Senate Community Affairs Committee
Inquiry into Suicide in Australia

Submission National Committee for Standardised Reporting on Suicide

February 2010

Contents

INTRODUCTION

The National Committee for Standardised Reporting on Suicide (NCSRS) is a cross jurisdictional committee that was established by Suicide Prevention Australia (SPA) 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.

The NCSRS has met twice to date. The first workshop, held in April 2009, focused on defining the scope and terms of reference for the NCSRS. The second workshop, held in September 2009, identified priority areas for action. Detailed reports containing the outcomes of these workshops are available in Appendices B and C. With support from the Department of Health and Ageing (DoHA), the NCSRS intends to meet four times per year with the next workshop due during the first quarter of 2010.

This multi disciplinary committee includes coroners and other representatives from State and Territory coroners offices, the National Coronial Information System (NCIS), the Australian Bureau of Statistics (ABS), Australian Institute for Suicide Research and Prevention (AISRAP), Australian Institute of Health and Welfare (AIHW), Australian Suicide Prevention Advisory Council (ASPAC), DoHA, State and Territory Health Departments, police, relevant peak bodies and service providers, forensic pathologists, funeral directors and researchers. Given the diversity of professions represented, this committee is well positioned to lead a collaborative approach to standardising reporting of suicide in Australia. A membership list for the NCSRS is included in Appendix A.

SPA has been in a unique position to establish the NCSRS; drawing on its status as a broad-based organisation that brings together diverse interests across disciplines, practitioners, researchers, and those in the community affected by suicide and self-harm. This approach to advocacy within the suicide prevention sector and in this specific instance with regards to suicide statistical reporting has enabled SPA to work across government (federal, state and local) and communities to draw together a cross-jurisdictional collective. The importance of SPA's ongoing role as the coordinating body for the NCSRS was endorsed at the September 2009 workshop.

Research has shown that recent suicide statistics in Australia are characterised by underreporting and inconsistency across regions (AIHW, 2009). This has implications for policy development, monitoring and evaluation and can lead to mis-informed and mis-directed prevention, intervention and postvention activities. Critically for suicide prevention initiatives, this may result in inadequate resource allocation and neglect of at-risk groups and regions. Arising from these concerns the NCSRS is committed:

1. To achieve cross-jurisdictional and multi-party agreement on adequate, standard and operationalised criteria and reporting formats for suicide and related data.

2. To work collaboratively across the range of stakeholders and projects addressing this issue towards systemic reform.

3. To identify gaps and priorities for the development of complementary projects to further the broad agenda of standardised reporting on suicide.

4. To establish working groups and pilot projects to implement these projects.

5. To collaboratively develop recommendations for changes within various components of the system as well as at a systemic level.

6. To identify resource implications of any proposed reform.

7. To develop a proposed implementation strategy to pilot and then implement national reform in standardised reporting on suicide.

In this regard, the NCSRS is grateful for the opportunity to make a submission to the Senate Inquiry into Suicide in Australia addressing in particular Term of Reference (TOR)(b):

The accuracy of suicide reporting in Australia, factors that may impede accurate identification and recording of possible suicides, (and the consequences of any under-reporting on understanding risk factors and providing services to those at risk).

The NCSRS acknowledges the high quality of Senate Inquiry submissions that address TOR (b) to date, and wishes to refer the Senate Committee in particular to the submissions received from members of the NCSRS including but not limited to:

- National Coroners Information System
- Australian Bureau of Statistics
- Suicide Prevention Australia
- Joint Submission from Lifeline Australia, Suicide Prevention Australia, The Inspire Foundation, OzHelp Foundation, The Salvation Army, The Mental Health Council of Australia and the Brain and Mind Research Institute, University of Sydney.

The NCSRS also refers the Senate Committee to the soon to be published journal article:

De Leo, D., Dudley, M., Aebersold, C., Mendoza, J., Barnes, M., Harrison, J.E., Ranson, D. (2010) 'Achieving standardised reporting of suicide in Australia: rationale and program for change'. *Medical Journal of Australia (*In Press).

