

Caution: some people may find some parts of this report distressing.

Please consider your personal needs carefully when reading this report about suicide in Tasmania. If this material raises concerns for you, contact Lifeline on 13 11 14 or another support option listed below.

While this report focuses on data, the Department of Health acknowledges the individuals, families and communities affected by suicide each year in Tasmania. The data in this report relates to the lives of Tasmanians that have died by suicide.

Aboriginal and Torres Strait Islander readers are advised that information relating to suicide of Aboriginal and Torres Strait Islander people is included in the report.

The Department of Health supports the use of the [Mindframe Guidelines](#) on responsible, accurate and safe reporting on suicide, mental illness and alcohol and other drugs. Please refer to these guidelines when reporting on statistics relating to suicide

Support Services

The information in this report may raise uncomfortable or distressing feelings. If you or someone you know is distressed or having thoughts of suicide or have been affected by suicide, please seek help through your GP or by contacting the following support services:

- Lifeline 13 11 14
www.lifeline.org.au
- Beyond Blue 1300 224 636
www.beyondblue.org.au/forums
- Suicide Call Back Services 1300 659 467
www.suicidecallbackservice.org.au
- Mensline Australia 1300 789 978
www.mensline.org.au
- Kids Helpline 1800 551 800
www.kidshelpline.com.au
- Tasmanian Aboriginal Centre Support Service 1800 132 260
- QLife Line LGBTI phone counselling service 1800 184 527
- Open Arms – Veterans and Families Counselling 1800 011 046
- Mental Health Services Helpline 1300 332 388

In an emergency call triple zero (000)

Report to the Tasmanian Government on Suicide in Tasmania

1 January 2012 - 31 December 2018

Authors: Dr Andrew Garrett
Senior Research Officer, Magistrates Court Coronial Division (Department of Justice)

Victor Stojcevski
Policy Manager, Magistrates Court (Department of Justice)

Publisher:
Department of Health

Date:
November 2021

© Crown in Right of the State of Tasmania November 2021

Foreword

This report provides an analysis of 505 deaths by suicide that were reported to, and investigated by, Tasmanian coroners throughout the period of 1 January 2012 and 31 December 2018.

I have commissioned the release of this second report on suicides in Tasmania, so that we can continue to build our understanding of suicide in this State and to enable an approach to suicide prevention policies and initiatives based on the best available Tasmanian information. The first report, the *Report to the Tasmanian Government on Suicide in Tasmania, 2012-2016* was publicly released in October 2020.

I would like to acknowledge the tragedy of all Tasmanians who have died by suicide, and I offer my deepest condolences to their families, friends, work colleagues, and their communities who are left behind and who miss them every day. I would also like to acknowledge the lived experience of people who have had a personal experience of suicidal distress.

Although the reporting period for this report pre-dates the COVID pandemic, it is important to acknowledge the impact that COVID continues to have on our communities, families, friends, and colleagues. We are fortunate in Tasmania that we haven't been as impacted as other states. However, the way in which our lives has been affected continues to create concern, and the impact of this should not be underestimated.

This report may raise uncomfortable or distressing feelings. The intention is to raise awareness of suicide and to guide conversations in a safe and appropriate way, which can assist in reducing the stigma associated with suicide. If reading this report does distress you, please seek timely support from your family, friends or work colleagues, or by contacting your GP, Lifeline on 13 11 14 or Beyond Blue on 1300 224 636.

I would like to acknowledge the important role of the media in relation to responsible reporting of suicide. The continued use of the evidence based Mindframe Media Guidelines by the Tasmanian media is greatly appreciated. Minimising details and means, location and graphic information associated with suicide deaths to reduce the risk for vulnerable people and to respect the privacy of loved ones who have been impacted by suicide is safe and responsible reporting.

The data for the report is collated from the Tasmanian Suicide Register (TSR). This report would not have been possible without the support of the Tasmanian Coroner, Her Honour Olivia McTaggart, who approves access to the TSR data and supports the ongoing role of the TSR informing both her office and broader policy development.

I would like to conclude by thanking the Magistrates Court of Tasmania particularly Mr Victor Stojcevski and Dr Andrew Garrett who have been instrumental in supporting and operating the TSR and for their efforts working with Tasmanian coroners, and the Mental Health, Alcohol and Drug Directorate, in particular Professor Ken Kirkby and Jane Austin, to finalise this report.

This report reveals that middle-aged men remain the group that are most likely to lose their lives to suicide. This entirely preventable tragedy is often poorly understood and often not spoken of when suicide is discussed. It is my hope that all men and those closest to them take some time to think about how to keep each other safe.



