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SUBMISSION TO STANDING COMMITTEE ON SOCIAL POLICY AND LEGAL AFFAIRS

Inquiry into the relationship between domestic, family and sexual violence and suicide

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Preamble

The Australian Bureau of Statistics (ABS) submission is focused on data, especially deaths data. The ABS recognises that behind each number is a person and a broader community affected by this death. The ABS acknowledges those with a lived experience of suicide and family, domestic and sexual violence and those who have lost a loved one to suicide or family, domestic and sexual violence.

The ABS also notes the diverse terminology used by people who have experienced domestic, family and sexual violence. This submission uses the term victim and perpetrator. This is because coronial data, including police reports, is often the source of information for suicide data. This terminology also aligns with the deaths coding framework used by the ABS. The ABS recognises that not all people who may have experienced domestic, family and sexual violence identify with, or prefer, this terminology.

The ABS uses and supports the use of Mindframe guidelines on responsible, accurate and safe reporting on suicide, mental ill-health and alcohol and other drugs. The ABS recommends referring to these guidelines when using the statistics in this report.

Introduction

The ABS welcomes the opportunity to make a submission to the House of Representatives Standing Committee on Social Policy and Legal Affairs inquiry into the relationship between domestic, family and sexual violence and suicide.

The ABS is Australia's national statistical agency. The ABS' purpose is to inform Australia's important decisions by delivering relevant, trusted and objective data, statistics and insights.

The ABS produces official statistics which provide insights into the impacts of domestic, family and sexual violence (DFSV), including mortality data which can provide some insights into the relationship between DFSV and suicide. ABS datasets include:

- Personal Safety Survey: This publication includes national data for men and women and state/territory estimates for women on the nature and extent of experiences of violence. The publication includes statistics about people's experiences of physical and sexual violence, emotional and economic abuse by a cohabitating partner, stalking, sexual harassment, child abuse and witnessing parental violence before the age of 15.
- Recorded crimes – Victims: This publication includes data on victims of family, domestic and sexual violence offences as recorded by the police.
- Recorded crimes – Offenders: This publication includes data about alleged offenders who have been proceeded against by police. It includes family and domestic violence related offences.
- Criminal Courts, Australia: This publication includes information on defendants whose case was finalised in the criminal jurisdictions of the Higher, Magistrates; and Children's Courts across Australia's states and territories. It includes family and domestic violence statistics.
- Crime Victimisation Survey: Produces an annual snapshot of victims of physical assault / threatened assault and whether assault was perpetrated by an intimate

partner - reported and not reported to police. It includes but is not limited to victimisation data on physical, threatened and sexual assault.

- National Mortality Dataset (NMD): This dataset comprises all deaths occurring in Australia that are registered by the jurisdictional Registries of Births, Deaths, and Marriages. The dataset includes detailed demographic (e.g. age, sex, region) and cause of death information. The cause of death completed by the doctor or coroner is coded to the International Classification of Diseases (ICD). The NMD is used extensively to inform policy and as a foundation for population and health research. This dataset forms the basis of the Causes of Death, Australia, Intentional self-harm (suicides), Australia and External causes of death, Australia publications. It is also the dataset used as the reporting mechanism for key national reporting measures including Closing the Gap. It's included in many data linkage assets held by both national and state authorities.

Compilation of suicide data as they relate to DFSV

Coding of deaths due to suicide

The NMD includes all deaths, including those due to suicide. It offers some insights into suicide and DFSV, although there are limitations to this. To assess the relatedness of DFSV to suicide an accurate number of deaths due to suicide must be recorded. Recording deaths as being due to suicide can be challenging, as deaths often present in complex circumstances. For example, a person may have a number of both risk and protective factors present and some mechanisms (e.g. drowning, car crash) can mean the intent is not always clear. Deaths due to suicide in Australia are referred to a coroner.

When coding causes of death the ABS accesses the National Coronial Information System (NCIS), an online data repository containing information on causes of death and related factors for all coroner-referred deaths in Australia and New Zealand. Information regarding the causes of death and associated factors is obtained from various reports including police, toxicology, autopsy and coronial findings. These reports are free text narratives. Content and structure differs across jurisdictions. The ABS trains expert staff to review these reports and assigns relevant codes from the International Classification of Diseases, 10th revision (ICD-10).

In line with ICD-10 guidelines, for all external causes of death (including those due to suicide), the following information must be recorded at a minimum:

- the intent of death (i.e. suicide, accident, assault etc),
- the mechanism of death (i.e. drug toxicity, drowning etc) and,
- the injury or poisoning (i.e. fractures, specified drug type).

Additional information coded on risk factors including mental health conditions, drug and alcohol disorders, chronic disease and psychosocial factors such as DFSV may also be coded if the information is available through various reports on the NCIS. This is discussed further in this submission in the section 'Risk factor coding'.

In the NMD, the ABS may code a death as due to suicide when:

- As part of the coronial finding, the coroner has stated the intent of death as suicide.
- If a formal finding is not made for a closed investigation (i.e. the coroner does not state the intent), an investigation of information on the NCIS may indicate a death was due to suicide, for example, where there was a suicide note.
- For open coronial investigations, indications that the death is a suspected suicide such as the police recording the death as being a suspected suicide. Cases are reviewed by the ABS once they're closed as part of the annual revisions process.

