CHAPTER 3

SUICIDE REPORTING & STATISTICS

Introduction

3.1 This chapter will address term of reference (b) the accuracy of suicide reporting in Australia, factors that may impede accurate identification and recording of possible suicides, (and the consequences of any underreporting on understanding risk factors and providing services to those at risk). This was an issue which received considerable attention during the inquiry in part due to an existing debate regarding the underreporting of suicide in Australia.

Data on suicide and trends

3.2 The Australian Bureau of Statistics (ABS), Australia's official national statistical agency, reports annually on all registered deaths where sufficient information exists for coding. The 2008 *Causes of Death* stated there were 2,191 deaths coded as Intentional self harm [Suicide]. Of these deaths 1,710 (78 per cent) were male and 481 (22 per cent) were female. Suicide was identified as the 14th leading cause of death as 1.5 per cent of all deaths in 2008.[1]

3.3 The ABS statistics over the past decade have suggested a steady decline in the number of suicides in Australia, from 2,683 in 1998 to 1,799 in 2006. However the ABS has acknowledged these figures may be influenced by reporting issues. Since 2005, the ABS has published a caution in relation to the reported suicides data. The caution reads:

> Care should be taken in using and interpreting suicide data due to issues affecting data quality. It is important to note that the number of suicide deaths may be affected by the number of open coronial cases with insufficient information available for coding at the time of ABS processing.[2]

3.4 On these unrevised figures the largest falls in the number of suicides reported appear to have occurred in the large states, particularly NSW and Queensland. The rate of suicide appears relatively even across Australia (9.8 deaths per 100,000) with the exceptions of Tasmania (15.4 deaths per 100,000) and the Northern Territory (22.8 deaths per 100,000).[3]

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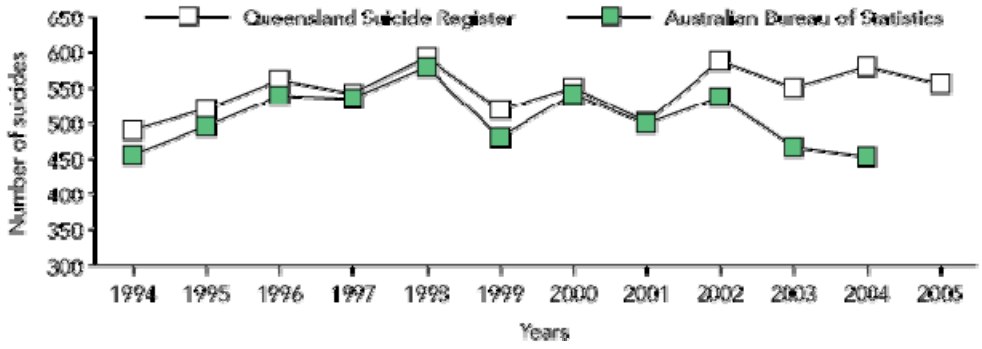
1 ABS, *Causes of Death*, 2008, p 9.

2 ABS, *Submission 111*, p. 8.

3 DoHA, *Submission 202*, p. 12.

3.5 In recent years there has been growing concern regarding the accuracy of the ABS statistics of deaths by suicide. For example in 2007 Professor Diego De Leo highlighted discrepancies between the ABS data for suicides in Queensland and the Queensland Suicide Register (QSR) maintained by AISRP.[4]

Comparison of Queensland Suicide Register and ABS data[5]



3.6 In 2009 the AIHW published a report into suicide statistics which investigated deaths occurring in 2004 using cases extracted from the National Coroners Information System (NCIS) from early 2008. It concluded that the ABS mortality data underestimated death by Intentional self harm [Suicide] '…to a significant extent, at least for deaths in 2004'. The revised estimate of 2,458 deaths from Intentional self harm [Suicide] compared to the ABS data of 2,110.[6]

3.7 In response to the concerns regarding the reporting of suicides in Australia SPA has facilitated the establishment of the National Committee for Standardised Reporting on Suicide (NCSRS) with the support of DoHA. The NCSRS is a cross jurisdictional committee to coordinate the various projects and stakeholders involved in the collection and compilation of suicide statistics, with the aim of achieving a standardised, accurate and consistent approach to suicide recording and statistical reporting.

4 Diego De Leo, 'Suicide mortality data needs revision', *Medical Journal of Australia*, vol. 186, no. 3, pp 157-158.

5 Diego De Leo, 'Suicide mortality data needs revision', *Medical Journal of Australia*, vol. 186, no. 3, p. 158.

6 AIHW, *A review of suicide statistics in Australia*, July 2009, pp 82 & 97.

ABS revisions

3.8 Reacting to the concerns raised regarding the underreporting of suicide deaths the ABS has implemented a revision process in the *Causes of Death* data collection process. All coroner certified deaths registered after 1 January 2007 will be subject to the revision process. The revision process will enable the use of additional information relating to coroner certified deaths as it becomes available over time, resulting in increased ability to identify suicide deaths. In particular this process will be able to include the results of completed coronial cases which have been finalised.