Dr Aaron Groves, Chief Psychiatrist, Tasmania

Contents

Foreword	3
Support services	5
Methodology and Preliminary notes	6
Data Sources	6
Inclusion Criteria	6
Scope of Analysis	6
Limitations	7
Presentation of Data	7
Note since last report	8
Summary and Key Findings	9
Chapter 1: Socio-demographics	11
Summary	11
Socio-economic Disadvantage	12
Employment and Occupation	13
Chapter 2: Overview of Suicides in Tasmania	15
Suicide Rates	15
Number of deaths by suicide by age group and year	16
Residential Location	17
Incident Location	18
Means of Suicide	19
Toxicological Testing: Identified Substances	20
Chapter 3: Mental and Physical Health and Access to Services	21
Mental Illness: Diagnosis	21
Mental Health: Access to Treatment and Legal Status	22
Mental Health: Treatment Provider	23
Physical Health: Diagnosis	24
Physical Health: Treatment Provider	25
Access to Health and Social Services	26
Contact with the Legal System	27
Chapter 4: Identified Stressors	28
Interpersonal and Family	28
Contextual and Situational	30
Appendix	31
Appendix 1: Mindframe Media Guidelines – Communicating about Suicide	31
Appendix 2: Overview of Socio-Economic Indexes for Areas (SEIFA)	32
Appendix 3: Overview of Occupational Categories	33
Appendix 4: Representation of Statistical Boundaries	35
Appendix 5: Overview of ICD-10 Coding Classifications	36
Appendix 6: Toxicology Testing	39

Support services

The data in this report relates to the lives of Tasmanians that have died by suicide.

It is acknowledged that this report may raise uncomfortable or distressing feelings.

If the report does distress you, please seek timely and appropriate support. For many of you this will be natural supports like family, friends and colleagues, but it is important for people to know that they can also contact:

Emergency Services 000

Other support services

- [Lifeline](#)¹ 13 11 14
- [Beyond Blue](#)² 1300 224 636
- [Suicide Call Back Service](#)³ 1300 659 467
- Mental Health Services Helpline 1300 332 388
- [Mensline Australia](#)⁴ 1300 789 978
- [Kids Helpline](#)⁵ 1800 551 800
- [Headspace](#)⁶ 1800 650 890
- Tasmanian Aboriginal Centre Aboriginal Support Service 1800 132 260
- QLife LGBTIQ+ phone counselling service 1800 184 527
- [Open Arms – Veterans and Families Counselling](#)⁷ 1800 011 046

¹ <http://www.lifeline.org.au/>

² <http://www.beyondblue.org.au/forums>

³ <http://www.suicidecallbackservice.org.au/>

⁴ <http://www.mensline.org.au/>

⁵ <http://www.kidshelpline.com.au/>

⁶ <http://www.headspace.org.au/>

⁷ <http://www.openarms.gov.au/>

Methodology and Preliminary notes

Data Sources

Data for this report is drawn from the Tasmanian Suicide Register (TSR), a collaborative project initiated in November 2017 between the Department of Health (Tasmania) and the Coronial Division of the Magistrates Court (Tasmania).

Australian Bureau of Statistics (ABS) (2012-2018) estimated resident population statistics were used to calculate death rates, and 2016 Socio-Economic Indexes for Australia (SEIFA) were used to classify levels of socio-economic disadvantage (Index of Relative Socio-economic Disadvantage (IRSD)) (See Appendix 2 for further details).

Inclusion Criteria

This report comprises suicide deaths occurring in Tasmania between 1 January 2012 and 31 December 2018. Classification of a suicide is based on coronial determination and the review of comprehensive evidence gathered as part of each coronial investigation. Only closed cases are included in this report. It is noted that there are a small number (less than ten) of suspected suicides that remain open within the reporting period, but due to ongoing investigation those cases are not included in this report.

It is acknowledged that there are some discrepancies in recording and classification of suicide at a jurisdictional level in Australia most notably due to variations in the level of information available to those classifying a death. The most commonly utilised Australian statistics of suicide-related deaths originate from the ABS annual reporting of Causes of Death data. The ABS code and classify mortality data based on the registration of deaths through *Births, Deaths and Marriages* which is further supplemented with information held by the National Coronial Information System (NCIS). ABS data includes the reporting of open cases, whereby a case has not been finalised and a determination of intent has not been reached by a coroner.

For the TSR, the research officer is located within the Coroner's office, enabling the most comprehensive review of all available evidence related to each suspected suicide case. This includes additional access to medical records, forensic and police reports, and historically relevant information provided by family, friends and peers of the deceased. The research officer also has the added benefit of discussing individual cases with coroners and other investigative officers, adding an extra level of accuracy when gathering information and interpreting coronial determinations and findings regarding intent.