As coronial cases can take time to close, since 2007 the ABS has applied a revisions process. For open coronial investigations, the ABS assigns preliminary coding to deaths data which is subsequently reviewed approximately 6, 18 and 30 months after this original coding. This allows time for coronial investigations to be concluded and for additional reports to be made available on the NCIS. Data is therefore termed 'preliminary', 'preliminary revised', and 'final' as revisions are undertaken and data is updated. Revisions have historically led to increased specificity of coding, identifying additional suicides and enabling more risk factor codes to be captured.

The table below shows the number of suicides over the last ten years for males, females and persons. An age-standardised mortality rate is included to enable comparisons to be made over time. Suicide was the 16th leading cause of death in Australia (11th for men and 27th for women) in 2024.

Suicide by sex, number and suicide rates, 2020 to 2024 (a)(b)(c)(d)

	Males		Females		Persons	
	No.	Rate	No.	Rate	No.	Rate
2020	2,416	19.0	768	5.9	3,184	12.4
2021	2,416	18.9	804	6.2	3,220	12.5
2022	2,507	19.4	833	6.4	3,340	12.8
2023	2,479	18.7	821	6.1	3,300	12.4
2024	2,529	18.7	778	5.7	3,307	12.2

a. Intentional self-harm includes ICD-10 codes X60-X84 and Y87.0.
b. Data is by date of registration.
c. Crude Rate. Deaths per 100,000 of the estimated resident population as at 30 June.
d. Causes of death data for recent years is preliminary and subject to a revisions process. The table includes preliminary data for 2024, preliminary revised data for 2023, revised data for 2022, and final data for 2021 and 2020.

People who have experienced high suicide rates

The Intentional Self-Harm (suicide) deaths in Australia publication which is a component of the *Causes of Death Australia* report includes extensive information on deaths due to suicide, including at risk groups. The most recent report shows:

- Over three-quarters of people who die by suicide are male.
- Suicide is the fifth leading cause of death for Aboriginal and Torres Strait Islander people. It is the second leading cause of death for Aboriginal and Torres Strait Islander males and the 10th for females. The most recent Closing the Gap figures showed the suicide rate was 2.8 higher than that of non-Indigenous people.
- Suicide rates are highest for those living in remote and very remote areas.
- Suicide rates for those who are most socioeconomically disadvantaged are over two times higher than those who are most socioeconomically advantaged.

Risk factor coding

The ABS codes risk factors for suicide using the ICD-10 as a framework. For the NMD, a risk factor is defined as characteristics that may increase the likelihood of experiencing adverse outcomes. Risk factors may include:

- Health conditions such as terminal illness or chronic diseases.
- Mental health conditions.
- Drug and alcohol use (both acute intoxication and chronic use).
- Psychosocial risk factors such as issues with families, financial issues etc. DFSV is considered a psychosocial risk factor.

The ABS has coded psychosocial risk factors in the NMD since 2017. The ABS receives funding from the Australian Institute of Health and Welfare (AIHW) Suicide and self-harm monitoring unit annually for this work. Psychosocial risk factors provide additional insights into deaths due to suicide. As far as the ABS is aware, the NMD is one of only a few mortality datasets internationally where psychosocial risk factors are applied by a statistical agency to deaths due to suicide using the ICD-10.

The ABS sources information on risk factors from the coronial investigation documents on the NCIS, most commonly police and coronial findings. Toxicology and autopsy reports may also provide important context. Capturing information on risk factors relies on the documentation available for any given death - a risk factor must be mentioned to be coded. The information available can be affected by the length of the coronial process, what's available from different jurisdictions and administrative processes.

Circumstances relating to a suicide are complex and multifaceted. Risk factors often co-occur and it may be the combination of multiple factors rather than a single reason that contribute to a person dying by suicide. Risk factors should not be considered in isolation. On average, a person who dies by suicide has 4.1 total risk factors recorded including 1.6 psychosocial factors.

The table below shows that across all jurisdictions, most people who died by suicide had risk factors reported as part of the coronial investigation, although there is a lag in the availability of information in NSW resulting in lower rates of reporting in 2023 and 2024. As a group, psychosocial risk factors were the most common risk factor.

Risk factor prevalence, proportion (%) of suicides with reported specified risk factors 2022-2024 (a)(b)(c)(d)

		NSW	Vic.	Qld	SA	WA	Tas.	NT	ACT
2022									
Total suicides	no.	941	769	799	246	395	85	47	58
Psychosocial risk factor/s	%	69.7	69.8	88.9	69.1	79.2	93.0	93.6	93.1
Mental and behavioural disorder/s	%	67.5	69.2	74.8	60.2	74.7	87.1	78.7	72.4
Natural disease/s	%	56.0	60.1	68.8	49.2	64.1	83.5	80.9	79.3
Any risk factor	%	87.7	94.7	98.3	91.1	99.0	98.8	100.0	98.3
2023									
Total suicides	no.	919	763	784	232	428	88	46	40
Psychosocial risk factor/s	%	38.4	75.1	84.1	77.2	73.1	81.8	60.9	80.0
Mental and behavioural disorder/s	%	37.2	76.9	71.9	75.4	76.4	64.8	71.7	82.5
Natural disease/s	%	33.3	68.8	67.1	67.7	66.8	50.0	41.3	77.5
Any risk factor	%	49.3	96.7	96.1	96.1	96.5	89.8	91.3	95.0
2024									
Total suicides	no.	934	747	796	238	419	81	52	40
Psychosocial risk factor/s	%	31.9	81.5	87.8	68.9	71.1	70.4	88.5	90.0
Mental and behavioural disorder/s	%	29.3	74.2	77.5	70.6	69.5	58.0	82.7	75.0
Natural disease/s	%	27.2	63.3	73.0	68.1	64.7	64.2	76.9	52.5
Any risk factor	%	39.8	96.4	97.1	95.4	92.1	90.1	100.0	97.5