3.9 This is a change from previous years where ABS processing of *Causes of Death* data was finalised approximately 13 months after the end of the reference period. Where insufficient information was available to code a cause of death, less specific codes were assigned. The ABS noted the revision process would increase the number of deaths that are identified as 'suicides' for a given reference period compared to statistics previously released for that period.[7]

3.10 On 31 March 2010 the ABS released the latest *Causes of Death* data including the revised data for deaths by suicide which was clearly higher than previously reported. The revised data from 2007 showed a 9.2 per cent increase in the number of deaths coded to suicide, from 1,881 to 2,054.[8]

3.11 The ABS also outlined to the Committee a number of other activities it has recently undertaken to improve the quality of suicide data. These included revised instructions for ABS coders in coding suicides to ensure greater consistency in outcomes between individual coders and the implementation of revised rules for the use of the 'undetermined intent' coding which has had the effect of removing a number of potential suicides from 'accidental' death codes, making potential suicides easier to identify.[9]

The collection of suicide data in Australia

3.12 The registration of deaths is the responsibility of the individual State and Territory Registrars of Births, Deaths and Marriages (RBDMs). As part of the registration process, information about the cause of death is supplied by the medical practitioner certifying the death or by a coroner. Each state and territory has its own legislation covering the death registration process, as well as the role and responsibilities of the RBDM. Additionally, each jurisdiction has its own coronial legislation covering the role and responsibilities of coroners and the manner in which deaths reported to the coroner are investigated and findings made.[10]

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7 ABS, *Submission 111*, p. 10.

8 ABS, *Causes of Death, 2008*, p. 85.

9 ABS, *Submission 111*, p. 8.

10 ABS, *Submission 111*, p. 3.

3.13 In order to classify a death as a suicide the current International Classification of Diseases (ICD-10) requires that specific documentation from a medical or legal authority be available regarding both the self-inflicted nature and suicidal intent of the incident.[11] The ABS *Causes of Death* notes:

> Coronial processes to determine the intent of a death (whether intentional self harm, accidental, homicide, undetermined intent) are especially important for statistics on suicide deaths because information on intent is necessary to complete the coding under ICD-10 coding rules.[12]

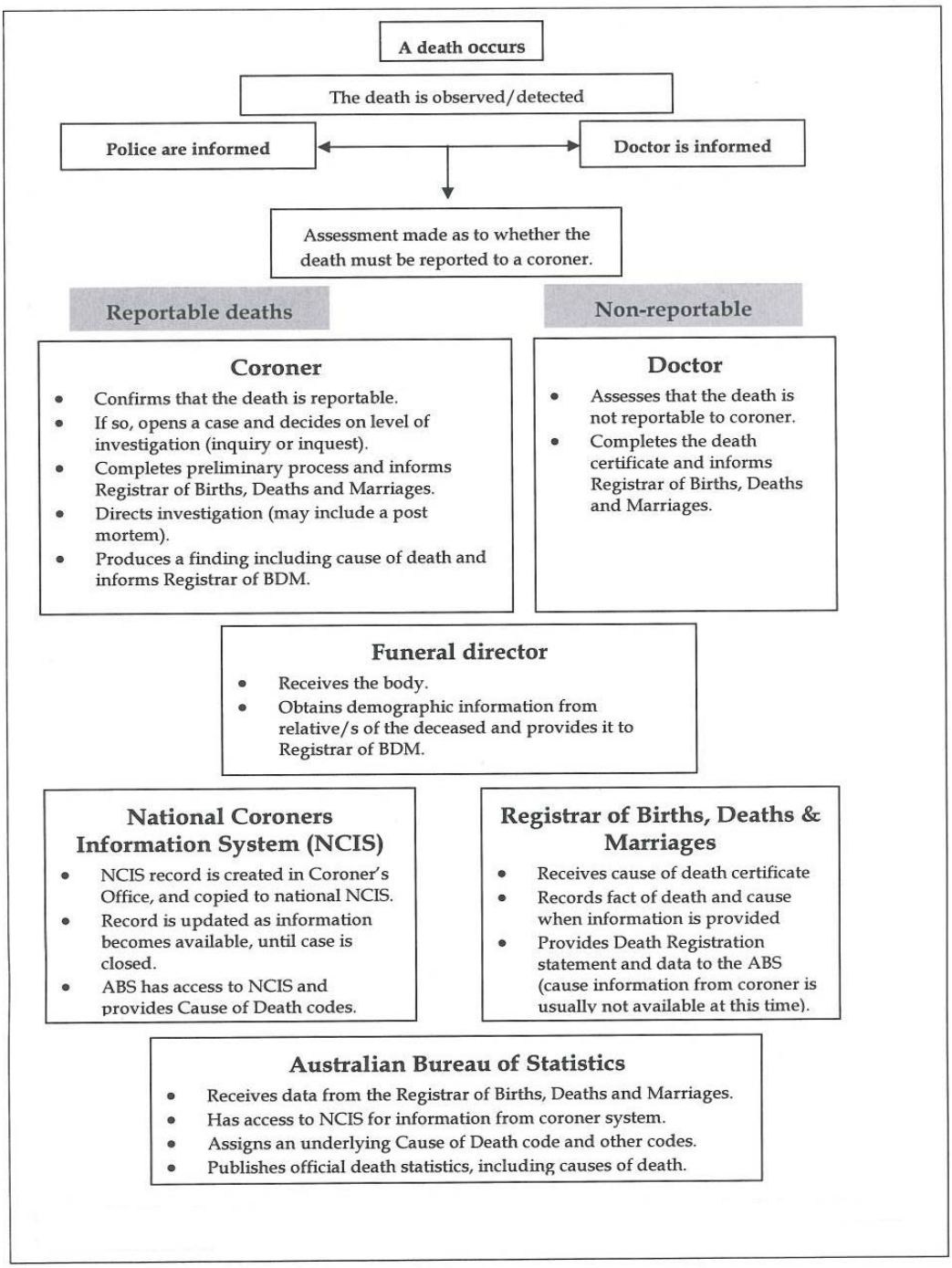
3.14 Since 2006 the ABS has used the NCIS as its primary source of information for coding causes of death for cases reported to the coroner. The NCIS is a database which contains information concerning every death reported to a coroner in Australia since 1 July 2000 (Queensland data commenced in 1 January 2001). Based on standardised coding performed by staff at coroners' offices around Australia, authorised users of the NCIS are able to view details about deaths reported to a coroner using a web based interface.[13]