Further, the TSR is based on all cases investigated by the Tasmanian Coroners' Office under the *Coroners Act 1995* (Tas), whereas the ABS organises state and territory-based mortality information according to the state or territory of residence of the deceased rather than the state or territory where the actual suicide occurred and was investigated, which may differ.

The variation in methods between the ABS and TSR, as described above, may yield some differences in reporting of deaths by suicide from year to year.

Scope of Analysis

Data in this report originates from coronial records that are routinely collected as part of coronial investigations into reportable deaths (as stipulated in the *Coroners Act 1995*).

Coronial investigations vary according to individual cases and include a wide-range of sources including police and forensic records, mental and physical health-related records, autopsy and toxicology reports, statements from family, friends, and peers, and any other records deemed to be appropriate for the investigation by the coroner

These files are examined by the research officer, and data captured in a Microsoft Access database referred to as the *Tasmanian Suicide Register (TSR)*. The TSR captures qualitative and quantitative data across a wide-range of fields, including socio-demographics, physical and mental health, interpersonal and contextual stressors, access to services (including government and non-government organisations), as well as capturing suicide method-specific details.

Data was extracted from the TSR for this report.

Limitations

Evidence for this report is examined utilising coronial records which can vary significantly in terms of depth and quality of evidence gathered during an investigation. Evidence is collected from a wide range of sources and will vary for each case. Data from this report should be interpreted with this in mind, in particular, that a lack of evidence of a factor does not guarantee that it was not present. Conversely, the presence of a factor does not indicate that the factor was a contributor to an outcome.

Reporting of suicide deaths in this report relies on coronial determinations to be finalised and therefore case numbers are open to fluctuate in future reports. Due to the complex nature of some investigations, determinations may take several years to be finalised and the case closed.

Presentation of Data

Data in this report includes suicide deaths that occurred over a seven-year period, from 1 January 2012 to 31 December 2018, and from here on will be referred to as 2012-2018.

In line with the national standards for reporting, categories may be suppressed when numbers are less than 5 and there are no appropriate or meaningful ways to aggregate the data. Where necessary for privacy reasons, numbers of less than 5 will be reported as 'NP' throughout this report. Any references to the symbol '≥' refers to 'equal to or greater than'.

To calculate Crude Death Rates (CDR, number of deaths per 100,000 population), the total number of cases in a given time period was divided by the total number of persons in the population, multiplied by 100,000. Estimated resident population figures (including age-specific and location-specific) published by the ABS from 2012 to 2018 were used to define the resident population in the CDR calculations.

$$CDR = \frac{\text{number of suicide deaths}}{\text{estimated resident population}} \times 100,000$$

As this report contains information on suicide deaths recorded over a period of seven years (2012-2018), the CDR was divided by seven to calculate the average annual rate.

$$\text{Average annual rate} = \frac{CDR}{\text{number of years}}$$

Note since last report

The first TSR report to Government discussed deaths occurring between 2012 and 2016. During this time, coronial access to medical records was largely limited to medical summaries provided by medical practitioners requested by coroners. These summaries were quite variable in length, and often only disclosed major medical events as deemed relevant by their treating physician. The ability of the TSR to code medical and psychiatric information for 2016 and prior deaths was limited to information contained in those reports. Since 2016 there has been a substantial improvement in access to hospital digital medical records (DMR) and electronic records from general practitioners. As a result, most coronial records now include greater insight into the presence and nature of medical and psychological conditions faced by individuals in the years prior to death. This improved access will provide more accurate information regarding health conditions in Tasmanian suicide deaths.

Summary and Key Findings

This section highlights the key findings in deaths by suicide from 2012 and 2018.

Of the 505 deaths by suicide in the Tasmanian Suicide Register between 2012 and 2018:

