

# Policy Position

## Suicide Data

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### Position

1. Australia needs accurate, reliable, timely data on suicide prevention to enable evidence-based policy, service delivery, program design and informed research.
2. Commonwealth Government to build capability in the suicide prevention sector to access, interpret and utilise suicide prevention data through a Data and Outcomes Fund.
3. State and Territory Governments to introduce a suicide and self-harm monitoring system in every jurisdiction to standardise classification of data in hospital and emergency settings, and make monthly data from state and territory suicide registers available.
4. All States and Territories should contribute suspected suicide data to the AIHW Secure Portal, including relaxing restrictions on access to more granular data for approved applicants who must undergo vetting processes.
5. The National Suicide Prevention Office should develop national definitions of self-harm and suicide attempts.
6. State and Territory Governments to embed mechanisms for enabling real-time data notifications for suicide deaths and attempts to enhance postvention and aftercare services and programs to respond timely to distress in communities.
7. The Commonwealth Government should address existing gaps in suicide data including for priority populations.
8. The ABS National Mental Health and Wellbeing Survey should be conducted more frequently and expanded to:
  - a. collect data on the linkages between risk factors of suicidality and suicidal behaviours, and
  - b. enable policy makers and service providers to target protective factors and measure the efficacy of strategies, policies and services.

### Context & Commentary

Access to accurate population-level data regarding suicidal behaviour, is crucial for targeted suicide prevention policy and program resourcing, development and implementation. Access to consistent and accurate data enables Government and the suicide prevention sector to effectively identify, target and reach key at risk populations in suicide prevention interventions.

## The need for reliable data

In the transition from the COVID-19 pandemic and reforms to policy and practice, ongoing translational research is key to understanding what works for whom and when. While 96% of the suicide prevention sector respondents to the 2021 State of the Nation survey agree their organisation needs access to reliable, accurate suicide prevention data, only half agree they have access to the data they need right now.[1]

More reliable, timely and robust data can improve policy development and planning as well as enable immediate prevention and postvention responses at a local level. While the establishment of the Suicide and Self-Harm Monitoring System is a step forward, there remain major gaps in the availability of data relating to suicide attempts and other priority cohorts including Aboriginal and Torres Strait Islander, LGBTQI+, and culturally and linguistically diverse communities.

While increasing availability of data is critical, better outcomes are reliant on sector capability to access, understand and interpret the available data. As the suicide prevention sector grows, it's critical the capability to make use of increased data is supported. The Commonwealth Government should make small, but wise and strategic, investment in data capability building through grants for easy-to-use resources and staff training can unlock the potential of this data. The funding would align with recent important progress made through the National Suicide and Self-Harm Monitoring System.

## Jurisdictional suicide attempt and self-harm monitoring systems

The National Suicide and Self-harm Monitoring System was first announced in the Commonwealth Government's 2019-20 Budget and has continued to develop and expand through continued Commonwealth funding. The National Suicide and Self-harm Monitoring System collates data reported through the ABS Causes of Death publication to provide a national dataset on suicide deaths in Australia. While this data collection mechanism is a step forward, there is an 18-month time lag on the data and experiences inconsistencies in underreporting due to lag in death registrations from time of reporting. [2] In recent years some jurisdictions have increased suicide death data availability through their state surveillance systems. For example, VIC and NSW provide available suicide data within approx. three months.

As the national dataset draws on data collected from jurisdictions, data could be improved through enhanced data collection on suicide attempts and self-harm at the state and territory level.

All health authorities across jurisdictions collect data on most public hospital emergency department presentations.[3] This data feeds into the National Non-Admitted Patient Emergency Department Care Database to provide national datasets on emergency presentations.[4] Australia uses the ICD-10 (International Statistical Classification of Diseases) for diagnostic coding to provide internationally comparable data.[5]

While collecting data on general presentations to hospitals, emergency departments and ambulance attendances is common practice, datasets on suicidal ideation, self-harm, and suicide attempts presentations in these settings vary significantly in completeness and quality.