11 ABS, *Submission 111*, p. 5.

12 ABS, *Causes of Death, 2008*, p. 47.

13 NCIS, *Submission 84*, p. 3.

Flowchart Causes of Death data collection[14]



14 Extracted from AIHW, *A review of suicide statistics in Australia*, July 2009, p. 19.

Impediments to accurate suicide reporting

3.15 A number of impediments to the accurate collection of suicide data in Australia were highlighted during the inquiry.

Determining intent

3.16 The difficulties in determining the intent of a person who might have completed suicide were frequently raised as an impediment to accurate suicide recording. Many examples were given of situations where it would be difficult to accurately determine the intent of a person in the absence of an obvious indication (such as the discovery of a suicide note). These scenarios included:

- drug overdoses which may be accidental or a suicide;
- single vehicle accidents where the driver has crashed into a fixed object;
- falls or drowning which could also be accidental;
- incidents of murder/suicide which could also be a double suicide; and
- hangings where there is the possibility of autoeroticism or there may be questions about the capacity of the person to understand the seriousness of their actions (for example young children).

3.17 The WA State Coroner, Mr Alastair Hope noted there was also a 'grey area' between recklessness and intent. He used the example of a person driving a '…vehicle in a manner which was so reckless that it would be very difficult to decide whether she wanted to die or just did not care'.[15]

Duration of coronial processes

3.18 The main rationale for the ABS revision process was that the time taken for coronial processes to occur did not allow data to be included in their regular annual reports. DoHA noted a key problem 'has been the increasing number of still pending decisions by coroners, that is ‘open’ cases, at the time the ABS must finalise the data for annual publication'. They also noted that there was significant variation in the case closure rates of states and territories, from 10.6 per cent in the ACT to 72.3 per cent in Queensland.[16]

3.19 While SPA considered the retrospective revision of suicide numbers was commendable, it noted the process would delay final counts and the benefit of this information by several years. Similarly Associate Professor James Harrison

15 Mr Alastair Hope, *Committee Hansard*, 31 March 2010, p. 69.

16 DoHA, *Submission 202*, p.16. Note: Mr Michael Barnes, Queensland State Coroner disputed the figure of 'open' cases. Mr Michael Barnes, Queensland State Coroner, *Proof Committee Hansard*, 18 May 2010, pp 49-50.

commented that this 'slowness greatly reduces the value of the data for purposes related to policy and programs'.[17]

Coronial legislation and practices

3.20 Coroners are judicial officers who under coronial legislation investigate reportable deaths and make findings as to the cause of death. Each State and Territory has its own coronial legislation which may prescribe the roles and responsibilities of the coroner differently. For example Mr Mark Johns, State Coroner of SA, told the Committee that under the coronial legislation in that jurisdiction there were two avenues for reportable deaths, either an inquest or making a finding. He noted that because of the wording of the legislation 'unless there is an inquest [the SA Coroner] will not make a coronial finding as to the intention of the deceased'.[18]

3.21 The NCSRS commented:

> Given differences in legislative requirements across States and Territories, particularly with regards to coroners' requirements to determine and report 'intent', national consistency may necessitate legislative reform as well as coronial practice guidelines. With a view to achieving a unified system, it is suggested that recommendations regarding coronial determination of intent be made at the National level for adoption by the various States and Territories.[19]