a. Psychosocial risk factors include ICD-10 codes Z00-Z99.
b. Mental and behavioural disorders include ICD-10 codes F00-F99.
c. Natural disease includes all disease and health related conditions with the exclusion of mental and behavioural disorders, injuries, external causes and some terminal conditions (G93, I46, I49, J96). Includes ICD-10 codes A00-E90, G00-R99, U07.1-U07.2, U08-U10.9.
d. Causes of death data for recent years is preliminary and subject to a revisions process. The table includes preliminary data for 2024, preliminary revised data for 2023 and revised data for 2022.

Mood disorders, including depression is the most commonly mentioned individual risk factor followed by suicide ideation across 2022-2024. Suicide ideation includes suicidal thoughts and suicidal threats. Problems in spousal relationships was the third most common risk factor mentioned. There is some differences in risk factors across age groups as shown in the next table.

Top risk factors, proportion of suicides by age group, 2022-2024 (a)(b)(c)

		5-24 years	25-44 years	45-64 years	65-84 years	85 years and over	All ages
Total suicides	**no.**	**1,124**	**3,686**	**3,376**	**1,464**	**297**	**9,947**
Mood [affective] disorders (F30-F39)	%	32.4	39.4	41.9	36.7	21.5	38.5
Depressive episode (F32)	%	30.8	36.3	39.6	35.6	21.2	36.2
Suicide ideation (R45.8)	%	32.7	31.3	30.0	26.9	27.6	30.3
Problems in spousal relationship circumstances (Z63.0 or Z63.5)	%	24.5	33.3	25.5	10.9	1.7	25.4
Personal history of self-harm (Z91.5)	%	30.8	24.9	20.7	15.4	8.8	22.3
Anxiety and stress related disorders (Z73.3, F40-F48 excl. F41.8, F45.4)	%	20.6	21.4	21.6	17.6	9.1	20.5
Other anxiety disorders (F41 excl. F41.8)	%	16.6	16.8	17.0	14.6	7.4	16.2

a. Intentional self-harm includes ICD-10 codes X60-X84 and Y87.0.
b. Data in this table indicates the percentage of deaths with each specified risk factor recorded. Risk factors may not be mutually exclusive, and therefore people with multiple psychosocial factors recorded will be counted in more than one category.
c. Causes of death data for recent years is preliminary and subject to a revisions process. The table includes preliminary data for 2024, preliminary revised data for 2023 and revised data for 2022.

Coding DFSV as it relates to suicide

The ABS uses the ICD-10 framework for coding causes of death and risk factors. The ICD-10 does not have a specific framework for coding DFSV. The ICD-10 can capture elements of codes related to DFSV. Examples of this are included in the table below. A more complete list of risk factors is available on the ABS website.

The inclusion terms show that many elements of DFSV are currently captured, but they are recorded in a way that makes it difficult to report on DFSV only as a risk factor. For example, domestic violence is an inclusion term in the ICD-10 code “Z63.0 Problems in relationship with spouse or partner” but it is alongside other more general terms such as the term ‘arguments’. While an argument may be an indication of DFSV this is not always the case and often further context is not provided in the coronial report. Some codes do provide a direct indication of DFSV, for example the ICD-10 code “Z61.4 Problems related to alleged sexual abuse of child by person within primary support group” indicate the person experienced sexual violence in childhood.

It is important that frameworks allow for flexibility. Frameworks can only be applied when complete and detailed information is available. Contextual information on deaths due to suicide depends on the information gathered via family, health professionals health and

other informants. ABS' ability to apply the coding framework depends on that information being made available to the ABS.

ICD-10 risk factors that may relate to Domestic, Family and Sexual violence

ICD-10 code description (alphanumeric code)	Inclusions
Problems related to alleged sexual abuse of child by person within primary support group (Z61.4)	• Primary support group includes family, friends and other people considered to be part of a close social circle.
Problems related to alleged sexual abuse of child by person outside of primary support group (Z61.5)	• Stranger
Problems related to alleged physical abuse of child (Z61.6)	• Physical abuse by family or primary support group • Family violence described as physical in nature
Other negative life events in childhood (Z61.8)	• Childhood family violence • Problems in childhood • Traumatic childhood • Childhood abuse, not elsewhere classified
Negative life event in childhood, unspecified (Z61.9)	
Problems in relationship with spouse or partner (Z63.0)	• Intimate partner violence • Relationship issues • Acute events as well as ongoing/reoccurring • Arguments which have happened proximate to death • Domestic violence • Violence orders (coded with Z65.3)
Problems in relationship with parents and in-laws (Z63.1)	• Arguments, disagreements, discord, conflict • Parents not approving relationships or other lifestyle choices
Disruption of family by separation and divorce (Z63.5)	• Relationship breakdown • Separation • Divorce • Children affected by separation or divorce if breakup still having current effect
Other specified problems related to primary support group (Z63.8)	• Family fights • Problems with pets • Friendship fights • Unrequited love (not in a relationship)
Problems related to other legal circumstances (Z65.3)	• Domestic Violence Orders • Child custody or support proceedings • Litigation • Restraining orders • Potential or impending legal circumstances or court appearances • Charges have been laid, awaiting commencement of court proceedings • Circumstances where death occurs in relation to illegal activities, where it is not captured elsewhere
Victim of crime and terrorism (Z65.4)	• Victim of assault (including sexual assault) • Victim of any crime