A key factor affecting the differences between emergency datasets is the lack of standardised nomenclature to describe and classify suicidal ideation and behaviour presentations. For example, self-injury could be coded with any other self-harm category.[6] There may also be insufficient evidence to determine a suicide attempt or suicide death at the time of presentation. Research indicates that ICD-10 coding for self-harm may not accurately classify self-harm cases as it lacks sensitivity to distinguish context of the self-harm (e.g. an accidental overdose vs an overdose intended as a suicide attempt).[7]

The National Suicide and Self-harm Monitoring System notes that hospitalisation data may vary among jurisdictions due to varying hospital policy and practices e.g. through changes to care type definitions, reporting of Indigenous status, and changes in the ICD-10 which can impact interpretation of trends.[8],[9]

Victoria is currently trialling a Self-harm Monitoring System to enhance data accuracy on self-harm presentations to emergency departments. [10] The system is still under development across eight emergency departments in Victoria (six in metropolitan areas and 2 in regional areas).[11]

Between 15% and 25% of people who make a suicide attempt will make an additional suicide attempt, with the risk highest in the three-month period following a suicide attempt.[12] The most common psychosocial risk factor for deaths referred to a coroner, including deaths by suicide between 2017-2020 was a 'personal history of self-harm'. [13]

For those who attempt suicide, but not admitted to hospital and many priority at-risk populations, the rate of access to aftercare and other supports is significantly lower. For example, while an estimated 393,700 reported self-harm over a 12 month period there are only 29,900 self-harm hospitalisations.

While we have seen some improvements in reporting deaths by suicide, significant gaps in data remain on suicide attempts particularly for among those who do not present to an emergency department or have an ambulance call out. Only half of those who die by suicide had any contact with an emergency department in the 12 months prior to their death. [14] There is a need to strengthen suicide attempt and self-harm data collection and sharing mechanisms within the community services sector, and in alternative spaces to emergency departments. This data should be provided to the Australian Institute of Health and Welfare to enhance national suicide attempts and self-harm datasets.

We support the National Suicide Prevention Adviser's Final Advice recommendation for the National Suicide Prevention Office to develop national definitions of self-harm and suicide attempts (3.3), and State and Territory Governments should introduce suicide attempt and self-harm monitoring systems in hospital and emergency settings.[15]

The sharing of suicide death and suspected suicide death data is largely restricted due to preserving the identification of persons who have died by suicide from the broader community. While we agree that identities should be protected, reasonable rationale exists for circumstances where specific bodies should be able to access data to advance research in suicide prevention and enable timeliness of service provision to reduce suicide contagion in individuals and communities.

Funding and resourcing are limited in the suicide prevention sector, particularly among non-metropolitan areas across jurisdictions. Access to data to enhance prevention, aftercare and postvention services will enable improved planning and distribution of resources to at-risk people and communities.

Among regions where the number of suicide deaths are minimal, data on the suicide deaths that do occur are aggregated into broader suicide datasets to enable reporting. This poses challenges for targeting service provision as the data is not accurate of the time the death took place, and the data is available too late to be of practical use in providing suicide prevention services to communities impacted by a suicide death.

While there is a place for the general public to be shielded from identifying particular persons, there is also a place where the data shouldn't be aggregated and used for suicide prevention purposes. It is envisaged valid use of this data would be for suicide prevention research and service provision purposes. We recommend all States and Territories should contribute suspected suicide data to the AIHW Secure Portal, including relaxing restrictions on data access for approved applicants who undergo vetting processes wishing to use the data for suicide prevention research and service provision purposes.

## **Access to real-time suicide death notifications**

A consistent theme throughout all iterations of our State of the Nation Annual Survey Report (2020, 2021, 2022) is the need for access to real-time notifications on suicide suspected and confirmed deaths, and suicide attempts for the suicide prevention sector. Access to timely notification data will enable coordinated and responsive suicide prevention services i.e. postvention and aftercare providers to respond to distress in the community when it occurs. Localised partnerships for data sharing purposes would significantly improve community driven suicide responses.

Currently suicide death notifications are not shared with services generally due to privacy regulations by data collection authorities. While notifications are not available, some jurisdictions in recognition of the need for timely support have implemented partnerships with Police to utilise database tools to enable timely referrals to support services for people in the community bereaved by suicide using a consent-based model.

For example, SupportLink is an IT platform built specifically as a police referral pathway. SupportLink has been operational in the ACT for the last 20 years, and in the NT since 2013. SupportLink has previously worked with QLD and VIC. The referral platform is managed by Referral Coordinators who assist in managing partnerships, following up on unanswered referrals to ensure people are receiving links to support, and manage agency partnership expectation agreements (e.g. there is an expectation that services must follow up a referral within 24 hours). There are a number of referral categories police can make referrals for, including for bereavement by suicide.

