSR.



74.3%
of suspected suicide deaths **were men**.

25.7%
of suspected suicide deaths **were women**.

In 2025, the age group with the highest number of suspected suicides was

Males	Females
30–34 year olds *63 people* (10.9%)	**30–34** year olds *25 people* (12.4%)

and the lowest was

10–19 year olds *23 people* (4.0%)	**80+** year olds *7 people* (3.5%)

In terms of age-specific rates, the age group with the highest suspected suicide rate was

Males	Females
45–49 year olds *36.1 per 100,000 population*	**30–34** year olds *12.2 per 100,000 population*

and the lowest was

10–19 year olds *6.1 per 100,000 population*	**10–19** year olds *4.5 per 100,000 population*

Section 1

Provides an overview of suspected suicides in Queensland and includes preliminary numbers and rates for suspected suicides in 2025.

Section 2

Reports on preliminary age-standardised rates by sex in Queensland from 2020 to 2025. In addition, this section provides a descriptive analysis (numbers and rates) for age groups, employment status, relationship status, remoteness, Hospital and Health Services (HHS), PHN, people from a non-English speaking background[4] and First Nations peoples.

4 iQSR information comes solely from information contained in the Form 1. The limitations of this indicator as the ethnolinguistic characteristics of a person do not accurately reflect their cultural or ethnic identity. The Commission also acknowledges that the Australian Bureau of Statistics has published Standards for Statistics on Cultural and Language Diversity and has recommended 'non-English speaking background' be replaced as a cultural and language data indicator. See https://www.abs.gov.au/statistics/standards/standards-statistics-cultural-and-language-diversity/latest-release

Section 3

Reports on mental health characteristics, previous suicidal behaviour, contact with health services and method for people who died by suspected suicide.

Key findings

This section summarises key findings from the iQSR in 2025.

In Queensland in 2025

The age-standardised suspected suicide rate was

13.5

per 100,000 population

accounting for population growth and changes in the population's age structure.

This rate was less than the rate in 2024 (13.6).

Overall,

781

people died by suspected suicide

There were

12 more people (1.6%)

who died by suspected suicide

769 people in 2024

Female suspected suicide increased

Female deaths *increased*

from 167 to 201

Female age-standardised rate *increased*

from 5.9 to 6.9 per 100,000

Male rates **decreased** over the same period

Groups

Of the 781 people who died by suspected suicide, 580 were male (74.3%), and 201 (25.7%) were female.

The age-standardised suspected suicide rate for males was 20.3 per 100,000. This rate is lower than the 2024 rate (21.7), representing a decrease of 6.5%. The number of male suspected suicide deaths decreased by 22 when compared to 2024 (from 602 to 580).

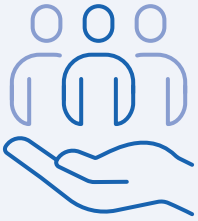
For females, the Queensland age-standardised suspected suicide rate was 6.9 per 100,000 in 2025. This rate is higher than the 2024 rate of 5.9, representing an increase of 16.9%.

The number of females who died by suspected suicide increased by 34 when compared to 2024 (from 167 to 201).

The age-standardised rate for males decreased while the rate for females increased from 2024 to 2025. The male rate was 2.9 times higher than the female rate in 2025.

Males aged 30 to 34 had the highest number of suspected suicides (63). For females, the highest number was also reported in the 30 to 34 age group (25). The highest age-specific suspected suicide rates by sex are shown in Figure 2.3.

Suspected suicides of First Nations people



A total of 87 First Nations people died by suspected suicide, representing 11.1% of all suspected suicides in Queensland for the year.

First Nations people aged 20 to 29 years had the largest proportion of First Nations suspected suicide deaths (28 people, 32.2% of the total 87 First Nations suspected suicides), followed by First Nations people aged 30 to 39 years old (24 people, 27.6%).

The proportion of suspected suicides of First Nations people was higher for females (13.9%) than males (10.2%).

Compared with non-Indigenous people, suspected suicides among First Nations people were concentrated in younger age groups. Nearly three-quarters (72.4%) of First Nations people who died by suspected suicide were aged 10 to 39 years, compared with 36.0% of non-Indigenous people. Conversely, just over one-quarter (27.6%) of First Nations people who died by suspected suicide were aged 40 years and over, compared with 63.9% of non-Indigenous people.

Remoteness areas[5,6]

Most suspected suicides occurred in major cities (407 people, 54.7%), followed by inner and outer regional areas (313 people, 42.1%).

The fewest number of suspected suicides (24 people, 3.2%) occurred in remote and very remote areas.

A higher proportion of female suspected suicides occurred in major cities, while a higher proportion of male suspected suicides occurred in regional areas.

5 Data is coded in the iQSR based on the Remoteness Area definitions published by the Australian Bureau of Statistics. See https://www.abs.gov.au/statistics/standards/australian-statistical-geography-standard-asgs-edition-3/jul2021-jun2026/remoteness-structure/remoteness-areas

6 Figures exclude cases where address was unknown or not applicable (e.g. interstate/overseas visitor).

Hospital and Health Services (HHS)[7]

The highest number of suspected suicides (145 people) occurred in the Metro South HHS catchment area, followed by Metro North (119 people) and Gold Coast (77 people).

The Central West and South West HHS catchment areas recorded the lowest numbers of suspected suicides (< 5 people combined). This data does not mean that a person had contact with an HHS prior to or at the time of their death, rather it notes they resided in the relevant HHS catchment area.

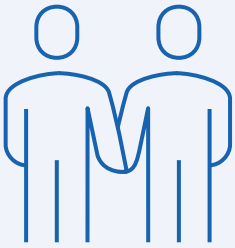
7 There are 16 Hospital and Health Service districts governed by Queensland Health. See https://www.health.qld.gov.au/maps for further information. This data does not mean that a person had contact with a Hospital and Health Service prior to or at the time of their death.

Primary Health Networks (PHN)[8]

The highest number of suspected suicides occurred in the Central Queensland, Wide Bay and Sunshine Coast catchment area (151 people, 20.3%), followed by Northern Queensland (147 people, 19.8%) and Brisbane South (145 people, 19.5%). This data does not mean that a person had contact with a PHN prior to or at the time of their death, rather it reflects that they resided in the relevant PHN catchment.

8 There are 7 Primary Health Networks in Queensland. See http://www.queenslandphn.org.au/ for further information. This data does not mean that a person had contact with a Primary Health Network prior to or at the time of their death.

Relationship status



Over a quarter of people who died by suspected suicide (225 people, 28.8%) were either married or in a de facto relationship.

The proportion of married or de facto people who died by suspected suicide was higher for males (30.0%) than females (25.4%). Conversely, the proportion of widowed people who died by suspected suicide was higher in females (4.0%) than males (2.8%).

Employment status

Overall, unemployed people were the most common group to die by suspected suicide (174 people, 22.3%), followed by people in full-time employment (134 people, 17.2%) and retired (95 people, 12.2%).

The proportion of suspected suicides in males reported to be in full-time employment was 1.8 times higher than their female counterparts (19.3% compared to 10.9%).

The proportion of suspected suicides among female disability pensioners was double that of males (3.5% compared to 1.7%).

Previous suicide attempts

Around one-third of those who died by suspected suicide (266 people, or 34.1%) had a reported history of previous suicide attempts.

This proportion was higher among females, with 83 women (41.3%) having previously attempted suicide, compared to 183 men (31.6%).

Information on previous suicide attempts was not reported or was missing for 37.1% of people who died by suspected suicide (290 people).

Reported diagnosis of mental health conditions

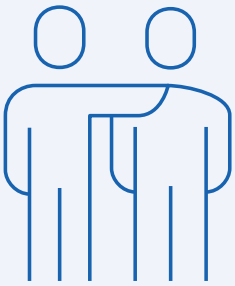
The number and proportion of people who died by suspected suicide and who were reported as having at least one diagnosed mental illness, including depression, anxiety disorder and/or schizophrenia, was 41.6% (325 people).

Diagnosed mental illnesses were more prevalent in females than in males (49.8% compared to 38.8%).

Caution should be taken when comparing reported mental health diagnoses with years prior to 2024. This is due to a change in coding practices in 2023. Data from 2024 onwards reflects the current recording practices.

The proportions of males (46.4%) and females (47.8%) reported with behaviour suggesting an undiagnosed mental illness were similar.

Help-seeking and service contact



Approximately 41% of individuals who died by suspected suicide (318 people) had recently been in contact with a mental health professional.

A smaller proportion (88 people, 11.3%) were reported as having been recently hospitalised for a psychiatric condition. Females were almost twice as likely as males to have been reported as recently hospitalised for a psychiatric condition (17.9% compared with 9.0%).

It is important to note that this information is based on preliminary data from the Form 1 and may not fully capture all service interactions.

Section 1

This section provides numbers and rates per 100,000 for people who died by suspected suicide in Queensland in 2025.

Queensland's suicide surveillance system currently includes the Queensland Suicide Register (QSR) and the interim Queensland Suicide Register (iQSR).

The *Suicide in Queensland Annual Report 2025* provides an overview of suspected suicide deaths in Queensland based on the iQSR.

The iQSR enables reporting on suicide trends in Queensland sooner, because the iQSR records information close to real time.