- The overall rate of suicide was 16.8 per 100,000 population.
- The highest rate of suicide occurred among 35 to 44 year age group (22.3 per 100,000 population).
- The lowest rate of suicide was in the 14 to 24 year age group (11.3 per 100,000 population).
- Nearly four times as many men (78 per cent) than women (22 per cent) died by suicide.
- Two thirds (65 per cent) were not in a relationship at the time of death.
- Nearly one quarter (23 per cent) of suicides occurred among people living in areas classified as the most disadvantaged and 15 per cent occurred in those living in the least disadvantaged areas of Tasmania.
- One third (36 per cent) were employed and 16 per cent were unemployed at the time of death.
- Two per cent of people who died by suicide reported a terminal illness at the time of death.
- Toxicology reports show that 86 per cent of persons who died by suicide had at least one substance identified, with 33 per cent having more than one substance group identified.
- The prevalence of pharmaceutical drugs was greater in females (87 per cent) than males (69 per cent), while illicit drugs were more common in males (15 per cent) than females (9 per cent).
- The majority (94 per cent) of people who died by suicide had at least one contextual or situational stressor, with males and females similarly affected. The two most common stressors were substance abuse or misuse (55 per cent) and experience of abuse or violence (48 per cent).
- Seventy-two per cent of deaths occurred in a residential setting with this proportion higher among females (76 per cent) than males (71 per cent).
- Nearly half (48 per cent) of those who died by suicide had contact with police, courts or corrections during their lifetime, occurring more commonly among males (50 per cent) than females (39 per cent).
- Around two thirds (64 per cent) had at least one previous diagnosis of a mental illness.
- The most commonly identified mental illnesses were mood (affective) disorders (50 per cent), followed by neurotic (anxiety), stress-related, and somatoform disorders (32 per cent).
- Two thirds (65 per cent) of people who died by suicide received at least one episode of mental health care in the 12 months prior to death and nearly half (47 per cent) received treatment in the six weeks prior to death.
- Five per cent of those who died by suicide were treated as an involuntary patient in the 12 months prior to death.
- Two thirds (65 per cent) had at least one reported physical illness and nearly half (46 per cent) experienced acute, chronic or cancer-related pain prior to death.
- Females had a higher prevalence of physical illness (76 per cent) and pain (63 per cent) than males (62 per cent and 41 per cent respectively).
- The majority of those who died by suicide had experienced at least one interpersonal and/or family stressor, with males and females similarly affected.
- Separation from a partner (actual or perceived) was the most common identified interpersonal / contextual stressor (55 per cent) followed by death of a family member (48 per cent) and conflict with partner/family (42 per cent and 40 per cent respectively).
- In 68 per cent of deaths the incident location was the same as the deceased's usual place of residence.
- One fifth (19 per cent) of persons who died by suicide were either retired or unable to work at the time of death either due to a mental and/or physical illness.

Note: The means of suicide in Tasmania for 2012 to 2018 are tabled in this report. This data should be discussed and reported sensitively and in line with the Mindframe Media Guidelines (Appendix 1).

This is the second report from the TSR to the Tasmanian Government on suicide in Tasmania. This report continues to build our understanding of suicide and benefits from the addition of 2017 and 2018 data.

The report draws on data from the TSR which demonstrates the aggregation of stressors and factors that may contribute to a person's suicidal distress and which may ultimately result in suicide.

The data illustrates that the highest rate of suicide occurred among the 35-to-44-year age group and the lowest rate of suicide was in the 14-to-24-year age group.

The data continues to demonstrate the range of interpersonal and family, and contextual and situational stressors that people have experienced and that were relevant to the suicide – stressors that may have occurred in the past or proximate to the suicide.

It remains the case that people who died by suicide in Tasmania accessed a range of services, both within and beyond the health sector in the lead-up to their death. This data points to a broad suicide prevention workforce with these interactions providing an opportunity for the workforce to respond compassionately to people in suicidal distress.

Suicide remains a complex problem with far-reaching impacts on individuals, families and communities. Our understanding of Tasmanian suicide data will deepen over time and subsequent reports will provide an opportunity to explore key themes in suicide in Tasmania.

Chapter I: Socio-demographics

Summary

Table I presents a general overview of the socio-demographic profile of suicides that occurred in Tasmania between 2012 and 2018.

- There was a total of 505 suicides reported in this time period
- The majority of suicides occurred among males (78%)
- The average age of suicide was 48.9 years, with an age range of 14-94 years
- The largest proportion of those who died by suicide were not in a relationship at the time of death (65%).

Table I: Socio-demographics of suicides, Tasmania 2012-2018

Socio-demographics	
Mean age (range) in years	48.9 (14-94) years
	N (%)
Males	394 (78%)
Females	111 (22%)
LGBTIQ	30 (6%)
Aboriginal or Torres Strait Islander	13 (3%)
Born overseas	79 (16%)
Speak a language other than English	30 (6%)
Relationship status	N (%)
Not in a relationship	330 (65%)
Married	97 (19%)
De-facto relationship	50 (10%)
Dating relationship / other (e.g. casual relationship)	28 (6%)
Children (biological or non-biological)	N (%)
Yes, at least one child	308 (61%)
Yes, at least one dependent child	116 (23%)

Socio-economic Disadvantage

Suicides occur in localities with different levels of relative socio-economic disadvantage. Table 2 below presents suicide numbers using the Index of Relative Socio-economic Disadvantage (IRSD) which is part of the Socio-Economic Indexes for Areas (SEIFA) classification (see Appendix 2 for details). This classification provides a summary of general socio-economic conditions including, measures of income, employment, and living conditions. It is important to note that the IRSD reflects the location where the deceased lived and does not reflect the circumstances of the individual. For comparison, proportions of the general Tasmanian population by IRSD are also presented.