3.22 In addition to legislative differences between jurisdictions the ABS highlighted the lack of standardisation in coronial reporting practices. They stated '…different reporting formats, structures and forms are used in different coronial offices' and that '…coronial statements about the intent of a death are worded in different ways, there may be no statement regarding intent and if there is a statement of intent, it can be located anywhere in the coronial finding'.[20]

3.23 There were also differences between the jurisdictions identified in the availability of full-time coroners as opposed to local magistrates acting as coroners. The NCSRS argued the use of full-time coroners would improve the consistency of reporting practices.[21]

3.24 DoHA noted that accurate suicide statistics depend on '…what coroners conclude and write, they are a by-product of their work'.[22] However currently

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17 Associate Professor James Harrison, *Submission 131*, p. 3.

18 Mr Mark Johns, *Proof Committee Hansard*, 4 May 2010, p. 2.

19 NCSRS, *Submission 229*, p. 11.

20 ABS, *Submission 111*, p. 5.

21 NCSRS, *Submission 229*, p. 14.

22 DoHA, *Submission 202*, p. 15.

facilitating quality mortality statistics is not a formal part of a coroner's role. Coroners can rule on the intent of person but are not mandated to do so.[23]

3.25 No jurisdiction in Australia requires a coroner to make a specific determination about intent. The NCIS noted that an informal review of relevant coronial findings revealed 29 per cent had no mention of intent made by a coroner.[24] Similarly the AIHW study of suicide statistics found a large variation between different jurisdictions in the extent to which coronial findings provide a clear statement of the conclusion that the coroner reached about the role of intent in the death.[25] The Queensland Coroner commented that NCIS coding was a '…much lower priority for coroners than case managing their own workloads with a view to making findings to satisfy family members' concerns and getting deaths registered onto the local deaths registries'.[26]

3.26 To resolve this issue the NCIS recommended the amendment of coronial legislation in each jurisdiction to require a determination of intent and professional education for coroners about the importance of their suicide determinations.[27]

3.27 The high standard of proof used by coroners was also identified as a possible factor in the underreporting of suicides. The standard of proof for coroners is the civil standard, namely the balance of probabilities, but the gravity of the consequences of a finding of suicide is also a consideration. A high degree of certainty regarding intent is often required before a coroner will rule a death as a suicide. However Mr Michael Dudley of SPA noted this legal standard of proof may be '…not necessarily the same as a research or a suicidologist's standard of proof'.[28] The NCIS commented:

> This test of probability can result in some instances where it is 'possible' that a suicide occurred although was not determined as such by a coroner, with a statement such as 'I am unable to determine whether the deceased intended to take their own life' seen in some coronial findings.[29]

Data entry and coding

3.28 The NCIS noted several issues with the recording of intent data on their system. The first was that some coroners' offices were not completing the *Intent Notification* field until an investigation by the coroner has been completed. This field was included to allow timely data collection as to the prevalence of 'suspected

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23 Diego De Leo et al, 'Achieving standardised reporting of suicide in Australia: rationale and program for change', *Medical Journal of Australia*, 2010, vol. 192, no. 8, p. 454.

24 NCIS, *Submission 84*, p. 9.

25 AIHW, *A review of suicide statistics in Australia*, July 2009, p. 93.

26 Mr Michael Barnes, *Proof Committee Hansard*, 18 May 2010, p. 49.

27 NCIS, *Submission 84*, p. 6.

28 Dr Michael Dudley, *Committee Hansard*, 1 March 2010, p. 31.

29 NCIS, *Submission 84*, p. 6.

suicides', without the need to wait until all coronial processes were completed. They also commented that where a coroner does not make a statement as to intent 'a conservative process of assigning intent has to be undertaken by the coronial clerks entering the code on NCIS'. They stated:

> This current method of determination of intent is ultimately unsatisfactory, as it places the onus of determination for suicide on a coronial clerk, and only allows for capture of the most unambiguous self harm events.[30]

3.29 The SA State Coroner also raised the issue of resources and staff in coronial offices in relation to accurately coding data in the NCIS system. He noted this task was delegated to relatively junior staff who were '… under a fair bit of pressure'. He suggested staff were not always identifying 'the more ambiguous causes of death' and as a result '… there is simply no way that in South Australia we are accurately recording via the NCIS all the suicides that occur'.[31]

3.30 Finally NCIS noted that for the ABS to have complete information when compiling official statistics the data entry into NCIS needs to be timely. They stated that a backlog of coding exists and not all coroners' offices are able to complete coding on the NCIS with 60 days of a coroner's finding. This could contribute to the underreporting of suicides.[32]

The system of data collection

3.31 The ABS noted the accuracy and timeliness of suicide statistics '…depends on the goodwill and resources available in other organisations'. It was noted that the complexity of the data gathering system meant it was 'so fragile that decisions made by individuals can have a massive impact'.[33]

3.32 SPA commented:

> Part of the current problem is attributable to the fact that, in Australia, suicide statistics depend on a complex process of information capture, distribution and processing that involves numerous organisations and individuals. No one body or portfolio is responsible for producing mortality data. Multiple parties collect data for different, sometimes disparate, purposes (e.g. legal, statistical, research-oriented) with different standards of proof and reporting timelines.[34]

3.33 Some witnesses argued that the recent ABS reliance on the NCIS had also affected the accuracy of data collection. Dr Michael Dudley of SPA noted that with

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30 NCIS, *Submission 84*, p. 8.