Each person's death has major and long-lasting impact on their families, friends and communities. Suicide is complex and multifaceted and understanding the many underlying and overlapping factors is vital to preventing and reducing suicide.

Queensland 2025

Table 1.1 shows key data from the iQSR for the 2025 calendar year.

Table 1.1: *Suspected suicide numbers and rate, Queensland 2025*

Statistic	2025 (calendar year)
The age-standardised suicide rate for Queensland	13.5 per 100,000 people
Deaths by suspected suicide in Queensland	781

Source: iQSR 2025

Key insights

16.9%
increase in female suspected suicide rate

52.0%
communicated previous suicidal intent

40.7%
had recent mental health service contact

Queensland 2025

First Nations people

Younger Queenslanders are disproportionately affected

87 First Nations suspected suicides

72.4%

aged 10–39 years

non-Indigenous Queenslanders

36.0%

Warning signs

Many people communicated distress before their death

52.0%

had communicated previous suicidal intent

34.1%

had a previous suicide attempt

Opportunities for intervention

Many people had contact with services

40.7%

had recently seen a mental health professional

11.3%

had recently been hospitalised for a psychiatric condition

Section 2

This section presents the key demographic characteristics of people who died by suspected suicide in Queensland in 2025. It also includes an overview of suspected suicides by geographic location, covering areas of remoteness as well as the catchments of Hospital and Health Services (HHS) and Primary Health Networks (PHN).

In total, there were 781 suspected suicide deaths. The age-standardised suspected suicide rate was 13.5 per 100,000 population.

Number and rates of suspected suicide by sex

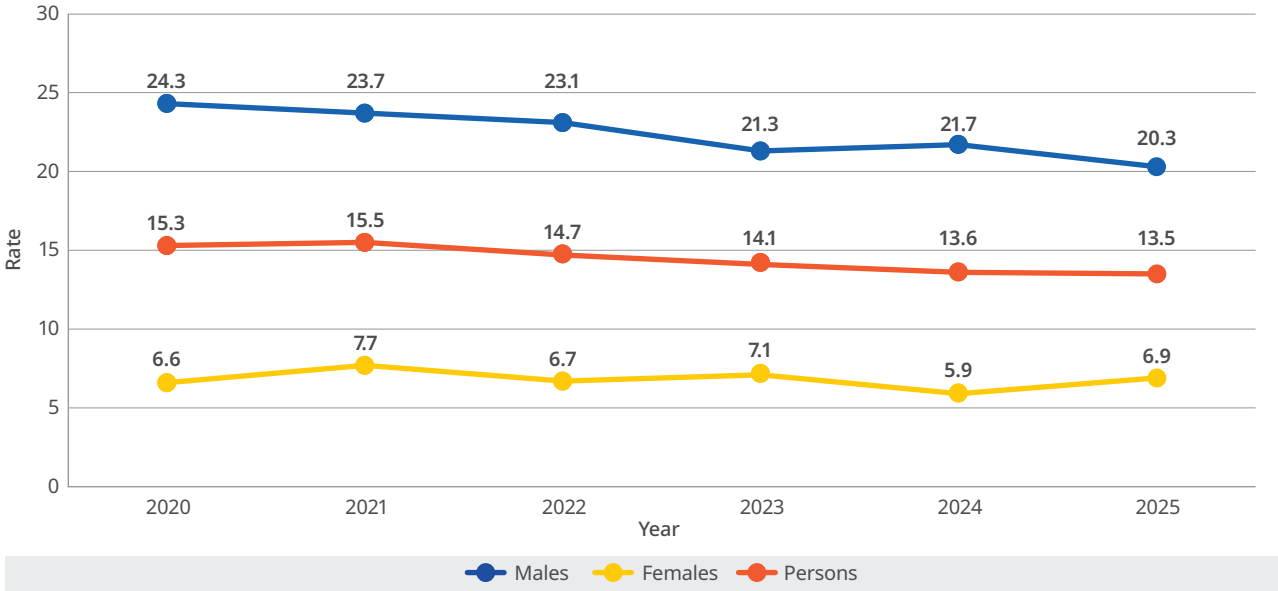
Data in this report is categorised by biological sex, as recorded in the Form 1. At present, this form does not capture gender diversity, and, therefore, gender identities beyond cisgender male and female are not reflected in the current reporting by the iQSR.

Of these, the majority were male (580 deaths, or 74.3%). The age-standardised suspected suicide rate for males declined from 24.3 per 100,000 in 2020 to 20.3 in 2025, marking a 16.5% reduction.

For females, the age-standardised rate increased from 6.6 per 100,000 in 2020 to 6.9 in 2025, a 4.5% increase over the five-year period.

Overall, the age-standardised suspected suicide rate across all persons decreased from 15.3 per 100,000 in 2020 to 13.5 in 2025, representing an 11.8% decline (Figure 2.1).

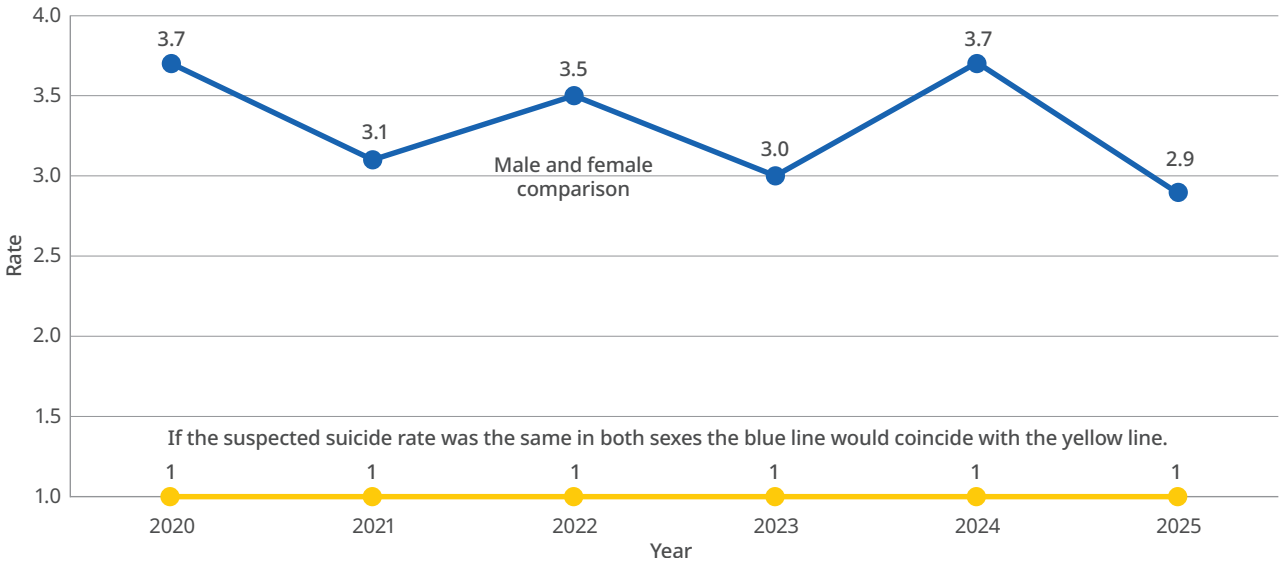
Figure 2.1: *Age-standardised suspected suicide rates by sex, Queensland 2020 to 2025*



Note 1: *Age-standardised suicide rate per 100,000 estimated resident population as at 30 June (mid-year) each calendar year.*
Note 2: *Age-standardised rates have been calculated using iQSR data and may differ from ABS's age standardised rates.*
Source: iQSR 2020–2025.

Over the five-year period from 2020 to 2025, age-standardised suspected suicide rates were consistently higher among males than females. The male-to-female rate ratio was highest in 2020 and 2024 (3.7), indicating that the male rate was 3.7 times the female rate in those years. The lowest ratio was observed in 2025 (2.9) (Figure 2.2). The narrowing of the gap reflects a decrease in the male rate and a concurrent increase in the female rate compared with 2024.

Figure 2.2: *Age-standardised suspected suicide rate ratio (males compared to females), Queensland 2020 to 2025*



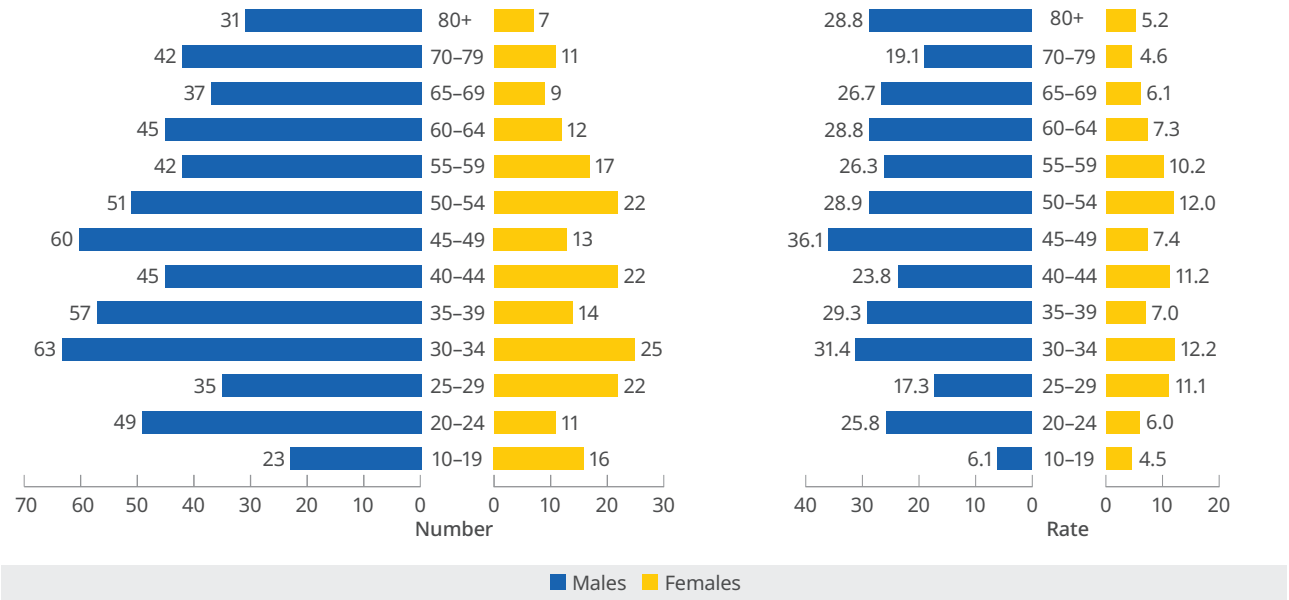
Number and proportion of suspected suicides by age group and sex