A copy of this article has been attached as Appendix D as a confidential, not for publication document.

Due to the depth of information provided by the above mentioned papers with regards to the accuracy and associated problems of suicide statistics in Australia, the current submission does not intend to restate the problems. Rather, this submission is focused on the priorities and plans identified by the NCSRS to set in motion reforms to improve suicide reporting in Australia.

The NCSRS has identified priorities and plans for achieving standardised and accurate reporting of suicide as originating in three related domains as well as broader systemic issues:

1. Information to Coroners
2. Coronial Inquest and Reporting
3. Data Coding and Statistical Reporting
4. Systemic Reform

The recommendations in this submission are structured to align with these sections of the system of mortality data collection and reporting.

Finally, the NCSRS would be pleased to provide further information to the Senate Committee throughout the inquiry process. Requests for information or witness testimony should be coordinated through SPA.

1. INFORMATION TO CORONERS

A. COLLECTION OF INFORMATION BY POLICE

Police are often the first responders to a suspected suicide or suicide attempt and provide a vital role in the process of gathering information for use by coroners, pathologists and other death investigators.

Recent progress has been made towards the implementation of a national standard form for police, to aid the collection of information regarding a death reported to a coroner. However, four of the eight States and Territories are yet to implement the form and there are inconsistencies in the use of the form. Technology and resource constraints are generally cited as the primary reasons for delay in adopting the form.

Correct use of the standardised form aids the investigation process and is essential for information completeness and quality. Mental health and suicide prevention education and training for police, including highlighting the public health and policy implications of quality data and specialised training for attending a death, will be beneficial for information quality as well as addressing the emotional impact and occupational health and safety concerns of attending suicide deaths.

Ongoing review and improvement of both the standardised form and education and training programs is vital to ensure quality of suicide statistics into the future.

NCSRS Action to Date: NCSRS is in the process of establishing a project group to examine this issue as a matter of priority.

Recommendation 1A: Government support, including resources and funding, for the national implementation of the standardised police form and associated education and training, as well as ongoing review, be provided as a matter of urgent priority.

B. 'PSYCHO-SOCIAL AUTOPSIES'

A range of information is gathered during a police investigation and undertaken on behalf of a coroner. This information has the potential to inform both coronial determinations and suicide prevention activities. The collection of more wide ranging background information concerning the deceased's social life and relationships and a complete medical and mental health history may assist the determination of suicide intent or risk. While many coroners do this, it is neither standard practice nor is it collated in a standardised manner.

Sources of information to be considered for collection in a psycho-social autopsy where suicide is indicated may include support and service providers, family members, doctors, the Family Law Court, schools, workplaces, and government departments (e.g. health, community services and justice).

Types of information to be collected in a psycho-social autopsy should include mental health, drug and alcohol, suicidal ideation, medical and criminal history as well as social and cultural factors such as relationship and employment status (including business and farm breakdown), Indigenous status and gay, lesbian, bisexual and transgender (GLBT) status. Whilst there is evidence that certain social and cultural factors provide increased risk of suicide, they are currently not consistently or routinely collected nor reported on.

NCSRS Action to Date: NCSRS is in the process of establishing a project group to examine this issue as a matter of priority.

Recommendation 1B: 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.

C. UNDER-REPORTING DUE TO AMBIGUOUS OR MISSING RECORDS

Undercounting of suicides occurs for a number of reasons, including practices affecting records on which ABS relies, missing information (e.g. use of "unknown" as an response option), ambiguous information regarding intent (e.g. single vehicle road crashes, drowning), underreporting of deaths by overdose in terminally ill patients, differential ascertainment (e.g. between jurisdictions), or lack of recorded information concerning some groups for example Indigenous identification (AIHW, 2007; SPA, 2008) or GLBT status (SPA, 2009). Under reporting of GLBT and Indigenous status is a major concern given the higher rate of suicide among these population groups revealed by existing data; a proactive approach to identifying individual demographics, such as enquiries with family or community members, would improve the accuracy of reporting.