31 Mr Mark Johns, *Proof Committee Hansard*, 4 May 2010, p. 4.

32 Ms Jessica Pearse, NCIS, *Committee Hansard*, 4 March 2010, p. 46.

33 Mr David Rosenberg, BMRI, *Committee Hansard*, 1 March 2010, p. 56.

34 SPA, *Submission 121*, p. 33.

the '…transfer to a purely electronic system, there had been an abandonment of file inspections at coroners' offices…' by the ABS. [35] Similarly Mr Michael Barnes stated that following the change to the new system it was unlikely '…there will be same consistency and accuracy as when [ABS] staff reviewed coroners' files themselves'.[36]

Police data collection

3.34 The NCIS noted that some progress had been made towards a national standard form for police to collect information regarding a death reported to a coroner. Several jurisdictions (ACT, Queensland, Tasmania and NSW) have introduced to varying degrees a standard national police form that records evidence of suspected suicide and demographic data.[37] However the other four jurisdictions had not implemented the national standard form and there were inconsistencies in the use of the form. Technology and resource constraints are generally cited as the primary reasons for delay in adopting the form.[38]

3.35 Ms Jessica Pearse of NCIS commented that there was no standard process for police in investigating a possible suicide. She stated they '…collect a range of information about what they consider relevant and, depending on that variable level of information provided to them, a coroner may not have all the relevant information needed to help make a determination'. She stated:

> Any method that would encourage more standard information collection—things like the deceased's history, any previous attempts and possible triggers—would assist in the best evidence-based determination being made by a coroner.[39]

3.36 The NCIS recommended support for research to determine the reliability of initial 'intent notification' codes based on police notifications and/or initial clerk assessments. They suggested an initial assessment as to 'suspected suicides' could provide a guide to current trends or patterns surrounding such instances in the community, which could later be revised/confirmed once coronial investigations are completed. [40] Similarly Associate Professor James Harrison highlighted that most deaths that are ultimately found by a coroner to be due to suicide have been flagged as likely suicides when they were notified to the coroner, generally by police. He argued this 'intent notification' could provide a good proxy measure as 'sufficiently complete data based on it could be reported quickly'.[41]

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35 Dr Michael Dudley, SPA, *Committee Hansard*, 1 March 2010, p. 30.

36 Mr Michael Barnes, *Proof Committee Hansard*, 18 May 2010, p. 49.

37 Diego De Leo et al, 'Achieving standardised reporting of suicide in Australia: rationale and program for change', *Medical Journal of Australia*, 2010, vol. 192, no. 8, p. 454.

38 NCSRS, *Submission 229*, p. 7.

39 Ms Jessica Pearse, NCIS, *Committee Hansard*, 4 March 2010, p. 46.

40 NCIS, *Submission 84*, p. 12.

41 Associate Professor James Harrison, *Submission 131*, p. 3.

National Police Reporting Form Template[42]

Section 13 – SUSPECTED SUICIDE

a) What evidence is there to indicate that the deceased intended suicide? (tick the relevant box(es)) ☐ Statement to Family/Friends ☐ Statement to Health Professional ☐ Note / Letter ☐ Other (specify):
b)(i) Has the deceased previously attempted suicide? ☐ No ☐ Yes ☐ Unknown
b)(ii) If yes, approx number of times:
c)(i)Has the deceased previously been hospitalised for self harm? ☐ No ☐ Yes ☐ Unknown
c)(ii) If yes, approx number of times:
d) Is there any possible motive / trigger for the suicide? (tick the relevant box(es)) ☐ Relationship Breakdown ☐ Sexual Abuse ☐ Financial Problems ☐ Loss of a Loved One ☐ Illness ☐ Prospect of Criminal Sanction ☐ Alcohol / Drug Dependency ☐ Unknown ☐ Other (specify)
e) Was deceased being treated / seen by any of the following professionals? (tick relevant box(es)) ☐ General Practitioner ☐ Psychiatrist ☐ Psychologist ☐ Case Manager
f)(i) Was the death accompanied by the murder / suicide of other person(s)? ☐ No ☐ Yes
f)(ii) If yes, what was the relationship between the deceased and the person(s)?