The number and rate of suspected suicides varied notably across age groups (Figure 2.3 and Table 2.1). Nearly half of all suspected suicides (372 people, 47.6%) occurred among people aged 30 to 54 years.

Among males, the highest number of suspected suicides was recorded in the 30 to 34 age group (63 people), followed by those aged 45 to 49 (60 people) and 35 to 39 (57 people). The highest numbers for females were observed in the 30 to 34 age group (25 people), followed by the 25 to 29, 40 to 44 and 50 to 54 age groups (22 people in each).

Overall, the suspected suicide rate for males was 2.9 times higher than that of females (Figure 2.2). Age-specific suspected suicide rates by sex are shown in Figure 2.3.

Figure 2.3: *Age-specific suspected suicide numbers and rates by sex, Queensland 2025*



Note 1: *Age-specific suicide rate per 100,000 estimated resident population as at 30 June 2025 (mid-year).*
Note 2: *Some percentages are rounded and do not total exactly 100.0%.*
Source: iQSR 2025.

Table 2.1: *Suspected suicide numbers and proportions by age group and sex, Queensland 2025*

Age group	Males		Females		Persons	
	Number	%	Number	%	Number	%
10–19	23	4.0	16	8.0	39	5.0
20–24	49	8.4	11	5.5	60	7.7
25–29	35	6.0	22	10.9	57	7.3
30–34	63	10.9	25	12.4	88	11.3
35–39	57	9.8	14	7.0	71	9.1
40–44	45	7.8	22	10.9	67	8.6
45–49	60	10.3	13	6.5	73	9.3
50–54	51	8.8	22	10.9	73	9.3
55–59	42	7.2	17	8.5	59	7.6
60–64	45	7.8	12	6.0	57	7.3
65–69	37	6.4	9	4.5	46	5.9
70–79	42	7.2	11	5.5	53	6.8
80 and over	31	5.3	7	3.5	38	4.9
Total	**580**	**100.0**	**201**	**100.0**	**781**	**100.0**

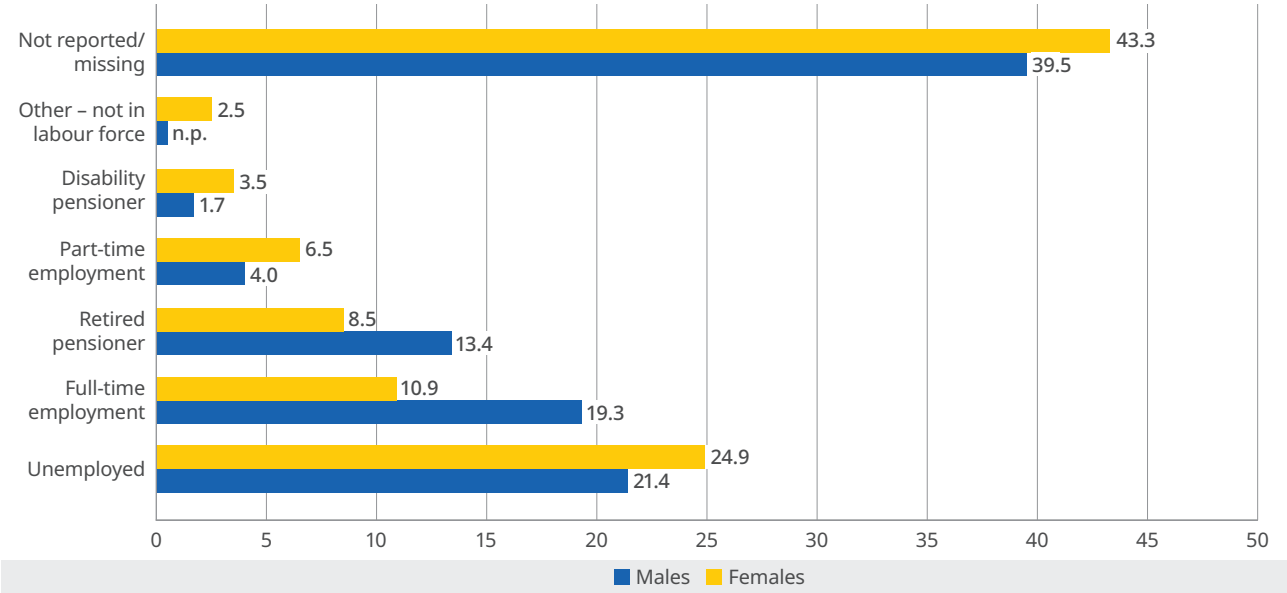
Note 1: *Percentages are based on the total number of suspected suicides recorded in 2025 within each sex category.*
Note 2: *Some percentages are rounded and do not total exactly 100.0%.*
Source: iQSR 2025.

Number and proportion of suspected suicides by employment status and sex

Among individuals reported to be in full-time employment at the time of death, the proportion of suspected suicides was 1.8 times higher for males than for females (19.3% compared to 10.9%).

The proportion of females reported as receiving a disability pension was 2.0 times higher than males (3.5% compared to 1.7%). Females were also more frequently reported as being 'not in the labour force' than males (2.5% compared to less than 1.0%).

Figure 2.4: *Proportion of suspected suicides by employment status and sex, Queensland 2025*



Note 1: *np = not published due to small counts. Some suppressed values may be derivable from published totals and should be interpreted with caution.*

Source: iQSR 2025.

Table 2.2: *Suspected suicide numbers and proportions by employment status and sex, Queensland 2025*

Employment status	Males		Females		Persons	
	Number	%	Number	%	Number	%
Not reported/missing	229	39.5	87	43.3	316	40.5
Other – not in labour force	np	np	5	2.5	9	1.2
Disability pensioner	10	1.7	7	3.5	17	2.2
Part-time employment	23	4.0	13	6.5	36	4.6
Retired pensioner	78	13.4	17	8.5	95	12.2
Full-time employment	112	19.3	22	10.9	134	17.2
Unemployed	124	21.4	50	24.9	174	22.3
Total	**580**	**100.0**	**201**	**100.0**	**781**	**100.0**

Note 1: *The category 'Employed (unknown mode)' was consolidated into 'Part-time employment', due to suspected suicides in one sex being less than 5.*

Note 2: *Some percentages are rounded and do not total exactly 100.0%.*

Note 3: *np = not published due to small counts (less than 5). Some suppressed values may be derivable from published totals and should be interpreted with caution.*

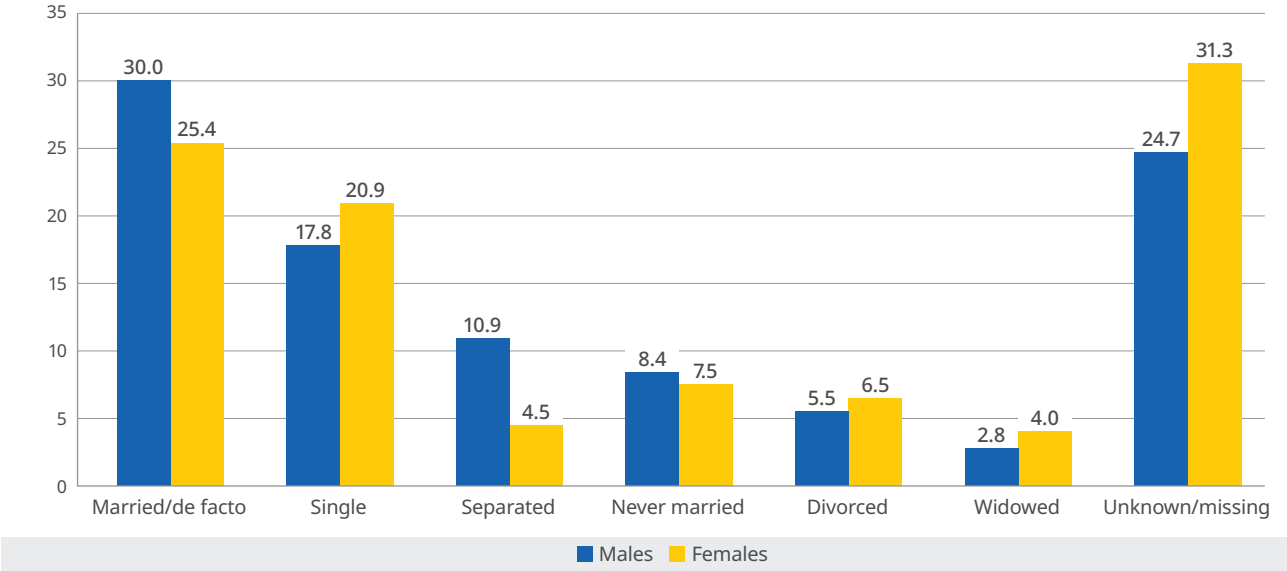
Source: iQSR 2025.