Improvements in the investigation process and data collection tools will assist in addressing some of these issues and inform suicide prevention activities, particularly when used in combination with graded scales of intent classification (see section 2 B).

NCSRS Action to Date: The NCSRS has identified this as an area for future investigation.

Recommendation 1C: Implement systems which prompt focused responses, particularly of key demographic factors indicative of suicide risk such as Indigenous identity and GLBT status, and encourage elaboration when completing data collection tools during an investigation. For example discourage or limit the use of "unknown" response options. Strategies may include cascading questions when risk is identified on police forms and for example, if Indigenous status is not known, an explanation of why and process to query further is required.

D. MODELS OF DATA LINKAGE AND SHARING OF EXPERTISE

The NCSRS supports the investigation of a system for use of unique patient identifiers across the Australian healthcare system. Access to an individual's linked healthcare data, with strict privacy safeguards, has the potential to improve completeness, efficiency and effectiveness of information provision to coronial inquiries and subsequent identification and analysis of suicides.

The establishment of relationships and pathways of communication between police, coroners and relevant government departments and service providers, can provide benefits including improved identification of suicides and rapid response of support services to bereaved communities (for example see pathways in the Northern Territory between the coroner's office and Department of Health and Families Mental Health Liaison Officers).

NCSRS Action to Date: The NCSRS has identified this as an area for future investigation.

Recommendation 1D: Commission research into models of data linkage and pathways for the sharing of expertise between agencies in the investigation of suspected suicide cases. The potential for implementation of such models / pathways to be transposed across States and Territories should be considered. A national patient identifier system should be introduced.

E. ARTICULATION OF *INTENT AND MANNER OF DEATH* TO CORONER

Articulation of expert assessments of *intent* of death (for example homicide, suicide, accident, etc), as well as *manner* of death (for example car accident, hanging) and *cause* of death (for example, head injury, asphyxiation) at key stages of an investigation (for example by forensic pathologists, experts called on for psycho-social autopsy such as Psychiatrist or Health practitioner, police, etc) may provide valuable expert advice for consideration by the coroner and assist in decision-making, as well as for subsequent coding by NCIS and ABS where a coronial finding on intent is not provided. A considerable number of cases have been identified where an explicit coronial finding of intent is not made, however manner of death may be one commonly used for suicide (such as hanging) but in the absence of other reports indicating intent, coroners and subsequently coders may be unable to classify these deaths as suicide.

NCSRS Action to Date: The NCSRS has identified this as an area for future investigation.

Recommendation 1E: Introduce mechanism for *intent*, *cause* and *manner of death* to be articulated at key stages of an investigation to assist coroners in decision-making.

F. IDENTIFYING PROBABLE 'REPORTABLE DEATHS' WHICH WERE NOT REPORTED TO CORONERS

Whilst all suspected suicides should be identified as 'reportable deaths' and subject to coronial inquiry, a formal filtering process in place at the Victorian Registry of Births, Deaths and Marriages has found a concerning number of cases, including suicides, which were incorrectly certified as non-reportable death. The extent of similar misreporting in other jurisdictions is not known.

NCSRS Action to Date: The NCSRS has identified this as an area for future investigation.

Recommendation 1F: Commission inter-sectoral, collaboratively funded research to determine the extent and causes of misreporting of reportable deaths in all jurisdictions. Implement corrective actions as appropriate.

2. CORONIAL INQUEST AND REPORTING

A. CORE DATA SET REQUIREMENTS AND ASSOCIATED LEGISLATIVE REFORM

To support accurate and consistent national reporting of suicide, coronial reporting must involve consistent requirements and interpretation across jurisdictions and must contain a core set of information to be coded and reported, to then be made available for use by policy makers, researchers and practitioners via the ABS. This core data set should include findings on 'cause of death' as well as 'manner' and 'intent' (see section 2 B for further discussion of 'intent'). This core set of data should also be designed to allow for linkage with supplementary primary data sets to allow more comprehensive analysis of issues (for example cross-analysis of suicide statistics and data from the National Survey of Mental Health and Wellbeing).

