

# National Committee for Standardised Reporting on Suicide

## Workshop Notes

Tuesday 7<sup>th</sup> April 2009, Melbourne

### AIMS OF THE COMMITTEE

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 standardized 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 standardized reporting on suicide.

### OUTCOMES OF THE WORKSHOP

At the completion of the workshop the Committee will have:

- Identified and summarized the current challenges in standardized reporting of suicide across various jurisdictions and areas of reporting across the system.
- Identified the range of current knowledge, research and projects addressing the problems, recent changes and projects working towards remedies.
- Identified the current gaps where further work is required.
- Articulate the nature of data required across the system, what is recorded consistently, by whom and how this can be improved.
- Explored what preliminary recommendations can be made on systemic reform.
- Established the relevant working groups / projects required to address the recommendations.
- Clarified the structure and purpose of the Committee and working groups.
- Identified the resource requirements to implement the projects.
- Identified the key components and process for establishing recommendations for reform and implementation strategy.
- Explored briefly the issues of timelines, anticipated resource implications and communication strategy for any recommendations and implementation.

# Current challenges in standardised reporting

## 1. Information to Coroners

*Including Police / Forensic Pathologists / Mental Health Reports / other*

- Ambiguities of particular methods or circumstances associated with putative suicide deaths
- Lack of standardised reporting and classification procedures e.g. relating to health and mental health (the eight states of Australia adopt different forms and procedures in classifying causes of death). No systematic way of obtaining information from a variety of potentially useful sources e.g. GPs, schools, mental health professionals, DOCS etc.
- Legislative constraints
- Social position of the deceased
- The association of suicide with euthanasia and/or chronic illness in older people
- Falsification to enable insurance claims
- Inconsistent use of Police form section 13 across jurisdictions nationally, however some progress in this implementation

## 2. Coronial inquest and reporting

- Burden of proof for coroners making a positive finding of suicide differs from the statistical requirements for research / policy purposes
- Differences in legislation and practice across jurisdictions
- Interpretations of role in making a finding on intent vary
- Inconsistencies and lack of systematic data collection/capture (see information to coroners above) impact on ability to make coronial finding on intent
- Though coroners may rule on intent (and are the only entity that makes a legal determination about it), they are not explicitly required in Coroners Acts to do so.
- Stigma associated with suicide and mental illnesses is a constant theme: sympathy with feelings of family (particularly in the case of children and young people) and personal opinions about stigmatization might render coroners particularly reluctant in determining suicidal intent.

## 3. Data coding and reporting

*Including Coronial Clerks / NCIS / ABS*

- Periods of classification system revisions (e.g. the transition from ICD-8 to ICD-9 and from ICD-9 to ICD-10), in which significant alterations in natural trends of mortality data may occur
- Inconsistencies in data collection and reporting procedures as noted above impact on consistency in coding across jurisdictions
- The impact of former processes - now superseded e.g. ABS not updating data file information once annual causes of death statistics are published.
- The requirement to code intent for every external cause of death within the NCIS is often problematic in the absence of a clear coronial determination about this element. In the absence of coronial determinations of intent, coding on the NCIS can reflect ISH deaths only in the small number of cases where it is beyond doubt that the deceased intended to die.
- The lack of collective shared expertise in assigning causes of death in doubtful cases (ensuring data quality).
- ABS outputs may also be affected by timing of compilations, but also by multiple causes of death, the number of staff handling workloads and the training of staff in relation to validating data. ABS staff numbers have reduced by 90% in recent years.

# Recommended future strategies

## 1. Information to Coroners

### POLICE FORM:

Consistent implementation of the use of the national standard form 13 by police throughout all jurisdictions in Australia. NCIS has subsequently prepared a report in March 2009 on implementation of this form across State / Territory jurisdictions.

Inclusion of Psychological Autopsy (type) report – brief report to include risk factors, or potentially incorporated / reviewed into the standard police form, with cascading sections of information – ie if suicide is suspected, opens cascading section for other risk factors.

This form could also then be used not only as a data collection tool, but also incorporated as per mental health risk assessment forms as a tool for police to guide appropriate questioning relevant to risk factors.

The need for police training re interviewing in relation to such forms and risk factors including but not limited to mental health was also flagged.

The distinction between the inquisitorial role of police in providing facts in such cases, as opposed to an adversarial role was discussed, as well as the need for police to be briefed in the utility of the data.

### OTHER INFORMATION:

Better access to medical records would assist, including GPs, specialists, mental health.

Could include wider health and medical input, however there are complexities in this. For example could include hospital morbidity data – there is currently a trial of linking in with this data in WA. There is an issue of complexity around access to certain primary data eg ‘provider level’ data is difficult to access.

There is also a need for standardised reporting process in this area however, this may be achieved through expansion of section 13 – eg so for Police investigation process it guides when and who to gather further information from (eg health practitioners) – a standardised form guiding this investigation process would assist in making it usual / consistent practice.