Stigma and family pressure

3.37 The stigma around suicide was also frequently mentioned as a reason a death may not be recorded as a suicide. Lifeline Australia commented that stigma as well as cultural and religious beliefs could lead to circumstances where 'family members either directly or indirectly seek to influence death certificate statements regarding suicide'.[43]

3.38 The ABS also noted there may be reluctance by coroners to record a finding of suicidal intent because of 'sympathy with the feelings of the family, or sensitivity to the cultural practices and religious beliefs of the family'.[44] It was suggested these types of inconclusive findings were delivered by coroners and others to 'spare the family shame and chagrin, the agonising doubts and questions'.[45]

3.39 Mr Alastair Hope, State Coroner of WA also noted that there is frequently pressure from families in the case of public inquests 'to find that the death is by accident or some other mechanism apart from suicide'. Family members may believe that a finding of suicide might reflect adversely on their own interaction with the deceased person.[46] The Queensland Coroner, Mr Michael Barnes commented that there had been 'numerous appeals against suicide finding by family members seeking

42 Extracted from NCIS, *Submission 84*, p. 15.

43 Lifeline Australia, *Submission 129*, p. 30.

44 ABS, *Submission 111*, p. 5.

45 Professor Colin Tatz, *Submission 16*, p. 2.

46 Mr Alastair Hope, *Committee Hansard*, 31 March 2010, p. 68.

a different finding and this may also cause coroners to be more hesitant to make a finding of suicide.[47]

3.40 No evidence was received which estimated the extent to which stigma influences the reporting of suicide. However the ACT Government noted the feedback it had received from '…emergency workers and others who are frequently first on the scene at motor vehicle fatalities report is that indicators such as [suicide] notes in single vehicles are frequently overlooked during coronial determinations'.[48]

Insurance and financial issues

3.41 Family and relatives may also fear that an official report of a death as a suicide may prevent or delay the payment of life insurance or other forms of financial payment. Lifeline Australia stated:

> In regional and rural areas in particular, this delay can have a catastrophic impact on the economic future of a family, such as where a family farm or business is involved. Accordingly, inaccurate recording of the cause of death can occur through the intention to avoid financial hardship for a family – especially in smaller communities where families know each other and socialise together.[49]

3.42 Other submissions noted the practice for life insurance policies to include a clause excluding payments for deaths by suicide within a certain period following commencement of the policy. Typically this exclusionary period was between 13 and 24 months. It was suggested that these life insurance policies contributed to the underreporting of deaths as suicides.[50]

Consequences of underreporting

3.43 The underreporting of suicide deaths was seen as masking the extent of the problem in Australia and thwarting efforts to assess the efficacy of suicide prevention programs and activities. Professor Ian Hickie from BMRI described the lack of accurate suicide figures as a 'national catastrophe'. He suggested underreporting of suicides presented two major problems for policy makers:

> First, it means we have no way of monitoring, with any confidence, that policy and program initiatives are having the intended effect.
>
> Second, it is highly unlikely that underreporting is really an issue across all population sub-groups. This means that we may be directing the already

47 Mr Michael Barnes, *Proof Committee Hansard*, 18 May 2010, p. 50.

48 ACT Government, *Submission 44*, p. 3.

49 Lifeline Australia, *Submission 129*, p. 30.

50 Diego De Leo et al, 'Achieving standardised reporting of suicide in Australia: rationale and program for change', *Medical Journal of Australia*, 2010, vol. 192, no. 8, p. 456.

> meagre resources for suicide prevention away from high risk groups in the community.[51]

3.44 Similarly the Royal Australian and New Zealand College of Psychiatrists (RANZCP) commented:

> Accurate statistics provide the foundation for appropriately targeted prevention strategies and research and understanding the full costs of suicide. Without reliable data, the effectiveness of suicide prevention strategies is not detectable.[52]

3.45 Underreporting was also seen as having consequences for research into the causes of suicide. The NCIS commented that a '…reduced amount of information collected in a consistent, searchable format about suspected suicides may also later limit the ability of researchers to identify risk factors for suicide'.[53]

3.46 The Suicide is Preventable submission commented that while there was general agreement that suicide rates are underreported in Australia there was disagreement about whether, despite this underreporting, '…enough is known to establish patterns, the dimensions of the phenomenon' and to base effective prevention programs.[54]

3.47 For example the Queensland Coroner Mr Michael Barnes considered the need for accurate suicide statistics was self evident, noting that it was difficult to design, implement or evaluate prevention strategies if there was uncertainty regarding the size, scope and distribution of the problem. He argued that the changes to way the ABS has been gathering data had resulted in 'obscuring even the trend in the statistics'.[55] SPA also highlighted the uncertainty created by underreporting. They stated:

> How much of the downward trend in deaths registered as suicides since 1998 is due to a real decline in the number of suicide deaths as opposed to under-enumeration or misclassification is therefore not immediately apparent, nor the full extent of the problem of under-reporting known.[56]

3.48 However Professor Graham Martin and others argued that suicide prevention activities to date have been 'quite successful' and there was evidence that there had been a real decline in the number of suicides in Australia, particularly amongst men,

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51 Suicide is Preventable, *Submission 65*, p. 11.