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.

A robust framework for the reporting of a core set of data by coroners will assist NCIS and ABS coders to make informed decisions in their coding processes and support improvements in suicide statistics. While coroners will still be required to maintain a high standard of proof when making a finding of suicide, subsequent coding and analysis may take all available information into consideration for research, reporting and service development purposes.

NCSRS Action to Date: NCSRS is in the process of establishing a project group to examine this issue as a matter of priority.

Recommendation 2A: Define and establish a core data set drawn from coronial reports, and implement associated legislative reform to ensure a unified system and practice across jurisdictions.

B. THE DEFINITION OF 'INTENT' AND A STANDARDISED GRADED SCALE FOR CODING

There is no clearly defined legal definition of suicide 'intent' consistently adopted in Australia. Ambiguities exist for coroners in cases where 'intentional self harm' is suspected or confirmed, yet 'suicide / intent to die' is unclear, or in situations where suicide is considered likely, yet impossible to be proven (for example single motor vehicle accidents).

Coroners are currently not explicitly required in any jurisdiction to report on intent. The high standard of legal proof required of coroners in making a finding of suicide according to the Briginshaw Principle causes many likely, possible and probable suicide deaths to *not* be reported as suicide by coroners and subsequently *not* coded as such in NCIS or ABS. This legal standard of proof is unnecessarily restrictive for purposes of research and policy planning statistics. NCSRS advocates the consideration of a graded

scale of intent to be introduced that complements coronial reporting requirements and can be utilised at subsequent data use stages for research and statistical purposes.

Psycho-social autopsies and core sets of coronial data will assist coroners and coders to make informed decisions about 'possible', 'probable' or 'certain' suicidal intent. Any such graded classification must be validated by research.

NCSRS Action to Date: NCSRS is in the process of establishing a project group to examine this issue as a matter of priority.

Recommendation 2B: Investigation of the data requirements of NCIS and ABS coders, and subsequent users of data (for example researchers). Research, develop, validate and introduce standardised graded scales of intent to be used within the coronial process to satisfy data user requirements.

C. CORONIAL COMMUNICATIONS DURING THE INVESTIGATION PROCESS

Coroners request a range of information during the course of a coronial investigation. One form of communication is letters distributed to investigating police officers, relevant experts (for example General Practitioners), and the family of the deceased. These letters vary in function but generally assist in informing the recipient of the investigation process and direct the collection of information. Appropriate content, process and timing of such letters have been found in Victoria to increase the effectiveness and efficiency of the inquest process.

NCSRS Action to Date: The NCSRS has identified this as an area for future investigation.

Recommendation 2C: In consultation with communication recipients, review communications by coroners' offices to police, experts, and the family of the deceased, directing the investigation process and the collection of data, across all jurisdictions. The content, process and timing of distribution of communications, including letters, should be reviewed and the potential for standardisation across jurisdictions considered.

D. INCREASING RESOURCES TO IMPROVE THE TIMELINESS AND ACCURACY OF DATA ENTRY INTO NCIS

The timeliness of data is as pertinent as its accuracy. Significant backlogs currently occur in NCIS databases as data is delayed through the coronial court system due to process and resource issues (particularly limited coronial clerks). This feeds through to ABS data which is delayed as a result (Walker and Madden 2008). This delay has been identified as one of the most significant issues in the external causes of death data in Australia.

Improvements in the timely utilization of existing data fields, such as 'Intent Notification' in NCIS, may if validated, assist in improving timeliness and quality of suicide data.

NCSRS Action to Date: NCSRS is in the process of establishing a project group to examine this issue as a matter of priority.