High-risk sexual behaviour (Z72.5)	• Sexual misadventure • Perpetrator or alleged perpetrator of sexual offences (coded with Z65.3)
Personal history of psychological trauma, not elsewhere classified (Z91.4)	• Psychological trauma as a result of physical trauma (coded with Z91.6)
Personal history of other physical trauma (Z91.6)	• Sexual assault (coded with Z65.4) • Physical abuse or assault, not elsewhere coded (coded with Z65.4)
Physical violence (R45.6)	• User of physical violence • Perpetrator of violence

Data outputs

DFSV related risk factors by sex

The table below shows the proportion of people who died by suicide who had selected risk factors mentioned in their coronial report that may relate to DFSV. As discussed, not all people who died by suicide with these risk factors present experienced DFSV (see section above). Key points include:

- Problems in relationship with spouse or partner was the second most common psychosocial risk factor in 2024, present for nearly 15% of people who died by suicide.
- In 2024, nearly 5% of women who died by suicide had mention of being a victim of crime. This compares to just under 1% for males who died by suicide.
- Males who died by suicide were more likely than females to have legal circumstances (this includes court orders), perpetrating physical violence and being affected by marriage and divorce as a risk factor.
- Females who died by suicide had a higher proportion than males of history of childhood sexual abuse and other negative events occurring in childhood.

Select risk factors, proportion of total suicides by year and sex, 2022 to 2024 (a)(b)(c)(d)

	2022			2023			2024		
	Male	Female	Person	Male	Female	Person	Male	Female	Person
Total suicides	2,507	833	3,340	2,479	821	3,300	2,529	778	3,307
Problems in relationship with spouse or partner (Z63.0)	14.9	14.3	14.8	13.5	12.2	13.2	15.1	13.2	14.7
Disruption of family by separation and divorce (Z63.5)	17.7	11.6	16.2	14.0	10.7	13.2	14.7	12.5	14.2
Problems related to other legal circumstances (Z65.3)	11.1	5.2	9.6	11.5	6.2	10.2	12.8	5.1	11.0

Other specified problems related to primary support group (Z63.8)	4.4	9.2	5.6	5.2	6.3	5.5	4.7	7.8	5.4
Physical violence (R45.6)	2.4	0.7	1.9	2.2	0.6	1.8	3.2	1.0	2.7
Victim of crime and terrorism (Z65.4)	0.9	3.0	1.4	0.8	3.5	1.5	0.9	4.9	1.9
Problems in relationship with parents and in-laws (Z63.1)	1.8	3.2	2.2	1.5	2.7	1.8	1.6	2.7	1.8
High-risk sexual behaviour (Z72.5)	1.6	0.0	1.2	1.2	0.1	0.9	2.0	0.0	1.5
Problems related to alleged sexual abuse of child by person within primary support group (Z61.4)	1.0	3.2	1.6	0.6	1.8	0.9	0.7	2.3	1.1
Other negative life events in childhood (Z61.8)	1.0	2.2	1.3	0.9	1.8	1.2	0.9	1.8	1.1
Personal history of other physical trauma (Z91.6)	0.4	2.6	0.9	0.5	2.1	0.9	0.5	1.9	0.8
Problems related to alleged physical abuse of child (Z61.6)	0.5	0.7	0.5	0.1	0.9	0.3	0.4	0.4	0.4
Personal history of psychological trauma, not elsewhere classified (Z91.4)	0.6	0.5	0.5	0.4	0.9	0.5	0.2	0.6	0.3
Negative life event in childhood, unspecified (Z61.9)	0.2	0.5	0.2	0.2	0.0	0.1	0.2	0.5	0.2

Problems related to alleged sexual abuse of child by person outside of primary support group (Z61.5)	0.3	0.1	0.3	0.0	0.1	0.1	0.0	0.4	0.1

a. Intentional self-harm includes ICD-10 codes X60-X84 and Y87.0.
b. Data in this table indicates the percentage of deaths with each specified risk factor recorded. Risk factors may not be mutually exclusive, and therefore people with multiple psychosocial factors recorded will be counted in more than one category.
c. Data is by date of registration.
d. Causes of death data for recent years is preliminary and subject to a revisions process. The table includes preliminary data for 2024, preliminary revised data for 2023 and revised data for 2022.

DFSV related risk factors by age

Risk factors as they relate to suicide and DFSV may be more prevalent at different life-cycle stages. Key statistics include:

- For both males and females aged between 25-44 years who died by suicide, approximately 20% had problems with a spouse or partner mentioned as a risk factor.
- A higher proportion of people who died by suicide aged under 25 years had problems in relationships with parents, problems related to primary support group (e.g. other family) and personal history of childhood sexual abuse mentioned as a risk factor.
- Risk factors that may be related to DFSV were least likely to be mentioned in suicides of those aged over 85 years. This does not mean these factors were not a factor for this group, they were just not mentioned in coronial reports accessed by the ABS.

