ABS Causes of Death 2023: media & sector briefing – Q&A

On Thursday, 10 October 2024, a media and sector briefing was held for the release of the Australian Bureau of Statistics (ABS) 2023 Causes of Death data.

This document responds to questions asked by the webinar attendees and features input from the following organisations:

- Everymind
- The Australian Bureau of Statistics (ABS)
- The Australian Institute of Health and Welfare (AIHW)
- The National Suicide Prevention Office (NSPO)
- The Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention (CBPATSISP)
- Manna Institute
- Movember

Access translated summaries of the annual national suicide data through *Mindframe* and *Life in Mind*:

- *Mindframe* summary – presented at the webinar.
- *Life in Mind* summaries – national suicide data; states and territories suicide data; and Aboriginal and Torres Strait Islander suicide data.

For more information and detailed data, visit:

- Australian Institute of Health and Welfare (aihw.gov.au)
- Causes of Death, Australia, 2023 | Australian Bureau of Statistics (abs.gov.au)

National Suicide Prevention Office, Advice on the National Suicide Prevention Strategy Consultation draft:

- The draft Advice on the National Suicide Prevention Strategy is open for public consultation until midnight Sunday, 27 October 2024.
- To find out more visit: Public Consultation - Advice on the National Suicide Prevention Strategy Consultation draft | Have Your Say - National Mental Health Commission.

Q&A

Q: Noticing that male suicide rates over the years fluctuate more than female rates, have there been any studies to explore why this may be? Are males more impacted by broad external (e.g. political, financial) factors than females are?

Everymind: Since 1907, the male age-standardised suicide rate has been more variable than the female rate (Source: AIHW deaths by suicide over time).

It is challenging to determine what impacts suicide rates over time. Causality (that is, showing a direct cause-and-effect relationship) is hard to prove for complex social issues like suicide. Individual, economic and social factors interact in complex ways, making it difficult to isolate specific reasons for changes in rates. For that reason, it is extremely difficult to confidently put forward an explanation for an increase or decrease in suicide rates.

There is some evidence that male and female suicide rates respond differently to changes in unemployment rates and the Consumer Sentiment Index (CSI), which can reflect how people feel about their current or expected economic circumstances (Source: Botha & Nguyen, 2021).

Movember has reflected that factors such as identity formation, social connection (or lack thereof), purpose/meaning amidst financial stress, relationship breakdown and the divorce rate spike in recent years along with economic uncertainty may also have contributed.

Q: For the difference between rates for those in cities vs. remote areas having specific mental health conditions - do you think this is due to lack of access to be diagnosed or other risk factors?

Everymind: It is challenging to determine what impacts suicide rates over time. The ABS Causes of Death data can show us trends but is not able to tell us why there are trends.

Manna Institute: Research by The National Institute of Health published in 2023 indicated that rates of mental illness are similar in rural and urban Australia. However, risks are increased due to significant workforce shortages in rural regions. These risks can create further issues given there are higher rates of chronic disease and obesity and lower levels of social economic status (in short; more people with complex health and social needs but less services to help in prevention or crisis care).

It's important to remember that we should not just focus on how a region accesses services, we need an intersectional, culturally-informed individual approach. This means understanding how men *and* women *and* people who are non-binary experience mental health challenges, what helps them access care, in addition to what is available to them. Likewise, how Aboriginal and Torres Strait islander communities want to be supported, and seeking input from groups whose voices may have not been included.

Research reminds us that we need to better understand how strategies can reduce health disparities between urban and rural populations. This then provides space for communities to access care in the early stages of distress, when access is often least burdensome and most effective. This focus on geographic location, access and need, can be better understood to limit the ripple effect of impact when mental health support reaches a crisis point.

Q: Statement that 80% of suicides were for people under 65yrs, are we then saying 20% of suicides are for people over 65yrs?

ABS: 82.5% of people who died by suicide in 2023 were aged under 65 and 17.5% were aged over 65.

Q: Has there been any reasons identified for the 85+ rate for males decreasing in comparison to the 55-59 rate?