Recommendation 2D: A review of the resources required to achieve timely and accurate data entry into NCIS needs to be determined and recommendations made.

E. CORONERS' RELUCTANCE TO MAKE DETERMINATIONS OF SUICIDE AND THEIR ROLE IN ADDRESSING PUBLIC HEALTH ISSUES

Research evidence suggests that coroners are at times reluctant to make a finding of suicide (in particular in cases of child suicide or when it is known it will cause family or community distress or effect insurance claims) and there are significant variations in coroners' interpretation of their requirements and ability to report on intent (refer to section 2 A for more information on intent).

The coronial investigation process nevertheless presents significant potential to inform reliable coding practices and to accurately understand the risk factors and inform suicide prevention activities. In this manner, coroners play a vital role in improving public health.

The development and implementation of strategies aimed at de-stigmatising suicide in the community and promoting the importance of the coronial process in suicide prevention and public health is important (refer to section 2 A for information on associated legislative reform for coronial processes).

NCSRS Action to Date: The NCSRS has identified this as an area for future investigation.

Recommendation 2E: Undertake collaborative work with coroners, forensic counselling services and those recently bereaved by suicide, to identify and examine those situations where suicide determinations may be at variance with families' wishes. Develop and implement strategies aimed at de-stigmatising suicide in the community and promoting the importance of the coronial process in suicide prevention.

F. INCREASE RESOURCING FOR FULL TIME CORONERS

The proportion of full-time coroners employed varies across jurisdictions, with regional areas particularly under resourced. Shortages in full-time staff lead to delays in the finalising of coronial investigations, resulting in extended periods of distress for bereaved families and a high number of 'open' cases, with flow on effects to the timeliness and accuracy of reported suicide statistics. The use of full-time coroners as opposed to Magistrates acting as coroners would also improve consistency in reporting practices, with a further option being that only full-time coroners deal with cases of suspected suicide.

NCSRS Action to Date: The NCSRS has identified this as an area for future investigation.

Recommendation 2F: Increased resourcing for appointing, training and retaining full time coroners.

G. SPECIALIST MEDICAL ADVICE FOR CORONERS

Forensic autopsy reports are provided for coroners during their investigations; however historic medical reports and advice, as well as wider medical and health reports (such as Psychiatric reports or advice) are not consistently provided or sought. Such reports would considerably assist coroners and subsequently NCIS and ABS coders in determining intent of death.

While coroners regularly consult medical advice in the form of forensic reports during their investigations, the recording and communication of the medical findings of death are not consistently passed to ABS. Access to a standardised medical autopsy form, separate to the coroner's report would assist NCIS and ABS coders to accurately recognize suicides and possible suicides that remain undetermined in coronial reports. Medical autopsy reports for example should include notation of the presence or absence of scars on wrists or other markers of previous self-harm or attempted suicide, presence or absence of medical disease that might cause depression (e.g. brain tumour) or precipitate suicide (e.g. recent diagnosis of cancer or HIV-AIDS), presence or absence of drugs that may cause depression or psychosis (including evidence acute and chronic alcoholism and drug abuse), and, if under treatment for depressive illness, presence or absence of anti-depressant drugs at an adequate therapeutic level. This information would contribute significantly to the consistency and comprehensiveness of coronial reports and subsequent NCIS and ABS coding.

NCSRS Action to Date: The NCSRS has identified this as an area for future investigation.

Recommendation 2G: Jurisdictional variations in the utilisation of medical advice be standardised according to best practice. Medical advice in the form of historic medical records as well as wider medical reports (such as Psychiatric) should be included in standard reports when suicide is suspected. Medical autopsy reports to be integrated as a core component of the coronial process to provide expert advice when determining cause of death and to inform subsequent coding.

H. SUICIDE AND INSURANCE

Life insurance policies that place restrictions on claims for death by suicide impose a further disincentive to provide evidence of suicide intent (including attempts to conceal intent or select an ambiguous method by the deceased). Such clauses can contribute to increased emotional and financial distress for bereaved family members.