Select DFSV risk factors, proportion of suicides by age group and sex, 2022-2024 (a)(b)(c)(d)

		5-24 years	25-44 years	45-64 years	65-84 years	85 years and over	All ages
Males							
Total suicides	**no.**	**778**	**2,797**	**2,592**	**1,139**	**209**	**7,515**
Problems in relationship with spouse or partner (Z63.0)	%	10.9	20.3	14.0	6.7	1.9	14.5
Problems related to other legal circumstances (Z65.3)	%	8.1	14.4	12.9	7.1	2.4	11.8
Other specified problems related to primary support group (Z63.8)	%	7.2	4.2	5.1	4.4	0.5	4.7
Physical violence (R45.6)	%	3.5	3.2	2.6	1.0	0.5	2.6

Victim of crime and terrorism (Z65.4)	%	1.4	0.8	1.0	0.6	0.5	0.9
Problems in relationship with parents and in-laws (Z63.1)	%	4.6	2.4	0.8	0.0	0.0	1.6
Females							
Total suicides	**no.**	**346**	**889**	**784**	**325**	**88**	**2,432**
Problems in relationship with spouse or partner (Z63.0)	%	14.2	19.3	11.1	4.0	1.1	13.2
Problems related to other legal circumstances (Z65.3)	%	4.3	8.2	5.2	1.5	0.0	5.5
Other specified problems related to primary support group (Z63.8)	%	9.0	6.7	9.1	7.7	3.4	7.8
Physical violence (R45.6)	%	0.9	0.9	1.0	0.0	0.0	0.8
Victim of crime and terrorism (Z65.4)	%	5.8	5.1	2.6	1.8	1.1	3.8
Problems in relationship with parents and in-laws (Z63.1)	%	9.8	2.8	1.3	0.3	0.0	2.9
Persons							
Total suicides	**no.**	**1,124**	**3,686**	**3,376**	**1,464**	**297**	**9,947**
Problems in relationship with spouse or partner (Z63.0)	%	11.9	20.0	13.3	6.1	1.7	14.2
Problems related to other legal circumstances (Z65.3)	%	6.9	12.9	11.1	5.9	1.7	10.3
Other specified problems related to primary support group (Z63.8)	%	7.7	4.8	6.0	5.1	1.3	5.5
Physical violence (R45.6)	%	2.7	2.6	2.2	0.8	0.3	2.1
Victim of crime and terrorism (Z65.4)	%	2.8	1.8	1.4	0.9	0.7	1.6
Problems in relationship with parents and in-laws (Z63.1)	%	6.2	2.5	0.9	0.1	0.0	1.9

a. Intentional self-harm includes ICD-10 codes X60-X84 and Y87.0.
b. Data in this table indicates the percentage of deaths with each specified risk factor recorded. Risk factors may not be mutually exclusive, and therefore people with multiple psychosocial factors recorded will be counted in more than one category.
c. Data is by date of registration.
d. Causes of death data for recent years is preliminary and subject to a revisions process. The table includes preliminary data for 2024, preliminary revised data for 2023 and revised data for 2022.

DFSV related risk factors for at risk groups

The ABS has risk factor data for suicide for Aboriginal and Torres Strait Islander people. This has not yet been published but is available upon request. The ABS is planning to work with experts in Aboriginal and Torres Strait Islander suicide prevention to ensure this is reported in a culturally safe manner and of value to the community.

The ABS published risk factor data by remoteness areas and by socioeconomic status in the latest Causes of Death, Australia publication.

Data gaps and opportunities

This section will address ToR 2 of the inquiry: Opportunities for improved reporting and investigation methodologies to accurately capture and report on deaths as a result of DFSV, including the adequacy of existing data collection practices related to DFSV and suicide, and the availability, quality, and consistency of data across jurisdictions.

Source data for the coding of suicides

The quality of the NMD is dependent on both the content and quality of source documents available as part of the coronial investigation and the timeliness of report availability on the NCIS. The ABS is able to share experiences of differences and work with stakeholders to potentially look for opportunities to enhance source data. Areas of focus where current data gaps exist:

Content of and access to coronial reports
The content of coronial reports made available on the NCIS can differ between jurisdictions, and these differences can impact ABS coding. While sufficient information is usually available to enable accurate underlying cause coding, some differences limit the number of associated causes that can be recorded, including important information on risk factors. This is pertinent in the coding of deaths due to suicide and DFSV. Opportunities exist to enhance the consistency of reporting from jurisdictional police and coroner courts. This would improve the documentation available for coding.

Opportunities also exist to align definitions across jurisdictions. This includes complex topics such as coercive control which can be inconsistently reported. Currently, data is not coded consistently for coercive control (both for victims and perpetrators) in the NMD due to both documentation and classification limitations.

There are also opportunities to improve the consistency of the type of information collected and reported as part of a coronial investigation into suicide. Risk factors that have occurred relatively recently before death may be reported more completely than risk factors occurring years earlier. There is some risk that information is missed for people who had a history of DFSV. Improvements to data quality could also be gained with more context to descriptions. It can be difficult to assess if DFSV is a risk factor when narratives use terms that can have multiple meanings such as “the deceased had a difficult childhood” or “the deceased had a volatile relationship”.