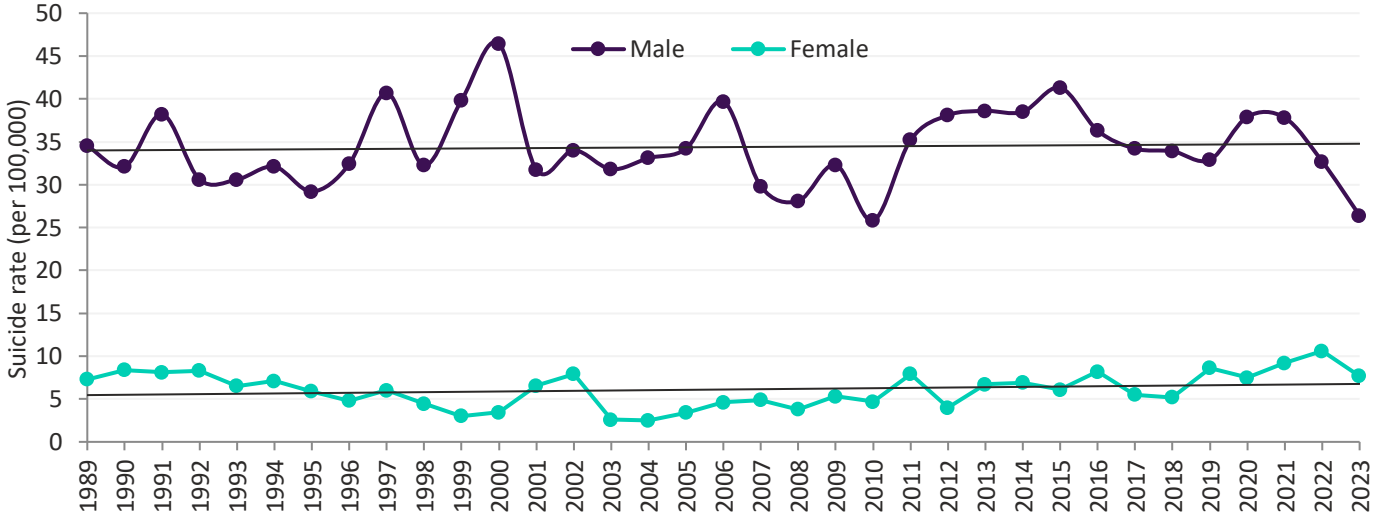
Q: Do we have any information that explains why there has been a decrease in suicides for older persons?

NSPO: The ABS Cause of Death data is able to show us trends, but not able to tell us why there are trends. Understanding why is of course critical to informing how we respond. Suicide is a complex phenomenon and so understanding why someone dies by suicide is often very complicated and personal. However, as was mentioned during the webinar, the National Suicide Prevention Office is currently developing a National Suicide Prevention Outcomes Framework to improve insights about what is working well and what needs to change. With continued improvements to suicide-related data in Australia and the emergence of the Suicide Prevention Outcomes Framework, we hope to be able to better understand what we need to do differently.

Everymind: It is challenging to determine what impacts suicide rates over time. Causality (that is, showing a direct cause-and-effect relationship) is hard to prove for complex social issues like suicide. Individual, economic and social factors interact in complex ways, making it difficult to isolate specific reasons for changes in rates. For that reason, it is extremely difficult to confidently put forward an explanation for an increase or decrease in suicide rates. When making comparisons over time, it is also important to consider how small numbers make rates quite volatile. For example, those aged 85+ account for 2.4% of male suicides and 3.3% of female suicides. So, the age-specific death rate for this age group is based on relatively small numbers, which means the rates can change a lot year to year (Source: AIHW Deaths by suicide over time).

An example of highly variable suicide rates can be seen in the graph of age-specific suicide rates for those aged 85+ below. For males, if we look at the last three to four years, there seems to be quite a significant drop in suicide rates. However, when we look over the entire time series, there have been many ups and downs, and it is difficult to see a clear, consistent trend.

It is also important to note that 2022 and 2023 data is still subject to change as coronial investigations are finalised so it can be some time before a complete trend can be analysed.



Q: Could you elaborate more on how systemic racism, social cohesion and politics - impact mental health of minority communities?

CBPATSISP: The following may assist in providing more information on this topic:

- Kairuz, C.A., Casanelia, L.M., Bennett-Brook, K. et al. Impact of racism and discrimination on physical and mental health among Aboriginal and Torres Strait Islander peoples living in Australia: a systematic scoping review. BMC Public Health 21, 1302 (2021). https://doi.org/10.1186/s12889-021-11363-x
- Sherwood, J. Colonisation – It's bad for your health: The context of Aboriginal health. Contemporary Nurse, 46(1), 28–40. (2013). https://doi.org/10.5172/conu.2013.46.1.28

Q: How does Torres Strait Islander and Aboriginal Culture play as a protective factor against suicides in Aboriginal and Torres Strait Islander communities?