Queensland Police Service have contracted a system 'InfoExchange' as IT providers for a referral gateway connecting police referrals to service providers which has been operational since 2015. The system has over 22 categories, including a sudden death category following death by suicide for families and friends.

550 services are connected to the platform to receive referrals. Similarly, Victoria Police e-Referral System (VPeR) has introduced a bereavement by suicide category to their referral system which links police referrals to service providers.

These systems are not notifications of suicide deaths, but instead referral pathways using a consent-based model to enhance timeliness of support to people bereaved by suicide. This is one step in moving towards increasing the timeliness of data to enable support to people in distress.

A previous suicide attempt is the strongest risk factor for a subsequent suicide death. While effective aftercare has been found to address this risk, many people discharged from hospital following an attempt do not receive treatment. This number is even larger for those who do not attend an Emergency Department following a suicide attempt. Additionally, bereavement by suicide has been evidenced as a risk factor of subsequent suicidal behaviour, making postvention services an essential component of suicide prevention.[16]

It is critical that State and Territory Governments embed mechanisms for enabling real-time data notifications for suicide deaths and attempts to enhance postvention and aftercare services and programs to respond timely to distress in communities.

## Gaps in data for populations at risk of suicide

There are a number of populations at higher risk of suicide than the general population that currently lack complete and accurate datasets on suicidality. Despite the availability of sophisticated data management systems, methodologies for collecting data on suicide deaths and social determinants among priority populations differ between the Commonwealth, States and Territories. The significant information gaps resulting from these differences hinder the targeting, tailoring, and assessment of suicide prevention strategies for priority populations.

Gaps in data exist for the following priority populations (but is not limited to): Aboriginal and Torres Strait Islander peoples [17], LGBTIQ+ communities [18], culturally and linguistically diverse communities [19], carers [20], and older people.[21]

We recommend the following to enhance data on priority populations:

- The Commonwealth Government to collect data on social determinants of health including socioeconomic and political context; social stratification; exposures, vulnerabilities and consequences of interactions with social systems, and differential outcomes in health in line with recommendation by the World Health Organization (2010).
- The Australian Bureau of Statistics, in consultation with the Australian Institute of Health and Welfare, should expand the National Survey of Mental Health and Wellbeing to collect information on Aboriginal and Torres Strait Islander psychosocial risk factors.
- Australia needs population-level data and accurate recording of deaths by suicide through counting LGBTIQ+ people in the Census, and improving data collection by coroners to inform policy, service and program development.
- Australia needs population-level data and accurate recording of deaths by suicide of individuals from culturally and linguistically diverse communities to improve data collection. This includes improving data collection by coroners to inform policy, service, and program development.
- Commonwealth Government should establish a centre of research excellence to lead national research specific to older persons mental ill-health and understanding suicide among Australian older people.
- Commonwealth Government through the AIHW undertake national data collection into the health and wellbeing of carers.
- States and territories to record and report on deaths by suicide and suicide attempts among carers and former carers through their Suicide Deaths Registers and other reporting systems including the Australian Bureau of Statistics.

## Under-utilised Datasets

The link between suicidality and the social determinants of health will be critical if we are to work towards a zero suicide goal.

In recent years Australia has seen emerging trends in housing affordability, casualization of the workforce, the impact of the COVID-19 pandemic, and the impact of compounding natural disasters such as bushfires and floods. [22],[23] Research is required into how these changes are affecting the mental health and wellbeing of Australians.

To this end, we support the Productivity Commission's recommendation to conduct 'routine national surveys of mental health' and to increase the frequency of which the ABS National Survey of Mental Health and Wellbeing is conducted to be no less than every 10 years (Productivity Commission, 2019).

The next iteration of the ABS National Mental Health and Wellbeing Survey should be conducted afresh within the next twelve months to obtain data on population-level suicidality and suicidal behaviour. Increasing the frequency of the National Mental Health and Wellbeing Survey would also help assess the extent to which suicide prevention strategies and policy/program mechanisms are working effectively.

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## If you or someone you know require 24/7 crisis support, please contact:

**Lifeline: 13 11 14**  
[www.lifeline.org.au](http://www.lifeline.org.au)

**Suicide Call Back Service: 1300 659 467**  
[www.suicidecallbackservice.org.au](http://www.suicidecallbackservice.org.au)

## For general enquiries

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