Timeliness of report availability when coding causes of death
The timeliness of report availability is important. Over the course of the ABS revisions of coroner referred deaths, the number of less specified causes decreases as additional information is made available on the NCIS. Additionally, as more information is made available to the ABS the number of risk factors coded for a death due to suicide increases. While a coronial investigation takes time and a coronial finding or dispensation cannot be available for some time, access to other information including the police report and autopsy is invaluable for high quality and accurate preliminary cause of death coding. While the majority of the current preliminary data is timely and of high quality, final datasets are more complete and can provide more accurate insights in policy relevant areas such as suicide prevention.

Coding frameworks

ICD-10 coding

Using the existing ICD-10 classification, the ABS could examine if family and domestic violence could be captured more systematically for the NMD. The ABS could work with state and territory teams to ensure that DFSV definitions align, frameworks are collecting the same information and are being applied consistently and results applied are similar. This would align with Recommendations 20 and 21 from the Rapid Review of Prevention Approaches which were the result of the rapid review of evidence-based approaches to prevent gender-based violence. Recommendation 21 specifically states that *"The Commonwealth and state and territory governments to develop a consistent approach to death review processes and improve knowledge on the relationship between DFSV and suicide".*

As the national statistical authority responsible for the review of all deaths in Australia for the purposes of the compiling the NMD and national mortality statistics, the ABS should be involved and resourced to contribute to this work.

As part of the psychosocial risk factor coding work, the ABS have undertaken some initial analysis to test how a framework or DFSV flag could be developed and applied with the ICD-10 using existing data. As there are many different manifestations of DFSV, the framework has looked at combining codes to provide insights. Potential code-sets are shown below in the following tables. The first table shows code-sets for victims of DFSV and the second table shows code-sets for perpetrators of DFSV. With further funding the ABS could continue to develop this framework, working closely with teams at the AIHW.

Potential ICD-10 code-sets for victims of DFSV

Code description (alphanumeric code)	Definition (from National Plan to End Violence against Women and Children, 2022-2032)	Combination of risk factors used to identify
Victim of domestic violence	Domestic violence refers to any behaviour within a past or current intimate relationship (including dates) that causes physical, sexual or psychological harm.	Z63.0 & Z65.3 & Z65.4
Victim of family violence	Family violence is a broader term that captures violence perpetrated by parents (and guardians) against children, between other family members and in family-like settings.	Z61.8 & Z65.3 & Z65.4 or Z63.8 & Z65.3 & Z65.4
Victim of violence, including sexual violence	Sexual violence refers to sexual activity that happens where consent is not freely given or obtained, is withdrawn, or the person is unable to consent due to their age or other factors. It also occurs any time a person is forced, coerced or manipulated into any sexual/sexualised activity. Sexual violence can be non-physical and include unwanted sexualised comments, intrusive sexualised questions or sexual harassment.	Z91.6 & Z65.4 or Z61.4 or Z61.5

Potential ICD-10 code-sets for perpetrators of DFSV

Code description (alphanumeric code)	Definition (from National Plan to End Violence against Women and Children, 2022-2032)	Combination of risk factors used to identify
Perpetrator of domestic violence (physical violence)	Domestic violence refers to any behaviour within a past or current intimate relationship (including dates) that causes physical, sexual or psychological harm.	Z63.0 & Z65.3 & R45.6
Perpetrator of family violence (physical violence)	Family violence is a broader term that captures violence perpetrated by parents (and guardians) against children, between other family members and in family-like settings.	Z61.8 & Z65.3 & R45.6 or Z63.8 & Z65.3 & R45.6
Perpetrator of sexual violence (sexual assault)	Sexual violence refers to sexual activity that happens where consent is not freely given or obtained, is withdrawn, or the person is unable to consent due to their age or other factors. It also occurs any time a person is forced, coerced or manipulated into any sexual/sexualised activity. Sexual violence can be non-physical and include unwanted sexualised comments, intrusive sexualised questions or sexual harassment.	Z72.5 & Z65.3

Initial results from the framework test are discussed below. Key considerations are:

- An ICD-10 framework is able to be applied to capture information on DFSV including for victims and those who have used violence.
- Different elements of DFSV can be captured using the ICD-10, including interpersonal violence, sexual violence and other family violence.
- Numbers are currently small – this likely represents an undercount. With funding and resourcing more work can be put into the framework, including engagement on definitions and looking to understand how gaps in source data affect the reporting (e.g. is there enough information within coronial reports, is this consistent across jurisdictions etc).
- The potential framework for perpetrators recorded a higher number of deaths due to suicide than the victim framework. This is possibly linked to how victims and their experiences are described in coronial reports (e.g. a person may not be specifically described as a victim, but instead a statement may be included such as “the deceased had a volatile relationship with a past partner”). The ABS will continue to engage with experts to ensure that best practice is applied when cause of death coding.

ICD-11 coding

The International Statistical Classification of Diseases and Related Health Problems, Eleventh Revision (ICD-11) is the next revision of the ICD. ICD-11 was adopted by the World Health Assembly in 2019 and came into effect globally on 1 January 2022. ICD-11 offers significant advantages over ICD-10 including an expanded code base which better reflects contemporary understanding of medical conditions, interventions and risk factors.