Number and proportion of suspected suicides by relationship status and sex

In 2025, 225 people (28.8%) who died by suspected suicide were reported as being married or in a de facto relationship. The proportion of married or de facto people who died by suspected suicide was higher for males (30.0%) than females (25.4%).

The proportion of single people was higher among females than males (20.9% compared to 17.8%), as was the proportion of widowed people (4.0% compared to 2.8%). Conversely, the proportion of separated people was higher among males than females (10.9% compared to 4.5%). The proportions of males and females were broadly similar across the remaining categories.

Figure 2.5: *Proportion of suspected suicides by relationship status and sex, Queensland 2025*



Note 1: *Percentages are rounded and may not total exactly 100.0%.*

Source: iQSR 2025.

Table 2.3: *Suspected suicide numbers and proportions by relationship status and sex, Queensland 2025*

Relationship status	Males		Females		Persons	
	Number	%	Number	%	Number	%
Married/de facto	174	30.0	51	25.4	225	28.8
Single	103	17.8	42	20.9	145	18.6
Separated	63	10.9	9	4.5	72	9.2
Never married	49	8.4	15	7.5	64	8.2
Divorced	32	5.5	13	6.5	45	5.8
Widowed	16	2.8	8	4.0	24	3.1
Not reported/ missing	143	24.7	63	31.3	206	26.4
Total	**580**	**100.0**	**201**	**100.0**	**781**	**100.0**

Note 1: *Percentages are rounded and may not total exactly 100.0%.*

Source: iQSR 2025.

Number and proportion of suspected suicides by non-English speaking background and sex

The iQSR relies solely on information recorded in the Form 1. It is acknowledged that the classification of 'non-English speaking background' has limitations as an indicator of cultural and linguistic diversity and may not accurately reflect a person's cultural, linguistic or ethnic identity.

In 2025, most people who died by suspected suicide (613 people, 78.5%) were reported as having an English-speaking background. A further 46 people (5.9%) were reported as being from a non-English speaking background, while information on language background was not reported for 122 people (15.6%).

The distribution of language background was similar for males and females. The proportion of people reported as being from a non-English speaking background was 6.0% among males and 5.5% among females, indicating little difference between the sexes.

Table 2.4: *Suspected suicide numbers and proportions by non-English speaking background and sex, Queensland 2025*

Non-English speaking background	Males		Females		Persons	
	Number	%	Number	%	Number	%
Yes	35	6.0	11	5.5	46	5.9
No	449	77.4	164	81.6	613	78.5
Not reported/missing	96	16.6	26	12.9	122	15.6
Total	**580**	**100.0**	**201**	**100.0**	**781**	**100.0**

Source: iQSR 2025.

Number and proportion of suspected suicides by First Nations people and sex[1]

In 2025, there were 87 suspected suicides among First Nations people, accounting for 11.1% of all suspected suicides in Queensland. The proportion of suspected suicides involving First Nations people was higher among females (13.9%) than males (10.2%).

Table 2.5: *Suspected suicide numbers and proportions for First Nations people by sex, Queensland 2025*

First Nations people	Males		Females		Persons	
	Number	%	Number	%	Number	%
Yes	59	10.2	28	13.9	87	11.1
No	465	80.2	154	76.6	619	79.3
Not reported/missing	56	9.7	19	9.5	75	9.6
Total	**580**	**100.0**	**201**	**100.0**	**781**	**100.0**

Note 1: *Percentages are rounded and may not total exactly 100.0%.*

Source: iQSR 2025.

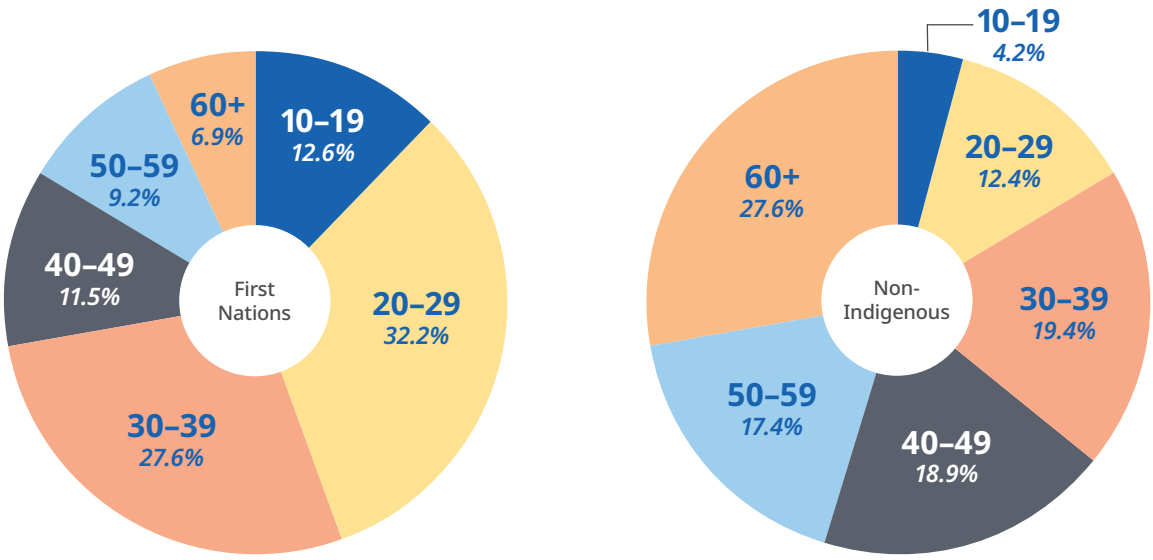
1 Readers should note that higher reported counts of suspected suicide deaths among First Nations people reflect improved Indigenous status ascertainment through enhanced data linkage and validation with the Queensland Registry of Births, Deaths and Marriages. These methodological improvements have reduced historical under-identification, resulting in more complete reporting. Accordingly, comparisons with previous years should be interpreted with caution.

The highest proportion of suspected suicides among First Nations people occurred among those aged 20 to 29 years, accounting for 28 deaths (32.2%). This was followed by people aged 30 to 39 years, with 24 deaths (27.6%). Together, these two age groups accounted for 59.8% of all suspected suicides among First Nations people.

First Nations people aged 10 to 19 years accounted for 11 deaths (12.6%), while those aged 40 years and over accounted for 24 deaths (27.6%).

When comparing across population groups, suspected suicides among First Nations people were concentrated in younger age groups. Nearly three-quarters (72.4%) of First Nations people who died by suspected suicide were aged 10 to 39 years, compared with 36.0% of non-Indigenous people. Conversely, just over one-quarter (27.6%) of First Nations people who died by suspected suicide were aged 40 years and over, compared with 63.9% of non-Indigenous people.

Figure 2.6: *Proportion of suspected suicides among First Nations people and non-Indigenous people by age group, Queensland 2025*



Note 1: *Percentages are rounded and may not total exactly 100.0%.*

Source: iQSR 2025.

Table 2.6: *Suspected suicide numbers and proportions for First Nations people by age group, Queensland 2025*

Age group	First Nations		Non-Indigenous		Persons	
	Number	%	Number	%	Number	%
10–19	11	12.6	26	4.2	37	5.2
20–29	28	32.2	77	12.4	105	14.9
30–39	24	27.6	120	19.4	144	20.4
40–49	10	11.5	117	18.9	127	18.0
50–59	8	9.2	108	17.4	116	16.4
60+	6	6.9	171	27.6	177	25.1
Total	**87**	**100**	**619**	**100**	**706**	**100.0**

Note 1: *The figures for the above table exclude 75 cases where ethnicity was missing or unknown.*

Note 2: *Percentages are rounded and may not total exactly 100.0%.*

Source: iQSR 2025.

Number and proportion of suspected suicides by remoteness[2] and sex

Of the 781 suspected suicides recorded, 37 cases (4.7%) lacked information about the person's residential location at the time of death and were excluded from the remoteness analysis. The remaining 744 cases (95.3%) were included in this analysis.