NCSRS Action to Date: The NCSRS has identified this as an area for future investigation.

Recommendation 2H: Life insurance policies need to be examined to reflect changes in the legal treatment of suicide and with a view to balancing public and insurance industry interest and minimising distress for bereaved families.

3. DATA CODING AND STATISTICAL REPORTING

A. GUIDELINES AND CONSISTENT CRITERIA FOR CODING STAFF IN ALL AGENCIES

Inconsistencies that appear in suicide statistics often arise from the variations in coding practices, terminology, criteria and guidelines that occur throughout the mortality data system. The NCSRS supports the development of consistent guidelines for coding staff across all stakeholder organisations to improve uniformity of terminology and coding processes.

The NCSRS acknowledges the improvements implemented by NCIS and ABS in this area recently, and advocates for continued dialogue between stakeholders to address ongoing inconsistencies.

NCSRS Action to Date: NCSRS is in the process of establishing a project group to examine this issue as a matter of priority.

Recommendation 3A: The establishment of consistent guidelines and criteria for coding staff in all bodies.

B. INCREASED RESOURCES FOR CODING SYSTEM DEVELOPMENT, UTILISATION AND MAINTENANCE

Improved and consistent guidelines for coding staff need to be supported by increased resources for the hiring, training and retention of staff, the procurement of efficient technologies and the ongoing development of the data coding systems.

NCSRS Action to Date: NCSRS is in the process of establishing a project group to examine this issue as a matter of priority.

Recommendation 3B: Increased resources for the development of uniform systems and their ongoing utilization and maintenance.

C. INVOLVEMENT AND INPUT TO ICD-11 DEVELOPMENT

The ABS is required to use the International Classification of Disease (ICD) codes when compiling death data. The ICD coding classifications necessitate a legal or medical ruling before ABS can code a death as suicide. This requires coroners' cases to be closed at the time of ABS data compilation, as well as a higher standard of proof than is necessary for research and policy development purposes.

The development of ICD-11 is currently underway. This is anticipated to be a major revision with significant changes to mental health classification. Australia's engagement in the ICD-11 development process is managed through the AIHW, which hosts the World Health Organization Collaborating Centre for the Family of International Classifications (WHO-FIC). AIHW has engaged coding experts from the

Australian Centre for Clinical Terminology and Information, University of Wollongong and the National Centre for Health Information Research and Training at the Queensland University of Technology to manage local input to the revision process, in addition to the input expected from individual representatives on Topic Advisory Groups*.*

It is important that two-way communication is facilitated between representatives of Australian suicide statistics, such as the NCSRS and the Australian WHO-FIC Collaborating Centre and relevant international groups such as the ICD Revision Steering Group, Mortality Reference Group and Topic Advisory Groups and the International Association for Suicide Prevention (IASP) Task Force on National Systems for Certifying Suicidal Deaths. Such international dialogue will promote consistency and quality in international suicide data.

NCSRS Action to Date: The NCSRS has identified this as an area for future investigation.

Recommendation 3C: Facilitate two-way communication between representatives of Australian suicide statistics and relevant international groups to promote consistency and quality in international suicide data. This includes influencing the development of ICD-11 to ensure the new classifications are appropriate to the Australian context and suicide mortality data in particular.

D. ELEVATING THE IMPORTANCE OF MORTALITY DATA WITHIN NHISSC

To ensure the consistent and accepted status of mortality data in Australia, there is a need for clearer portfolio responsibilities and allocation of appropriate resources. Elevating the importance of mortality data, including suicide data, within the National Health Information Standards and Statistics Committee (NHISSC) will assist in achieving this aim.

NCSRS Action to Date: The NCSRS has identified this as an area for future investigation.

Recommendation 3D: Assign clear portfolio responsibilities with appropriate resource allocation, and elevate the importance of mortality data within the NHISSC.