In addition to new codes, the ICD-11 has a new coding structure that allows for greater flexibility such as the ability to apply extension codes, cluster diseases, risk factors and contextual information together to provide more insights into relationships between diseases, external causes and risk factors. A number of these enhancements would assist in developing a framework for DFSV, especially as it relates to suicide. Examples of ICD-11 codes are shown in the table below. ICD-11 includes codes such as “personal history of psychological abuse” which could assist in data collation on coercive control.

Australia has not yet started using ICD-11 for mortality or morbidity coding. The ABS is part of the Australian Collaborating Centre (ACC) alongside other agencies including the AIHW, the Independent Health and Aged Care Pricing Authority and state and territory health department. As part of their coordination role for the ACC, the AIHW also chairs the Australian ICD-11 Task Force. This group (which includes the ABS) is undertaking activities to inform a decision on the implementation of ICD-11 in Australia in a range of contexts, including for mortality coding. The move to ICD-11 is significant and involves updating metadata, dual coding exercises and detailed communication on how to interpret time series. The ABS is responsible for the implementation of ICD-11 for mortality data. Some dual coding exercises are planned to demonstrate the capability. Looking at DFSV as a risk factor as part of these exercises could be investigated. While some progress has been made, it is expected that significant investment will be required. The proposal to use ICD-11 across the health system would also mean that mortality data would be able to be compared and combined with other health data to better understand patient journeys through the system prior to death.

ICD-11 Code	Description	Code examples	Application
Problems associated with relationships	Problems associated with relationships	• QE50.4 Relationships with parents, in-laws and over family members • QE51.1 History of spouse and partner violence • QE52.0 Caregiver-child relationship problems	
Problems associated with harmful or traumatic events	Personal history of maltreatment	• QE82.0 Personal history of physical abuse • QE82.1 Personal history of sexual abuse • QE82.2 Personal history of psychological abuse • QE82.3 Personal history of neglect	• History of maltreatment codes apply to non-accidental acts that result in harm or have reasonable potential of harm • Category is for victim of maltreatment only
Problems associated with the justice system	Problems associated with the justice system	• QE40 Problem associated with conviction in civil or	• When included with other codes can be

		criminal proceedings without imprisonment • QE41 Problem associated with imprisonment and other incarceration • QE4Y Other specified problems associated with the justice system	used to identify a perpetrator
Time in Life	17 pre-defined age groups	• XT9V Middle Childhood (5-10 years) • XT15 Young Adult (20-24 years) • XT6S Adult (25-64 years)	• Provides information on temporal relationship between DFSV occurrences and death
Perpetrator-victim relationship	36 pre-defined relationships	• XE041 Legal spouse • XE8TC Ex-partner • XE8EU Other blood relative • XE6WK Roommate • XE9S0 Grandparent	• Provides information on relationship between victim and perpetrator of DFSV • Does not specify whether victim or perpetrator
Gender of perpetrator	4 pre-defined genders	• XE5YG Male • XE56C Female • XE6W8 Other • XE9SL Unknown	• Provides information on gender of perpetrator
Proximal risk-factors for intentional self-harm	19 pre-defined risk factors (not all related to DFSV)	• XE9SZ Conflict in relationship with spouse, partner, boy/girlfriend • XE8HX Sexual abuse • XE2RX Neglect • XE4UX Dowry	• Provides information on DFSV occurrences immediately prior to death.

Other causes of death

A strength of the NMD is that the same ICD-10 framework is applied to all causes of death in Australia and the risk factor coding applied to all coroner referred deaths. This means that enhancements to the source data and developing and applying a consistent coding framework for DFSV will also be able to be applied to other causes of death that can inform the death toll such as assaults.

Data Linkage

The NMD compiled by the ABS is used as the core dataset in linked data assets both by Commonwealth and state and territory authorities, including the Person Linked Integrated

Data Asset (PLIDA) housed at the ABS and the National Health Data Hub (NHDH) housed by the AIHW. As linked datasets are a key data initiative to providing further insights into DFSV it is important that the NMD continues to have investment, including the accurate coding of suicides and assaults and the development and application of a risk factor framework for coding DFSV as part of the psychosocial coding work.

Opportunities for other ABS datasets that can inform the burden of DFSV

Other opportunities exist to enhance ABS datasets that may inform DFSV. These are listed below.

Ongoing improvement to national data criminal justice system collections – police (offenders, victims), courts, and corrections/prisons (ABS)

ABS has well established systems and relationships with state and territory criminal justice agencies. These departments provide statistical information about people that come into contact with the criminal justice system from police (as victims or offenders), defendants in the criminal courts and prisoners under the supervision of corrective services. These data are brought together, conceptually harmonised across state and territory legislations to produce nationally consistent and comparable publications.

Key gaps in this national data are:

- Availability of DFSV data in ABS prisoners' collection. This could be resolved with the Criminal Justice Data Asset (CDJA) (see below), where DFSV flags from police/courts can be linked to prisoners' data.
- National comparability of Aboriginal and Torres Strait Islander status data recorded by police (and transferred to criminal courts) (VIC, WA, TAS and ACT).
- National count of assaults recorded by police (Victorian data not published due to quality concerns, ABS is working with Victoria Police to resolve this).

Criminal Justice Data Asset (CJDA)

There is currently no national source of statistical information about how criminal offenders (perpetrators) interact and flow through the criminal justice system, across state and territory boundaries and over time.