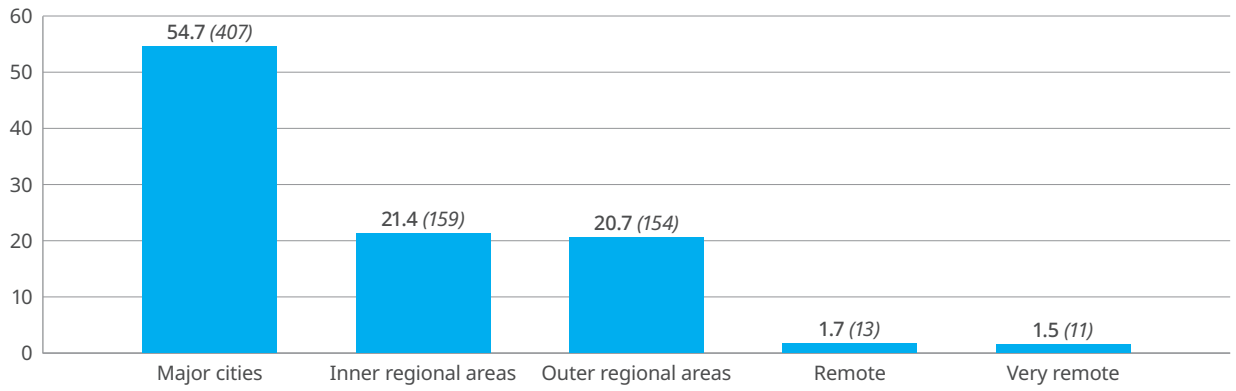
Among these, over half (407 people, 54.7%) were reported to be living in major cities, while 313 (42.1%) were from regional areas and 24 (3.2%) from remote and very remote areas. A higher proportion of female suspected suicides occurred in major cities (118 people, 61.5%) compared with males (289 people, 52.4%). A higher proportion of male suspected suicides occurred in regional and remote areas.

Table 2.7: *Suspected suicide numbers and proportions by remoteness and sex, Queensland 2025*

Remoteness areas	Males		Females		Persons	
	Number	%	Number	%	Number	%
Major cities	289	52.4	118	61.5	407	54.7
Inner regional areas	121	21.9	38	19.8	159	21.4
Outer regional areas	121	21.9	33	17.2	154	20.7
Remote	11	2.0	np	np	13	1.7
Very remote	10	1.8	np	np	11	1.5
Total	**552**	**100**	**192**	**100**	**744**	**100**

Note 1: *np = not provided (under 5 suspected suicides in one or both sexes).*
Note 2: *The figures for the above table exclude 37 cases where address was unknown or not applicable (e.g. interstate/overseas visitor).*
Note 3: *Percentages are rounded and do not total exactly 100.0%.*
Source: iQSR 2025.

Figure 2.7: *Proportion of suspected suicides by remoteness, Queensland 2025*



Source: iQSR 2025.

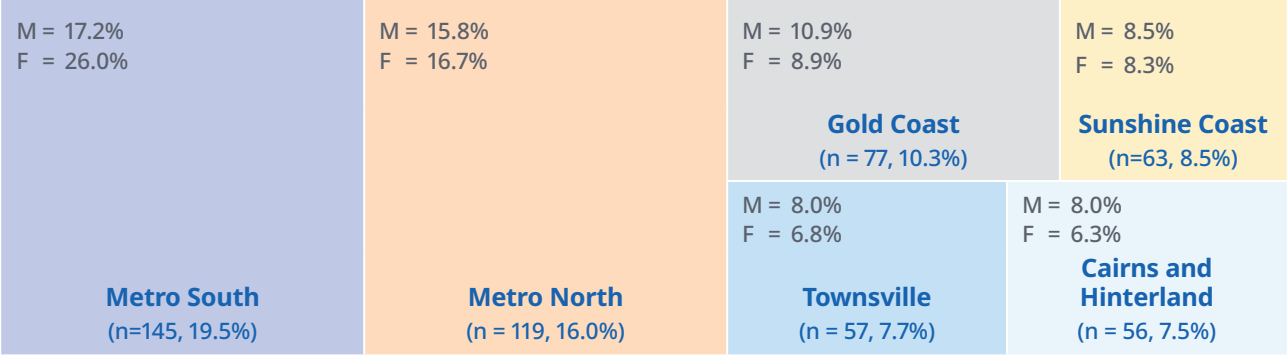
2 Information reported based on place of residence at time of death.

Number and proportion of suspected suicides by Hospital and Health Service and sex

As noted above, 37 cases (4.7%) had no residential location recorded and were excluded from the analysis by HHS, with the remaining 744 cases included.

Of the cases included in the analysis, over one-third (264 deaths, 35.5%) occurred within the Metro North and Metro South HHS regions, followed by the Gold Coast and Sunshine Coast HHS regions (140 deaths, 18.8%).

Figure 2.8: *Hospital and Health Services where most suspected suicides occurred by number, proportion and sex, Queensland 2025*



Source: iQSR 2025.

The proportion of female suspected suicides occurring among residents of the combined Metro South and Metro North HHS regions was higher than that of males (42.7% compared with 33.0%).

It is important to note that this data is based on the person's place of residence within an HHS catchment area and does not indicate whether the person had contact with that HHS before or at the time of death.

Table 2.8: *Suspected suicide numbers and proportions by Hospital and Health Service and sex, Queensland 2025*

HHS	Males		Females		Persons	
	Number	%	Number	%	Number	%
Metro South	95	17.2	50	26.0	145	19.5
Metro North	87	15.8	32	16.7	119	16.0
Gold Coast	60	10.9	17	8.9	77	10.3
Sunshine Coast	47	8.5	16	8.3	63	8.5
Townsville	44	8.0	13	6.8	57	7.7
Cairns and Hinterland	44	8.0	12	6.3	56	7.5
West Moreton	38	6.9	13	6.8	51	6.9
Wide Bay	37	6.7	10	5.2	47	6.3
Darling Downs	30	5.4	11	5.7	41	5.5
Central Queensland	32	5.8	8	4.2	40	5.4
Mackay	25	4.5	7	3.6	32	4.3
North West	9	1.6	np	np	10	1.3
Torres and Cape	np	np	–	–	np	np
South West	np	np	np	np	np	np
Central West	–	–	–	–	–	–
Total	**552**	**100**	**192**	**100**	**744**	**100**

Note 1: *np = not provided (less than 5 suspected suicides in one or both sexes).*
Note 2: *'–' indicates a value of zero.*
Note 3: *Figures above table exclude 37 cases where address was unknown or not applicable (e.g. interstate/overseas visitor).*
Note 4: *Some percentages are not provided and/or are rounded and do not total exactly 100.0%.*
Source: iQSR 2025.

Number and proportion of suspected suicides by Primary Health Network (PHN) and sex

As noted above, 37 cases (4.7%) had no residential location recorded and were excluded from the analysis by PHN, leaving 744 cases that have been included.

Of the PHN catchment areas, the Central Queensland, Wide Bay and Sunshine Coast PHN accounted for the largest proportion of suspected suicides (151 people, 20.3%), followed by Northern Queensland PHN (147 people, 19.8%) and Brisbane South PHN (145 people, 19.5%).

Table 2.9: *Suspected suicide numbers and proportions by Primary Health Network and sex, Queensland 2025*

PHN	Males		Females		Persons	
	Number	%	Number	%	Number	%
Central Queensland, Wide Bay, Sunshine Coast	117	21.2	34	17.7	151	20.3
Northern Queensland	116	21.0	31	16.1	147	19.8
Brisbane South	95	17.2	50	26.0	145	19.5
Brisbane North	87	15.8	32	16.7	119	16.0
Darling Downs and West Moreton	67	12.1	25	13.0	92	12.4
Gold Coast	60	10.9	17	8.9	77	10.3
Western Queensland	10	1.8	np	np	13	1.7
Total	**552**	**100.0**	**192**	**100.0**	**744**	**100.0**

Note 1: *np = not provided (under 5 suspected suicides in one or both sexes). Reader-derived calculations of suppressed cells may be possible and should be interpreted with caution.*

Note 2: *Figures above table exclude 37 cases where address was unknown or not applicable (e.g. interstate/overseas visitor).*

Note 3: *Some percentages are not provided and/or are rounded and do not total exactly 100.0%.*

Source: iQSR 2025.

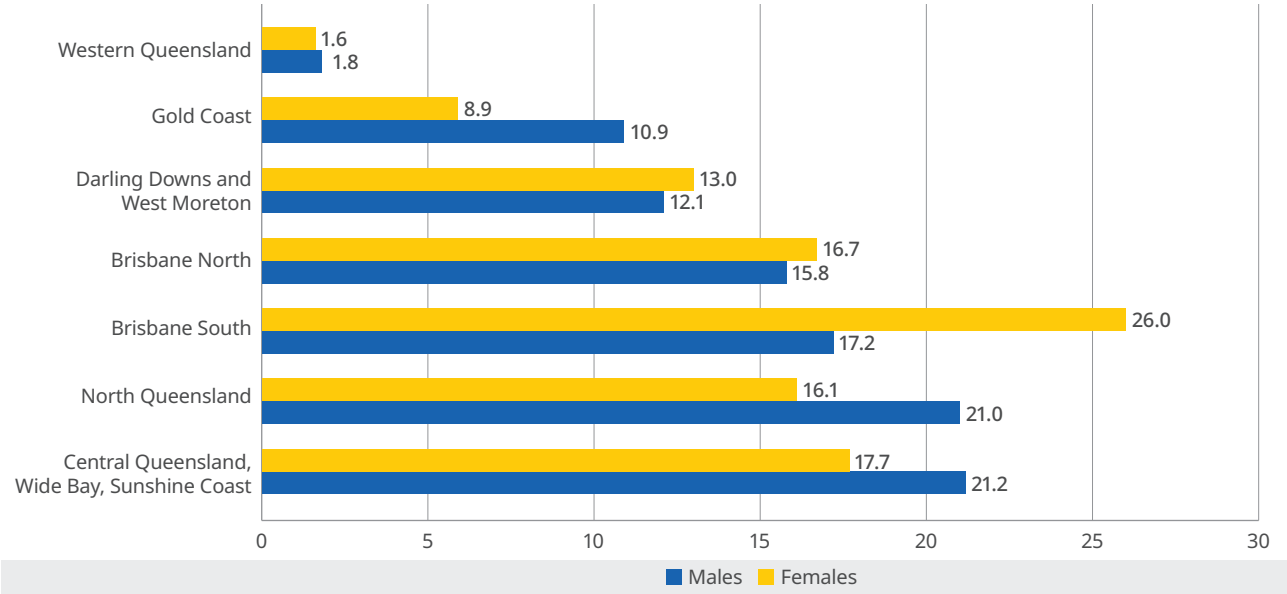
The proportion of suspected suicides among females was higher in the Brisbane South and Brisbane North PHNs, with 42.7% of female suspected suicides occurring among residents of these PHNs compared with 33.0% of male suspected suicides.