4. SYSTEMIC REFORM

A. INFORMATION DEVELOPMENT PLAN (IDP)

The NCSRS has identified the need to develop an IDP to identify user needs for suicide (and suicide attempt) statistics and to develop strategies to meet these needs. In preparing an IDP, a comprehensive survey of currently available suicide data will be conducted, gaps and deficiencies in data identified, and priorities and strategies to achieve an appropriate range of suicide data prepared. Given the complexities of suicide, the IDP will consider data beyond the health paradigm.

The preparation of an IDP is necessarily a highly consultative and collaborative process, and will require involved parties to allocate significant resources and assume appropriate responsibilities.

It is the view of the NCSRS that an IDP is an essential step on the road to achieving a quality system of suicide data in Australia.

NCSRS Action to Date: NCSRS is in the process of establishing a project group to examine this issue as a matter of priority.

Recommendation 4A: Provide support and resources for the preparation of an Information Development Plan addressing suicide data in Australia.

B. WEB PORTAL FOR SUICIDE DATA

Following the development of an IDP, it is envisaged that a web portal be created that will collate all suicide statistics for easy and consistent use by researchers, policy developers, service providers and other data users.

NCSRS Action to Date: The NCSRS has identified this as an area for future investigation.

Recommendation 4B: A web portal be developed and made available, bringing together all available data relating to suicide prevention.

C. MULTIPLE CAUSE AND CONDITION DATA

The ABS codes every condition or cause of death listed on the medical certificate or in the Coroner's report. However, this data is not consistently identified, extracted and analysed to explore relationships with suicide.

NCSRS Action to Date: The NCSRS has identified this as an area for future investigation.

Recommendation 4C: Commission research on multiple cause / condition data to explore relationships with suicide.

D. SUICIDE ATTEMPT DATA

In order to inform and evaluate suicide prevention activities, it is vital that the conceptual model of 'suicide data' be expanded to include data on suicide attempts. Suicide attempt data should also be supplemented by and distinguished from comprehensive data on incidences of non-suicidal self harm. This will require policy changes and data collection from a wide range of sources including, but not limited to, police and emergency departments.

NCSRS Action to Date: The NCSRS has identified this as an area for future investigation.

Recommendation 4D: Expand the conceptual model of 'suicide data' to include suicide attempts and self harm.

E. COMMUNICATION

The work being undertaken by the NCSRS is at the leading edge of examining suicide statistics, both on the Australian and international scene. The success to date of this cross-jurisdictional collective in securing multi-party agreement on suicide data by taking a collaborative view of systemic reform is worthy of acknowledgement.

While it has been publicly recognized that the official suicide statistics in Australia are an under-estimation of the actual number of deaths by suicide, the significant remedial actions being taken to address these complex issues has had less attention. In order to keep the Australian public well-informed of the positive actions being undertaken and the true state of suicide prevention, the NCSRS plans to develop a communications strategy in consultation with the Mindframe Initiative. This strategy will ensure accurate, non-sensationalised information is provided to the media and all key stakeholders outlining their obligations for responsible public reporting, properly explaining and representing the status of suicide statistics, and highlighting the potential impact of remedial actions on official suicide rates.

NCSRS Action to Date: The NCSRS has identified this as an area for future investigation.

Recommendation 4E: Support the development and implementation of a communications strategy in consultation with key stakeholders such as the media, government departments, coroners and suicide prevention organisations, to inform the public of the status of suicide statistics and any changes / impact on official suicide statistics.

CONCLUSION

The NCSRS is grateful for the opportunity to respond to the Senate Inquiry's request for submissions with an outline of the key issues that impact on TOR (b).

The above recommendations represent NCSRS discussions that incorporate the extensive experience and knowledge of suicide reporting issues among our members. The convening of NCSRS reflects the need for a collaborative and coordinated approach to the standardisation of suicide reporting in Australia. Through its membership NCSRS has harnessed the resolve of relevant stakeholders to identify and address the impediments to accurate identification and reporting of suicides. The NCSRS is committed to continuing its progress to date with the establishment of expert project groups to address each recommendation, while retaining its overall consultative and reference group functions.