52 RANZCP, *Submission 47*, p. 12.

53 NCIS, *Submission 84*, p. 13.

54 Suicide is preventable, *Submission 65*, p. 10.

55 Mr Michael Barnes, *Proof Committee Hansard*, 18 May 2010, pp 49-50.

56 SPA, *Submission 121*, p. 33.

despite the problems with data collection and the issue of misclassification of deaths.[57] Professor Robert Goldney commented that ambiguity in suicide statistics had a long history but that '… detailed analyses have been re-assuring in establishing that broad trends can be reliably inferred from data provided'.[58]

3.49 Similarly Dr Ching Choi and Dr Lado Ruzicka commented that while it was clear that the ABS have been under reporting suicide deaths, '…it is not at all clear that the declining suicide mortality trend is not real'. They pointed to the declining trends in many other developed countries as well as the decline in suicides associated with firearms but noted suicides by hanging have not declined.[59]

Scope of reporting

3.50 Another area of reform in reporting was the scope of data collected in relation to suicide. RANZCP noted that the 'lack of information in death records on some characteristics of people dying by suicide further contributes to the ignorance of suicide risk factors and distribution'.[60] The Committee frequently heard evidence that there was little reliability in the recording of the characteristics of a person who completed suicide. Additional information such as whether the person was Indigenous, gay, lesbian, bisexual, transsexual or intersex or from a particular ethnic community was not being consistently recorded.[61] Others noted that the lack of ethnicity data made it impossible for assessments of trends and issues in culturally and linguistically diverse communities.[62]

3.51 The NCSRS noted that a range of information gathered during a police investigation which has the potential to inform both coronial determinations and suicide prevention activities and research. They suggested the collection of more wide ranging background information concerning the deceased's social life and relationships and a complete medical and mental health history could assist the determination of suicide intent or risk. The NCSRS recommended a standard psycho-social autopsy be developed, taking into account a broad source of information, and implemented as a matter of course in all cases of suspected suicide.[63]

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57 Professor Graham Martin, *Committee Hansard*, 2 March 2010, p. 80; Professor Graham Martin, *Submission 107*, p. 13. Dr Andrew Page; Professor Greg Carter; Professor Richard Taylor; Dr Michael Dudley; Dr Stephen Morrell; Professor Graham Martin and Professor Wayne Hall, *Submission 64*, p. 5.

58 Professor Robert Goldney, *Submission 51*, p. 1.

59 Dr Ching Choi and Dr Lado Ruzicka, *Submission 42*, p. 2.

60 RANZCP, *Submission 47*, p. 13.

61 SPA, *Submission 121*, p. 33; Central Australian Aboriginal Congress, *Submission 19*, p. 1.

62 Ethnic Communities Council of Western Australia, *Submission 36*, p. 1.

63 NCSRS, *Submission 229*, pp 7-8.

3.52 Accurate and timely recording of suicides could also enable authorities to identify problem areas, clusters of suicides or areas requiring postvention services following a series of related suicides. Lifeline Australia stated:

> Better access to accurate information on suicide and suicidal behaviour could enable more effective local responses to communities and regions in Australia – notably in cases where several deaths by suicide occur in a short space of time. The early identification of 'clusters' of suicide in localities or particular social/demographic groups will support more effective suicide prevention responses.[64]

3.53 A number of submissions and witnesses argued that not only did the number of suicides in Australia need to be accurately recorded but other factors also needed to be tracked. Professor Ian Hickie noted that contacts with care were common for people before they attempted suicide but that no national tracking mechanisms existed to link cares services to patient outcomes. He stated:

> …we need to track those who have contact with the health system through its emergency departments, its primary care services and particularly its specialist mental health services. We have seen a complete lack of will in the health systems to join up occasions of service with the key outcome of care: are you alive or dead at three months? Are you alive or dead at 12 months? If dead, what is the cause of death? They are the simple things that we need to know.[65]

3.54 Professor Ian Hickie also commented that there may be services which do not want to be held accountable for outcomes because they provide short episodes of care to people who may be at risk of suicide.[66]

3.55 Broader data collection regarding suicide could also assist service providers refine the targeting of groups at risk of suicide. OzHelp commented it would be assisted if data such as age, gender, occupation, income and other social determinants of health could be collected.[67] Orygen Youth Health Research Centre argued that the failure to record suicide attempts '… restricts our ability to accurately monitor progress towards reducing suicide and significantly hampers research in this area'.[68]

3.56 The Private Mental Health Consumer Carer Network Australia recommended that the reporting protocol of deaths with 28 days of discharge from a mental health facility be linked to coronial reporting requirements. The Network concluded that

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64 Lifeline Australia, *Submission 129*, p. 29.