In contrast, a higher proportion of male suspected suicides occurred among residents of the Central Queensland, Wide Bay and Sunshine Coast and Northern Queensland PHNs (42.2% for males compared with 33.9% for females).

No notable differences in the distribution of male and female suspected suicides were observed across the remaining PHNs.

It is important to note that these data reflect the person's place of residence within a PHN catchment area and do not indicate whether the person had contact with a PHN prior to, or at the time of, death.

Figure 2.9: *Proportion of suspected suicides by Primary Health Network and sex, Queensland 2025*



Source: iQSR 2025.

Section 3

This section presents an overview of the mental health characteristics, previous suicidal behaviour, contact with health services and reported method for people who died by suspected suicide in Queensland in 2025, based on data from the iQSR.

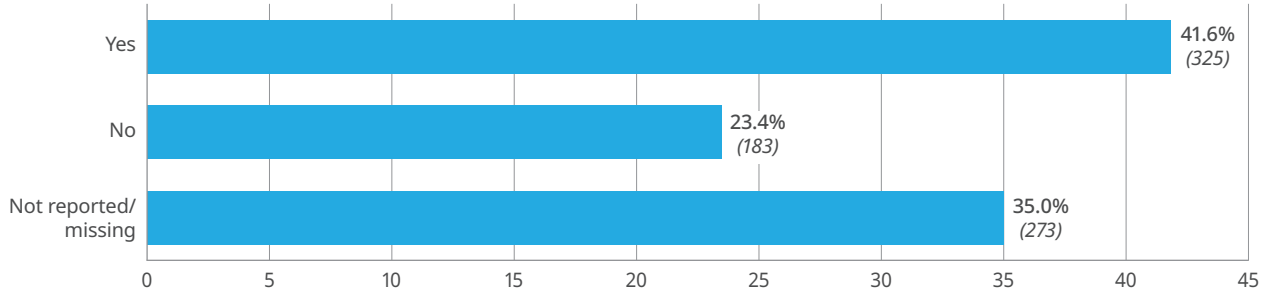
The information is drawn from Form 1 reports, which contain relevant details recorded by attending police officers.

Reported diagnosis of mental illness[1]

Among the 781 suspected suicides, 325 people (41.6%) were reported to have a diagnosed mental illness at the time of death. The most reported conditions were depression (230 people), anxiety (91 people) and substance use disorder (56 people). The prevalence of reported mental illness was higher among females than males, with 49.8% of females compared with 38.8% of males having a reported diagnosis.

41.6%
of individuals were reported to have a **diagnosed mental illness**

Figure 3.1: *Diagnosis of mental illness by sex, Queensland 2025*



Source: iQSR 2025.

Table 3.1: *Reported diagnosis of mental illness by sex, Queensland 2025*

Diagnosis of mental illness	Males		Females		Persons	
	Number	%	Number	%	Number	%
Yes	225	38.8	100	49.8	325	41.6
No	149	25.7	34	16.9	183	23.4
Not reported/missing	206	35.5	67	33.3	273	35.0
Total	**580**	**100**	**201**	**100**	**781**	**100**

Source: iQSR 2025.

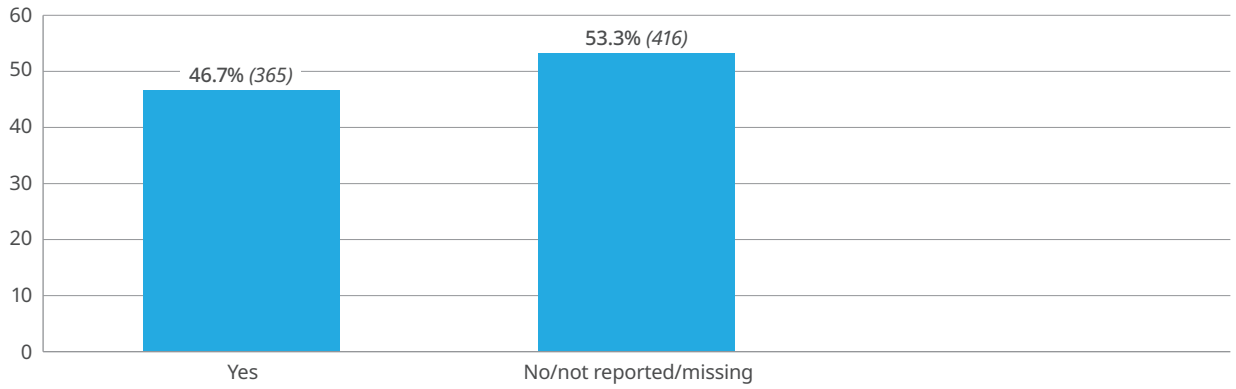
1 Information provided in the Form 1 against the question: *'Has the deceased been diagnosed with a mental health illness?'*.

Behaviour suggesting an undiagnosed mental illness[2]

Of the 781 suspected suicides, 365 (46.7%) were reported on the Form 1 as displaying behaviour indicative of a possible undiagnosed mental illness. The proportions were similar for males (46.4%) and females (47.8%).

46.7%
of individuals displayed behaviour indicative of a **possible undiagnosed mental illness**

Figure 3.2: *Behaviour suggesting an undiagnosed mental illness, Queensland 2025*



Source: iQSR 2025.

Table 3.2: *Behaviour suggesting an undiagnosed mental illness by sex, Queensland 2025*

Behaviour suggesting an undiagnosed mental illness	Males		Females		Persons	
	Number	%	Number	%	Number	%
Yes	269	46.4	96	47.8	365	46.7
No/not reported/missing	311	53.6	105	52.2	416	53.3
Total	**580**	**100**	**201**	**100**	**781**	**100**

Source: iQSR 2025.

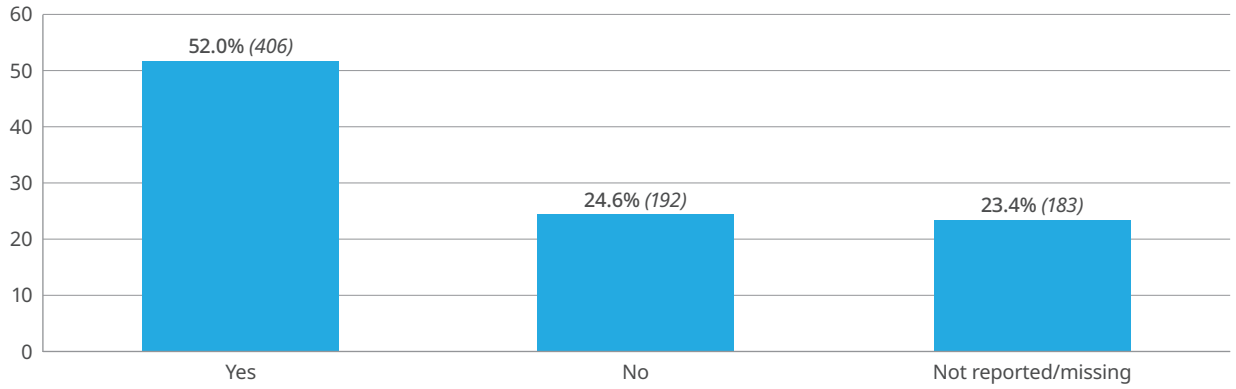
2 Information provided in the Form 1 against the question: '*Did the deceased show any behaviour that suggested they had an undiagnosed mental illness?*'.

Communication of a previous suicidal intent[3]

Over half of the 781 people who died by suspected suicide were reported as having communicated previous suicidal intent (406 people, 52.0%). The proportion was similar for males (52.6%) and females (50.2%).

52%
of individuals had **previously communicated suicidal intent**

Figure 3.3: *Communication of a previous suicidal intent, Queensland 2025*



Source: iQSR 2025.

Table 3.3: *Communication of a previous suicidal intent by sex, Queensland 2025*

Communication of a previous suicidal intent	Males		Females		Persons	
	Number	%	Number	%	Number	%
Yes	305	52.6	101	50.2	406	52.0
No	144	24.8	48	23.9	192	24.6
Not reported/missing	131	22.6	52	25.9	183	23.4
Total	**580**	**100**	**201**	**100**	**781**	**100**

Note 1: *Percentages are rounded and may not total exactly 100.0%.*
Source: iQSR 2025.