Given the gravity of issues facing the NCSRS, as well as the complexities in the processes of information capture, distribution and reporting, and the involvement of all Australian jurisdictions, numerous organisations and many individuals, ongoing broad scale support of the group from the Australian and State and Territory Governments (including relevant departments and agencies) as well the community will be essential to its success. Enhancing this success will be appropriate resource allocation, assignment of accountabilities, and the facilitation of collaboration and coordination to implement the recommendations outlined in this submission and to ensure the continuous improvement of suicide reporting in Australia.

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SIGNATORIES

This submission has the support of the following individuals and organisations:

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APPENDIX A

Membership | National Committee for Standardised Reporting on Suicide

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Dr Noel Woodward | Head of Forensic Pathology Services, Victorian Institute of Forensic Medicine

Dr Charles Naylor | Chief Forensic Pathologist, Forensic and Scientific Services

Ms Helen Lucas | Registrar General, Registry of Births, Deaths and Marriages

Mr Laurie Glanfield | Director General, Attorney General Department of NSW

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Associate Professor James Harrison| Director, Research Centre for Injury Studies, School of Medicine, Flinders University

Dr Robert Parker| Director of Psychiatry, Top End Mental Health Services, Department of Health and Community Services Northern Territory

Emeritus Professor Ian Webster| Chairperson, Australian Suicide Prevention Advisory Council

Mr Chris Killick-Moran| Director, Suicide Prevention Programs Section, Mental Health and Suicide Prevention Programs Branch, Mental Health and Chronic Disease Division, Dept of Health & Ageing Australian Govt

Ms Suzy Saw | Adviser in the Data Analysis & Program Evaluation Section, Mental Health and Workforce Division

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Leading Senior Constable Sarah Hose | Coroners Assistant's Unit, State Coroner's Office

Acting Senior Sergeant David Dimsey | Coroners Assistant's Unit, State Coroner's Office

Leading Senior Constable Tania Cristiano | Detective Senior Sergeant, State Coroner's Office

Mr Cameron Herpich |Coordinator, Office of the State Coroner, Coronial Support Unit, Operations Support Command, Queensland Police Service

Dr Clive Cooke | Chief Pathologist, Department of Forensic Pathology, The Western Australian Centre for Pathology and Medical Research, Queen Elizabeth II Medical Centre

Dr Chris Lawrence | State Forensic Pathologist, Department of Forensic Medicine, Health & Human Services

Professor Roger Byard Marks |Chair of Pathology, The University of Adelaide

Professor Olaf Drummer | Head of Forensic Scientific Services, Victorian Institute of Forensic Medicine

Ms Susan Beaton | National Advisor on Suicide Prevention, Lifeline Australia

Mr Shawn Phillips | Executive Officer, WA Ministerial Council for Suicide Prevention, Telethon Institute for Child Health Research

Professor Richard Taylor| UNSW

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Dr Andrew Page | Senior Lecturer, Discipline of Epidemiology and Biostatistics, School of Population Health (SPH), University of Queensland

Professor Colin Tatz

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Ms Sue Walker |Associate Director, National Centre for Classification in Health School of Public Health Queensland University of Technology

Dr Andrew Stocky | Psychiatrist

Mr Marc Bryant | Mindframe Projects Manager, Hunter Institute of Mental Health

Ms Jaelea Skehan | Acting Director / Program Manager, Hunter Institute of Mental Health

Mr Trevor Hazell | Director, Hunter Institute of Mental Health

Mr John Mendoza |Director, ConNetica Consulting Pty Ltd (Chair, National Advisory Council on Mental Health Adjunct Professor, Health Science, University of the Sunshine Coast, Adjunct Associate Professor, Medicine, University of Sydney

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