65 Professor Ian Hickie, BMRI, *Committee Hansard*, 1 March 2010, p. 58.

66 Professor Ian Hickie, BMRI, *Committee Hansard*, 1 March 2010. p. 58.

67 OzHelp Foundation, *Submission 86*, p. 8.

68 Orygen Youth Health Research Centre, *Submission 82*, p. 3.

efforts must be made to collect, report and review all occasions of death by suicide following discharge from mental health services.[69]

3.57 Mr Michael Barnes suggested one solution to the scope and accuracy of the recording of suicides would be to expand the QSR model nationally. The QSR is a database of suicide mortality data managed since 1990 by AISRP. The database gathers information on deaths by suicide of all residents of Queensland, including data obtained from police reports, post-mortem and toxicology reports. This information is predominantly provided by the Queensland Office of the State Coroner and cross-checked with the data available on the NCIS. Causes of death are then scrutinised in the QSR following a Suicide Classification Flow Chart, developed by AISRP, and categorised into: Beyond Reasonable Doubt, Probable, or Possible.[70]

Conclusion

3.58 Accurate and timely statistics are essential to the creation, implementation and evaluation of good policy in any area, but particularly for social and health policy. The rate of suicide is widely used internationally as a broad progress measure or indicator of the effectiveness of social and health (particularly mental health) policy.

3.59 The Committee acknowledges that because of the difficulties around determining intent a completely accurate recording of suicides in any given year is unlikely to be achieved. However this does not preclude substantially more accurate, timely and useful recording of suicide. The Committee considers that accurate and timely statistics about suicide and attempted suicide should be given a high priority under the NSPS.

3.60 The Committee acknowledges the recent efforts made by the ABS to improve the accurate recording of suicide data through revisions. Without the benefit of several years of ABS revised data, it is not clear whether there is a clear downward trend in deaths registered as being a result of suicide. As the revision of previous years by the ABS continues this situation will become clearer.

3.61 The creation of the NCSRS, which brings together many of the participants and users of suicide data collection system, demonstrates there is considerable goodwill and a shared commitment to reforming many of the technical issues which prevent accurate suicide reporting.

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69 Private Mental Health Consumer Carer Network Australia, *Submission 10*, pp 4-6. Follow up procedures are discussed further in Chapter 4.

70 DoHA, *Submission 202*, p. 47.

Recommendation 2

3.3 The Committee recommends that Commonwealth, State and Territory governments, in consultation with the National Committee for Standardised Reporting on Suicide, implement reforms to improve the accuracy of suicide statistics.

3.62 It is clear that standardising coronial legislation and practices in relation to determining intent would have the effect of improving the quality of suicide reporting in Australia. However the Committee has concerns about proposals to require coroners to make determinations as to the intent of the deceased in relation to possible suicides. There is a significant difference between a coroner publicly recording a death as a suicide and a coroner officially recording a death as a suicide. The Committee considers it may be possible to develop a system whereby coroners maintain their discretion to not publicly make a finding of suicide (on compassionate grounds) but are required to record their determination officially (on the NCIS or otherwise). This is a difficult area of reform as it involves coronial legislation and practices in all jurisdictions. The Standing Committee of Attorneys-General appears an appropriate forum to progress this issue, particularly considering its previous experience in implementing uniformity of legislation across Australian jurisdictions.

Recommendation 3

3.63 The Committee recommends that the Standing Committee of Attorneys-General, in consultation with the National Committee for Standardised Reporting on Suicide, standardise coronial legislation and practices to improve the accurate reporting of suicide.

3.64 Standardising the input that coroners receive from primary sources such as police will also positively impact the recording of suicides. The important role that police currently (and potentially could) undertake in gathering information about persons at risk of suicide was highlighted to the Committee a number times during the inquiry. The Committee is concerned that the police forces of Victoria, SA, WA and NT do not appear to have implemented the standardised national police form for the collection of information regarding a death reported to a coroner.

Recommendation 4

3.65 The Committee recommends all Australian governments implement a standardised national police form for the collection of information regarding a death reported to a coroner.

Recommendation 5

3.66 The Committee recommends that the Commonwealth, State and Territory governments enable timely distribution of suicide data from coroners' offices regarding suicides to allow early notification of emerging suicide clusters to public health authorities and community organisations.

Recommendation 6

3.67 The Committee recommends that State and Territory governments provide additional resources and training to staff in coronial offices to assist in the accurate and timely recording of mortality data.

3.68 In relation to life insurance policies the Committee is cautious to make any recommendations to change the practice of standard exclusions if the person completes suicide within a certain time period after the policy is commenced. The financial implications of these policies would have the effect of discouraging the reporting of deaths as suicides in some cases. Nonetheless there is also possibility that a change to these insurance policies could act as a dangerous incentive or encouragement those at risk of suicide.

Recommendation 7

3.69 The Committee recommends the National Committee for Standardisation of Reporting on Suicide liaise with peak insurance and financial associations, such as the Insurance Council of Australia, regarding exclusionary conditions in contracts which may deter the reporting of suicides.