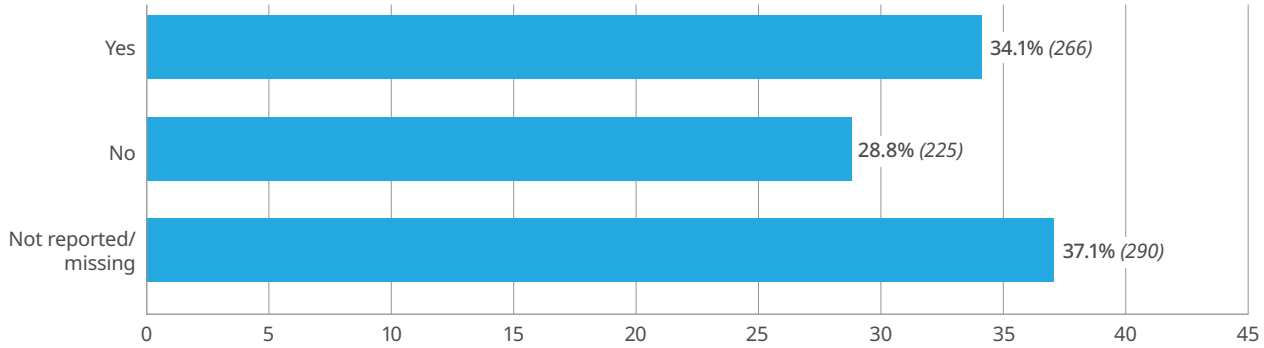
3 Information provided in the Form 1 against the question: '*Has the deceased previously communicated an intent to suicide?*'. The question is answered via checkbox – 'yes', 'no' or 'unknown'.

Previous suicide attempt[4]

Of the 781 suspected suicides, 34.1% (266 people) had reportedly attempted suicide on a previous occasion. Females were 1.3 times more likely to have been reported as having a previous suicide attempt than their male counterparts (41.3% compared to 31.6%).

34.1%
(one third) of individuals had **a known previous suicide attempt**

Figure 3.4: *Previous suicide attempt, Queensland 2025*



Source: iQSR 2025.

Table 3.4: *Previous suicide attempt by sex, Queensland 2025*

Previous suicide attempt	Males		Females		Persons	
	Number	%	Number	%	Number	%
Yes	183	31.6	83	41.3	266	34.1
No	177	30.5	48	23.9	225	28.8
Not reported/missing	220	37.9	70	34.8	290	37.1
Total	**580**	**100**	**201**	**100**	**781**	**100**

Source: iQSR 2025.

4 Information provided in the Form 1 against the question: *'Has the deceased previously attempted suicide?'.*

Recent contact with health service by sex[5]

Females who died by suspected suicide were 1.2 times more likely than males to have had contact with a mental health professional (44.3% compared to 38.3%). Additionally, the proportion of females recently hospitalised for a mental illness was 2.0 times higher than that of males (17.9% compared to 9.0%).

41%
of individuals had **recent contact with a mental health professional**

Table 3.5: *Recent contact[6] with health professionals (mental illness) and hospitalisations (mental illness) by sex, Queensland 2025*

Recent contact with a mental health professional	Males		Females		Persons	
	Number	%	Number	%	Number	%
Yes	222	38.3	89	44.3	318	40.7
No/not reported/missing	358	61.7	112	55.7	463	59.3
Total	**580**	**100**	**201**	**100**	**781**	**100**

Recent hospitalisation for a mental illness	Males		Females		Persons	
	Number	%	Number	%	Number	%
Yes	52	9.0	36	17.9	88	11.3
No	310	53.4	88	43.8	398	51.0
Not reported/missing	218	37.6	77	38.3	295	37.8
Total	**580**	**100**	**201**	**100**	**781**	**100**

Note 1: *Percentages are rounded and may not total exactly 100.0%.*

Source: iQSR 2025.

5 Information provided in Form 1 against the questions: *'Was the deceased recently treated/seen by any of the following professionals for a mental illness?'* (Doctor/Psychiatrist/Psychologist/Case manager), and *'Was the deceased recently hospitalised for a psychiatric condition?'*.

6 Information is dependent on data collection and reporting on Form 1.

The remaining content of this section focuses on suicide methods and may be distressing to readers. Data is captured on method to inform suicide prevention activities and acknowledges that reporting of suspected suicide methods requires sensitivity and care.

To skip this section, please go to page 36.
A list of support services is also available on page ii if you would like to speak with someone after reading this report.

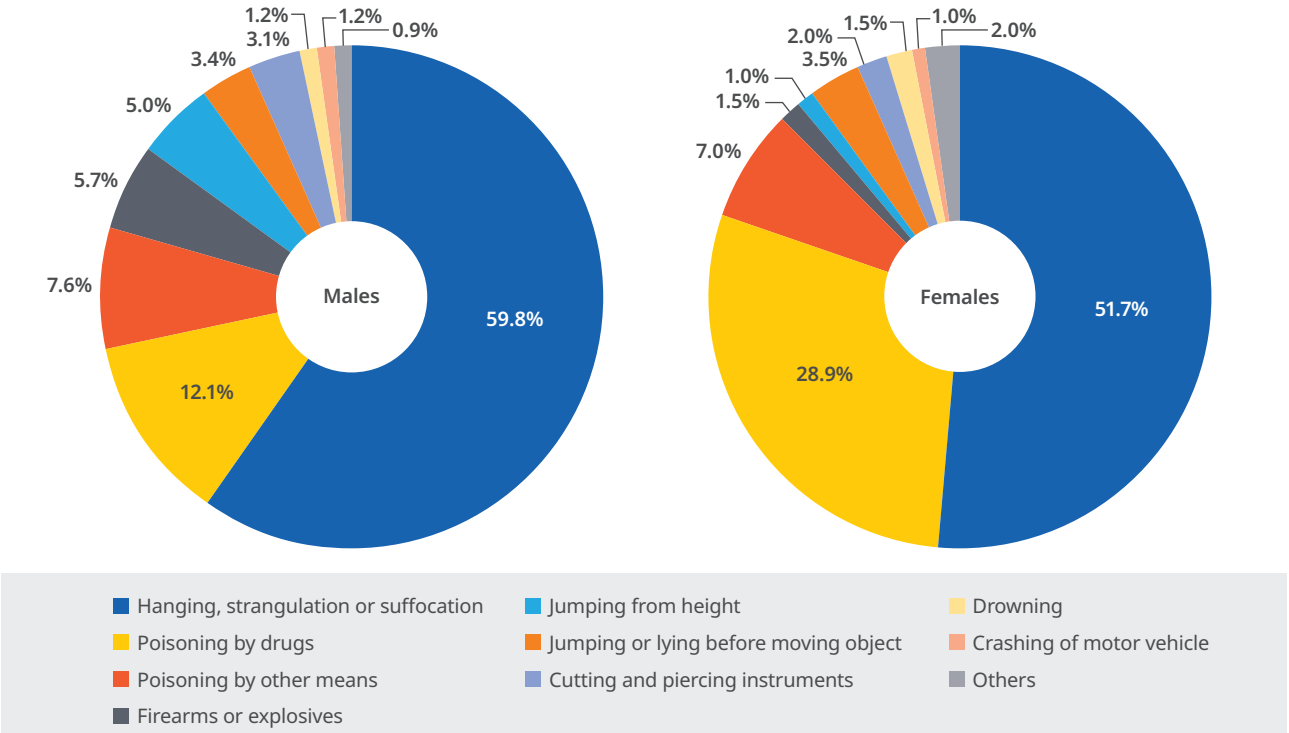
Suspected suicide methods

Reporting on methods of suspected suicide requires sensitivity and care.

Figure 3.5 and Table 3.6 present the methods reported for suspected suicides in Queensland in 2025. These figures are based solely on Form 1 data and may not align with the official cause of death determined by a coroner's investigation.

The most commonly reported method of suspected suicide was hanging, strangulation or suffocation (451 people, 57.7%). The second most common method was poisoning by drugs (128 people, 16.4%).

Figure 3.5: *Suspected suicide method proportions by sex, Queensland 2025*



Source: iQSR 2025.

The third most commonly reported method of suspected suicide was poisoning by other means. Together, these methods accounted for the majority of suspected suicides (637 people, 81.6%).

Table 3.6: *Suspected suicide methods, Queensland 2025*

Suspected suicide methods	Persons	
	Number	%
Hanging, strangulation or suffocation	451	57.7
Poisoning by drugs	128	16.4
Poisoning by other means	58	7.4
Jumping from height	36	4.6
Firearms or explosives	31	4.0
Other	27	3.5
Cutting and piercing instruments	22	2.8
Jumping or lying before moving object	10	1.3
Crashing of motor vehicle	9	1.2
Drowning	9	1.2
Total	**781**	**100**

Note 1: *'Other' includes burns/fire, unspecified, etc.*
Note 2: *Percentages are rounded and may not total exactly 100.0%.*
Source: iQSR 2025.

Appendix

interim Queensland Suicide Register (iQSR) purpose[1]

The Queensland Government established the iQSR in 2011 to provide real-time data on suspected suicides across the state. The iQSR compiles information from police reports submitted by the Queensland Police Service (QPS).