CBPATSISP: The following may assist in providing more information on this topic:

- Black, Carlina; Frederico, Margarita; Bamblett, Muriel. 'Healing through culture': Aboriginal young people's experiences of social and emotional wellbeing impacts of cultural strengthening programs. La Trobe. Journal contribution (2024). https://doi.org/10.26181/25209593.v1

In addition, the book 'Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice' is a good resource for more background on Aboriginal mental health and wellbeing.

Q: The overseas-born suicide rates don't seem to have many for South/SE Asia/East Asia. Data collection/language limits or genuinely lower rates or don't know? Thanks.

ABS: Data on country of birth is collected from the death registration form. This form is most commonly filled out by the funeral director with family and friends providing responses. Countries are coded by the ABS to the Standard Australian Classification of Countries (SACC).

The rates presented in the Causes of Death publication have been age-standardised to enable comparison across countries and regions with different population sizes and age-structure of that population. For people who were born in South-East Asia there were 312 people who died by suicide over the five-year period between 2019-2023. While fewer people died due to suicide who were born in other regions across the same time period (for example, 129 people died by suicide who were born in Eastern Europe), the population size and structure results in a lower rate.

Q: How has personal history of self-harm risk factor trended over time? E.g. increase/stable/decrease?

ABS: Personal history of self-harm has a steady trend over time. Since the start of coding of psychosocial risk factors in 2017, over 20% of deaths due to suicide each year have a personal history of self-harm mentioned as a risk factor. When data is considered "final" (when the majority of coronial investigations for a year are closed and updated information has been sent to the ABS), personal history of self-harm is mentioned in approximately 25% of deaths due to suicide.

Everymind: The National Study of Mental Health and Wellbeing provides some insight into the prevalence of self-harm in Australia. In 2020-22, 1.7 million Australians aged 16–85 years (8.7%) had self-harmed in their lifetime and 342,100 (1.7%) had

self-harmed in the past 12 months. Self-harming behaviours weren't measured in the 2007 iteration of the National Study of Mental Health and Wellbeing so there is currently no population comparison over time.

The Australian Institute of Health and Welfare (AIHW) releases data on non-suicidal self-injury (self-harm) in NSW, Victoria, Queensland, Tasmania, ACT and the Northern Territory. However, interpretation of trends and changes in rates is complicated by large variations due, in part, to small numbers which produce large confidence intervals (Source: AIHW Ambulance attendances: Suicidal ideation, and suicidal and self-harm behaviours).

The Lancet Commission on self-harm was recently released and discusses how society and culture play a major role in driving self-harming behaviours and how tackle societal and commercial determinants of self-harming behaviours. While self-harm is often viewed as something that increases the likelihood of suicide (i.e., a risk factor), it is important not to pathologise self-harm. This means we shouldn't automatically label it as a symptom of mental illness or assume it always signals suicidal intent. People engage in self-harming behaviour for a variety of reasons that don't necessarily involve wanting to end their lives. These motivations can include self-soothing, emotional regulation, communication, validation of identity, self-expression, or enacting a sense of power or agency. It's essential to understand these diverse motivations and not oversimplify how we conceptualise self-harm (Source: The Lancet Commission on self-harm).

Q: What work is being done to identify victims and perpetrators of domestic violence who die by suicide?

ABS: The ABS is currently looking at how victims and perpetrators of domestic violence who die by suicide could be better captured in the national mortality dataset. Currently, a perpetrator or victim domestic violence who dies by suicide does have psychosocial risk factors coded, with common codes used being those pertaining to spousal relationships and legal issues. While this is a start, it is recognised that issues on domestic violence nor if the person was a victim or perpetrator can be isolated in the dataset. The ABS is working to develop a framework using the psychosocial risk factor coding that would enable these factors to be analysed independently and provide important information on family and domestic violence in Australia. There are some challenges to this – for example, domestic violence is often described differently in coronial reports. A definition is required to enable the consistent recording of this information. The ABS will continue to consult and work with stakeholders on this topic.

AIHW: The relationship between family, sexual and domestic violence, and suicidal and self-harming behaviours, is of great concern to communities and governments. For example, the Coroners Court of Victoria released an analysis of their records, Experience of family violence among people who suicided, Victoria 2009-16. The AIHW is investigating what may be possible to analyse on this topic in the current data environment, such as the National Health Data Hub.