To address this critical data gap, the ABS has been funded to work closely with their long term and well-established partners in the criminal justice sector (across police, criminal courts and corrective services) to build the CJDA. Using administrative data provided by the sector, the CJDA links police recorded offenders with defendants finalised in criminal courts and adult prisoners under the authority of corrective services for policy and research purposes.

Once in production, CJDA will facilitate unique national, state and territory analysis of offender (including DFSV offenders) pathways through the justice system, offender rates, risk factors associated with offending behaviours, and whether persons who choose to use violence are being held to account.

All 24 state and territory data custodians (police, criminal courts, corrective services) have provided in-principle support for the development and production of a nationally linked

CJDA. A feasibility study has been concluded and demonstrated the technical viability and utility of the CJDA. The ABS also commissioned an external Privacy Impact Assessment on the CJDA, the final report and ABS response are available on the ABS website.

While the CJDA is being developed as a stand-alone asset, the feasibility study also demonstrated potential to link to the Person-Level Integrated Data Asset (PLIDA). One of the key benefits to be realised by linking CJDA with PLIDA is to facilitate more in-depth analysis of cohorts in the criminal justice system, such as detailed socio-demographic and health factors and how these may interact as risks and preventive factors associated with offending. Any use of the CJDA, including other linkages, will require endorsement from state and territory criminal justice data custodians.

Personal Safety Survey, 2021-22

The Personal Safety Survey (PSS) is Australia's leading data source for measuring the prevalence and nature of family, domestic and sexual violence, and is critical for informing outcomes of the National Plan to End Violence against Women and Children 2022-32. The PSS has been conducted every 4-5 years since 2005. Most recently in 2021-22. The survey collected information from men and women aged 18 years and over residing in private dwellings across Australia (excluding very remote areas). Interviews were conducted with one randomly selected adult.

Key statistics

Sexual violence

- An estimated, 22% of women and 6.1% of men have experienced sexual violence since the age of 15.

Anxiety or fear for personal safety after sexual assault

- Two thirds (67%) of women who experienced sexual assault by a male in the last ten years, reported that they experienced anxiety or fear for their personal safety in the 12 months after the most recent incident.

Cohabiting partner violence and abuse

An estimated 4.2 million people aged 18 years and over (21%) have experienced violence, emotional abuse, or economic abuse by a cohabiting partner since the age of 15.
Women were more likely than men to have experienced partner violence or abuse since age of 15:

- 17% of women and 5.5% of men have experienced partner violence
- 23% of women and 14% of men have experienced partner emotional abuse
- 16% of women and 7.8% of men have experienced partner economic abuse

Whether emotionally abusive partner threatened or attempted suicide

The PSS includes 21 behaviours under the definition of emotional abuse. This includes where a partner threatened or attempted suicide which were aimed at preventing of controlling the persons behaviour, causing them emotional harm or fear.

For the full list of behaviours collected, refer to the Emotional abuse chapter of the PSS publication or the Glossary.

The below data table can be used to support ToR 4 of the inquiry: The use of suicide and threats of suicide as a tactic of coercive control by perpetrators of DFSV.

Persons aged 18 years and over who experienced emotional abuse by a cohabiting partner since the age of 15, Whether emotionally abusive partner threatened or attempted suicide

	Emotionally abusive partner threatened or attempted suicide		Experienced emotional abuse by a cohabiting partner since age 15	
	Estimate	Proportion	Estimate	Proportion
Women				
Experienced emotional abuse by a current partner	61,600	14.3%	431,000	100.0%
Experienced emotional abuse by a previous partner	583,600	30.0%	1,944,400	100.0%
Men				
Experienced emotional abuse by a previous partner	240,500	22.6%	1,062,700	100.0%

Key risk factors of cohabiting partner violence and abuse

The PSS shows that different cohorts experience partner violence and abuse at different rates. For example, there are differences in prevalence rates:

- across age groups
- disability status
- financial stress of household
- family composition
- childhood experiences of physical and sexual abuse and witnessing parental violence.

Experienced anxiety or fear for personal safety due to Partner violence (physical or sexual)

- Of the 173,300 women who have experienced violence by their current partner, 49% experienced anxiety or fear for their personal safety as a result of the violence.
- Of the 1.5 million women who have experienced violence by a previous partner, 69% experienced anxiety or fear for their personal safety as a result of the violence.

Updates to the next iteration of the Personal Safety Survey (PSS)

The next PSS will enhance the suite of statistics to collect:

Person characteristics

- ABS Sex, Gender, Variations of Sex Characteristics and Sexual Orientation Variables Standard implemented for respondent
- Self-assessed mental health status

General Feelings of Safety

- Feelings of safety in local area during day
- Feelings of safety at home around people usually live with
- Feelings of safety at place of study
- Feelings of safety at work

Characteristics of violence and abuse

- Areas of life impacted by violence/abuse: health; daily life and social activities; employment/education; housing, security and finances
- Whether felt the formal support or advice received helped meet needs
- Reasons for not seeking advice or support from formal source
- Type of leave taken after violence / reasons for not taking leave
- Whether violent partner ever sought advice or support to change violent behaviour
- Contributions to partners violence

Abuse before the age of 15 by a child or young person

- Whether experienced sexual abuse before the age of 15 by a child or young person