### OTHER SUGGESTIONS:

Suggestion of having data collection methods whereby the ‘opt out’ is more work than filling in the detail – ie if select “don’t know” then need to explain why.

The introduction of consistent forms of data collection in all jurisdictions as well as across the system e.g. an extension of section 13 form (as used in NZ coroners’ offices), and standardised mental health data collection could be used as practical guide / checklist / template that has structured questions to guide the thinking process, similar to the CLS model (ref David Rason) with a cascading system for data collection processes rather than excessive resources being used to always gather all data.

Appointing, educating and training qualified and dedicated NCIS coders and police inquiry officers, with particular skills and/or familiarity in mental health and drug and alcohol.

Specific consultations and review of procedures to ensure the effective identification of indigenous suicides.

## **2. Coronial inquest and reporting**

Consistency in coronial processes with regards to reporting on intent with Chief Coroners advocating in each jurisdiction.

The need for ongoing education, coronial guidelines, bench books, practice notes were all flagged.

The need for legislative clarity re the explicit requirement to report on intent or potentially 'graded' intent was raised, as well as any legislation restricting specific reporting.

The advantage of more full-time coroners was discussed.

The use of coronial 'narrative' regarding circumstances surrounding death, as opposed to just medical cause / mechanism of death, may assist in pointing to suicide where cases are not as clearly defined for a coronial determination, but may be for coding / research purposes.

Obtaining agreement on a core concept and definition, and on operational case criteria. The latter should include a method for weighing uncertainty, for example, a graded determination of the likelihood of suicide, as 'beyond reasonable doubt', 'probable', or 'possible', based on structured criteria. This would enable clearer determinations whilst addressing the high burden of proof for positive finding.

Use of prompts and specified forms of words (e.g. 'was suicide considered in this case?').

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. Applying a model of therapeutic jurisprudence with a view to supporting families but also enabling data to be recorded and preserved to reflect the true facts about intent.

## **3. Data coding and reporting**

The need for clearer portfolio responsibilities and resources for mortality system in Australia.

Obtaining agreement on a core concept and definition.

The latter should include a method for weighing uncertainty, for example, a graded determination of the likelihood of suicide, as 'beyond reasonable doubt', 'probable', or 'possible', based on structured criteria and/or with guidelines for coronial clerks to apply in assigning probably / possible suicide to coding.

More resources for data entry into NCIS at the coroners courts required as well as to appoint, educate and train qualified and dedicated NCIS and ABS coders.

Clear direction regarding user needs and priorities to be defined including timeliness, accuracy, consistency.

Evaluating the new ICD-10 coding rules (operational criteria) as adopted by ABS.

Commissioning research to assess the resource implications of enhanced data collection and coding requirements for data stakeholders, assessing the potentially competing priorities of completeness, reliability and rapidity.

Commissioning research to elucidate what aspects of the recent decline in Australian suicide statistics are due to real changes and which are due to artefact.

Need to cost the resources required by various data stakeholders to maintain and enhance current information standards around suicide

## **Systemic approaches to change**

Important to consider the ways to consolidate the different purposes and burden of proof between coroners for legal purpose vs ABS for reporting purpose vs researchers and policy-makers.  
→ need to develop methods for preserving access to primary risk and demographic data that can be read in consistent ways, but with different criteria / benchmarks at different stages in the system.

The need for a clearer 'portfolio' for mortality systems, which currently don't sit anywhere

NCSRS will need to consult with the ABS Mortality Statistics Advisory Group (ABS MSAG), and the Australian Mortality Data Interest Group (AMDIG). There may be value talking with the Mortality Reference Group (subcommittee) of WHO, especially as ICD-10 is revised.

Important to consider how the case for standardised reporting on suicide relates to other issues of standardisation. Ensure that any new systems will examine ways to improve systems of reporting across the board where possible, rather than just in relation to suicide. Also need to ensure for example that any supplementary information collected that may indicate a risk factor for suicide is also considered in relation to other behaviours for which these factors may be indicating risk.

## **Practical implications to consider for any proposed reform**

To be further explored, including:

- Media communications strategy – coordinated, planned, well-timed effort with key bodies
- Research to better understand the decline in suicide statistics as to real changes and artefact
- Investigation to better understand the resource implications of enhanced data collection and coding
- Insurance industry reform regarding suicide given exceptions for suicide

## Next steps

Overall very positive feedback on the committee establishment and opportunity to work collaboratively across the various stakeholders on the issue.

Need to prioritise reform processes in each section of the system, with short- and long-term goals and ensure any reform process is manageable.

Identify other committee members to involve, including a role with the ability to advocate / coordinate across jurisdictions such as SCAG (Standing Committee of Attorneys General - Laurie Glanfield AM perhaps via C.Aebersold)

Establishment of priorities, potential working groups and projects to be determined based on initial workshop content in next meeting.

Implementation strategy to be developed at subsequent workshop

**Suggestion to hold an auxiliary 1 day workshop of the NCSRS with the Asia Pacific Coroners Conference in Canberra in November 2009, as well as a further 1 day workshop around mid year 2009.**