Everymind: In August 2024, the Australian Government received a final report from the expert panel appointed to undertake a rapid review of evidence-based approaches to prevent gender-based violence: Unlocking the Prevention Potential: accelerating action to end domestic, family and sexual violence (DFSV).

The report includes 27 recommendations, including some related to suicide.

- **Recommendation 13:** Governments to work together to strengthen multi-agency approaches and better manage risk, with a lens on harm and safety, for victim-survivors of DFSV, including risk of homicide and suicide. This should include developing and implementing risk assessment and management principles across relevant roles, strengthening information sharing within and across jurisdictions, introducing and expanding multi-agency responses, and strengthening systems responses to high-risk perpetrators.

- **Recommendation 21:** Governments to develop a consistent approach to death review processes and improve knowledge on the relationship between DFSV and suicide. This should include establishing and uplifting death review panels across all jurisdictions, strengthening national coordination and consistency of death review processes, and initiation an urgent inquiry into the relationship between DFSV victimisation and suicide,

The Coroner's Court of Victoria prepared a data summary on experiences of family violence among people who died by suicide in Victoria (2009-2016) to assist the expert review.

Between 2009 and 2016, 24.5% of suicides in Victoria had evidence that the person had experienced family violence (as a victim and/or perpetrator). Experiencing family violence was identified in a greater percentage of suicides among females (28.2%) than males (23.2%). These experiences are divided into three groups: "perpetrator only", "victim only" and "both victim and perpetrator".

Over 50% of people who died by suicide had only ever been perpetrators of family violence. 65.1% of the males were in the perpetrator only group, compared to 16.0% of females. Most females (62.1%) were in the victim only group.

The National Sexual Assault, Family and Domestic Violence Counselling Line – 1800 RESPECT (1800 737 732) – is available 24 hours a day, seven days a week for any Australian who has experienced, or is at risk of, family and domestic violence and/or sexual assault.

Q: In the last ABS 2021, page 5 Torres Strait Islander communities reported to have 0% anxiety and depression - why would this be the case?

Everymind: Apologies but we can't identify the document this question refers to based on the information supplied. If you asked this question and would like us to look into it, please send through a link to the document and the page number to everymind@health.nsw.gov.au.

Q: Was there any data in relation to LGBTQIA+?

ABS: The ABS does not currently have access to information on whether the person who died was LGBTIQA+. While this is currently a data gap, the ABS would support efforts to find ways to source this information for future datasets. As the ABS reports on all deaths in Australia, the ABS dataset would need to look at ways for this information to be included across the entire dataset which may be complex. While the ABS cannot speak on behalf of other organisations, the ABS is aware that important work is occurring across other organisations (especially those working in the suicide sector) looking at similar topics.

Everymind: The AIHW has been working to include the priority populations identified under *The National Mental Health and Suicide Prevention Agreement* (the Agreement) as part of the National Suicide and Self-harm Monitoring System. Under the agreement, governments have a responsibility to support priority populations, who may be at higher risk of mental ill health and suicide due to vulnerability caused by social, economic, and environmental circumstances.

Suicide among LGBTIQA+ people

Although many LGBTIQA+ people live healthy and happy lives, research suggests they are disproportionately impacted by suicide.

The increased risk of suicide among LGBTIQA+ individuals is not inherently linked to their sexuality, gender identity or intersex characteristics. Instead, these risks stem from psychological distress caused by related discrimination, prejudice, abuse and exclusion.

Data from the Australian Bureau of Statistics (ABS) National Study of Mental Health and Wellbeing shows that LGBTQ+ people are more likely to have self-harmed and have experienced suicidal thoughts than their heterosexual or cisgender peers.

- Almost half of all LGB+ people (47.8%) had thought about suicide in their lifetime, compared with just over one in seven heterosexual people (15.3%).
- More than one in four trans people aged 16–85 years (28.5%) had thought about suicide in their lifetime, compared with one in six cis people (16.5%).
- Four in five non-binary people (79.6%) had thought about suicide in their lifetime, compared to 14.9% of men and 18.0% of women.

More detailed findings from the ABS report are summarised on the *Life in Mind* portal.

The AIHW Suicide and Self-harm Monitoring System also presents data on suicidal thoughts, suicidal behaviours and self-harm among LGBTQ+ Australians from surveys targeting the LGBTIQ+ community: Private Lives 3 (PL3) and Writing Themselves In 4 (WTI4).