Covering data from 2011 to the present, the iQSR offers preliminary insights into suspected suicides and enables real-time monitoring of trends and changes in suicide numbers throughout Queensland.

Table A.1: *Uses of the interim Queensland Suicide Register data (iQSR)*

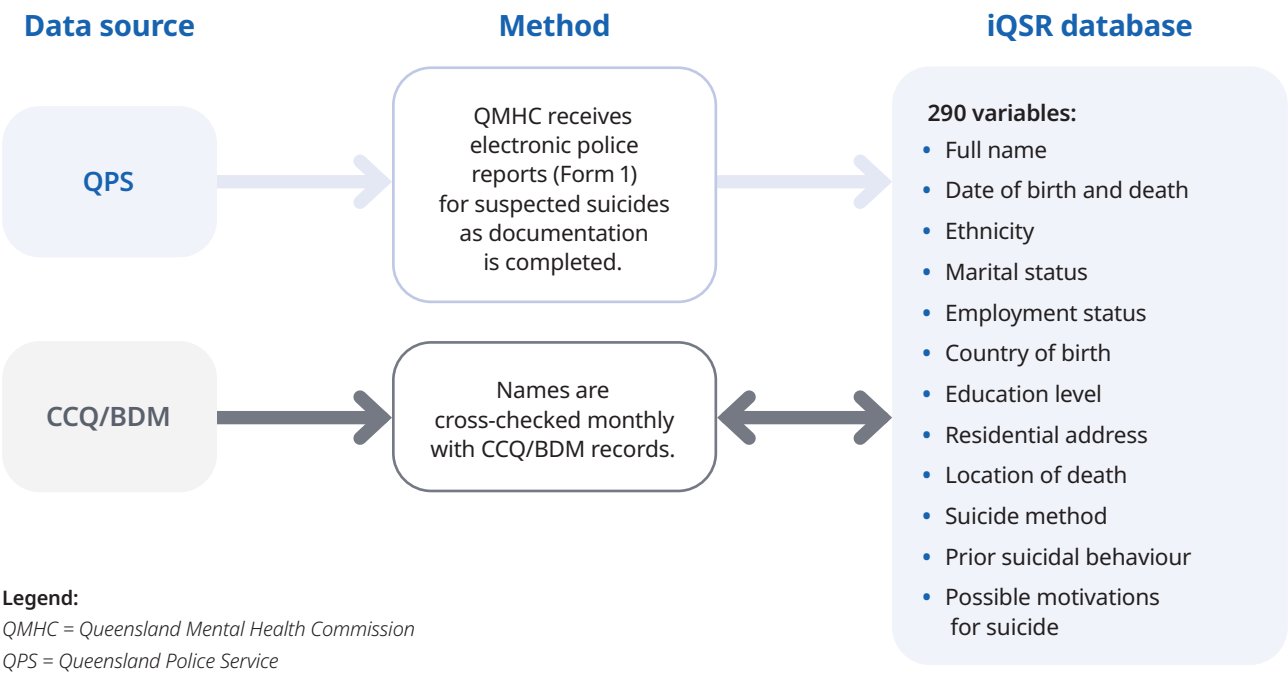
Use	Yes
Identify disproportionately impacted groups, individuals, places and situations	✓
Detect and respond to high-risk locations and contagion	✓
Document the impact and distribution of deaths by suicide	✓
Enable epidemiological research (e.g. create and test hypotheses, including the impacts of environment exposures, emerging or changing patterns and long-term trends)	✓
Evaluate prevention measures by analysing trends (e.g. large-scale aftercare interventions for people who have attempted suicide)	✓
Plan public health, prevention and postvention actions at local, state and national levels	✓
Advocate for prevention and postvention actions at local, state and national levels	✓
Identify emerging and preventable suicide methods	✓
Support tailored local, state and national suicide prevention efforts	✓

1 Flowchart is based on AISRAP publication – *Suicide in Queensland Annual Report 2021–2022* with modifications to account for applicable data flows used in this report.

Data sources

Information in the iQSR is drawn exclusively from the *Form 1 Police Report of Death to a Coroner*. This form provides details to assist the coroner's investigation, including socio-demographic data, circumstances surrounding the death, and contextual information such as descriptions of the deceased's mental health and any significant life stressors prior to death. Figure A.1 depicts the process of data collection for the iQSR.

Figure A.1: *Flowchart depicting the process of the iQSR*



Legend:
QMHC = Queensland Mental Health Commission
QPS = Queensland Police Service
CCQ = Coroners Court of Queensland
BDM = Registry of Births, Deaths & Marriages
iQSR = interim Queensland Suicide Register

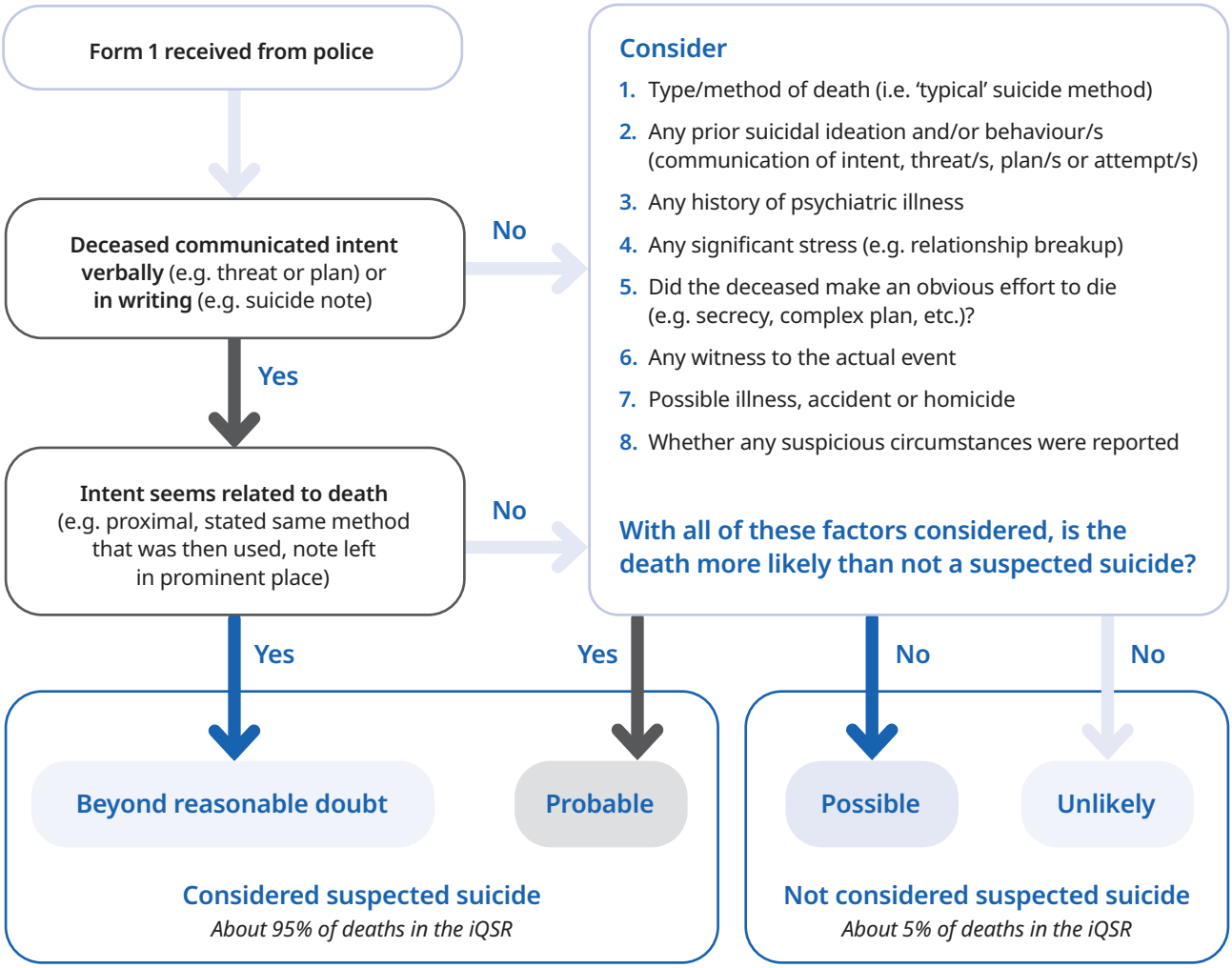
Suicide classification

A decision tree (Figure A.2) is used to code deaths into one of the 4 probabilities of suicide, based on the following criteria:

- **Unlikely:** the available information indicates that a suicide was unlikely (e.g. emphysema, coronary artery atherosclerosis).
- **Possible:** the available information suggests a suicide might have occurred, but there is a substantial possibility that the death is due to other internal or external causes of death (e.g. accident, illness or homicide).
- **Probable:** the available information does not constitute 'beyond reasonable doubt', but death by suicide is still more likely than by any other cause.
- **Beyond reasonable doubt:** the available information refers to one or more significant factors that, in combination, constitute a pattern highly indicative of suicide (e.g. written or verbal intent).

For the purposes of the iQSR, deaths that are assessed to be either unlikely or possible suicides are not included in the register, while deaths considered 'probable suicide' or 'beyond reasonable doubt' are included in the register.

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



2 Decision tree above was originally authored by AISRAP – *Suicide in Queensland Annual Report 2021–2022.*

DELIVERING FOR QUEENSLAND

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