Table 2 shows that between 2012 and 2018 in Tasmania:

- 23% of suicides occurred among people living in areas classified as the most disadvantaged and 15% of suicides occurred in those living in the least disadvantaged areas of Tasmania
- Compared to the general population, suicides tended to be over-represented in the more disadvantaged areas (quintiles 1 and 2) and under-represented in the least disadvantaged quintiles (quintiles 4 and 5).

Table 2: Number of suicides by Index of Relative Disadvantage (IRSD) (quintiles) and IRSD proportions in the Tasmanian general population, Tasmania 2012-2018

Index of Relative Disadvantage (IRSD)	N (%)	% Tas. Pop.
Quintile 1 (<i>most disadvantaged</i>)	114 (23%)	17%
Quintile 2	141 (28%)	25%
Quintile 3	109 (22%)	24%
Quintile 4	60 (12%)	15%
Quintile 5 (<i>least disadvantaged</i>)	74 (15%)	19%
Total	498 (100%)	100%

Note: this table excludes seven cases that did not have a fixed address within Tasmania and therefore could not be classified. Proportions do not differ when excluding these cases.

Quintiles divide a distribution into five equal groups. For SEIFA (IRSD), the distribution of scores are divided into five equal groups. The lowest scoring 20% of areas are given a quintile of 1, the second-lowest 20% of areas are given a quintile number of 2 and so on, up to the highest 20% of areas which are given a quintile number of 5.

ABS 2016 estimated resident population statistics were used to determine the proportion of the general Tasmanian population residing within each quintile.

Employment and Occupation

The following tables (3 and 4) present an overview of the employment profile of those who died by suicide between 2012 – 2018 in Tasmania.

Table 3 shows that between 2012 and 2018 in Tasmania:

- 36% of those who died by suicide were employed at the time of death
- 19% of persons who died by suicide were either retired, or unable to work at time of death either due to a mental and/or physical health illness
- 16% of persons who died by suicide were unemployed at the time of death.

Table 3: Number of suicides by employment status, Tasmanian 2012-2018

Employment status	N (%)
Employed (including workers compensation or extended medical leave)	182 (36%)
Unable to work (due to mental or physical health)	98 (19%)
Retired/Pensioner	96 (19%)
Unemployed	83 (16%)
Student	28 (6%)
Other (home duties, prisoners, Centrelink supported caring duties etc)	11 (2%)
Unknown status	7 (1%)
Total	505 (100%)

Note: Student refers to individuals enrolled in secondary school/college, or a program of study at a university, or vocational training provider (e.g. TAFE).

Note: percentages may not add to one hundred due to rounding errors.

As shown in Table 3, 36% of suicides occurred in persons who were employed. To further investigate suicide numbers by usual occupation, an individual's occupation at time of death was classified according to the Australian and New Zealand Standard Classification of Occupations (ANZSCO) index (for details on ANZSCO, see Appendix 3 Table 1A).

Table 4 below also allows for comparison to population level data by presenting the proportion of the general Tasmanian population according to occupation category. Table 4 shows that between 2012 and 2018 in Tasmania:

- Of those employed, technicians and trades workers formed the largest group (23%) of those who died by suicide, followed by labourers (17%). These two groups were disproportionately higher among suicides in comparison to the general Tasmanian population
- Sales workers accounted for 6% of suicide deaths, compared to 10% of the general Tasmanian population.

Table 4: Number of suicides by usual occupation among employed persons (over the age of 15 years) compared to proportions within the overall Tasmanian population, Tasmanian 2012-2018

Usual occupation*	N (%)	% Tas. Pop.^
Technicians and trades workers	41 (23%)	14%
Labourers	31 (17%)	12%
Professionals	25 (14%)	19%
Managers	25 (14%)	12%
Community and personal services workers	23 (13%)	12%
Machinery operators and drivers	16 (9%)	6%
Sales workers	11 (6%)	10%
Clerical and administration workers	10 (5%)	13%
Total	182 (100%)	100%

*Usual occupation is classified using the Australian and New Zealand Standard Classification of Occupations. See Appendix 3 Table 1A for classification details.

^ Proportions drawn from the 2016 ABS Census data: employed people aged 15 years and over:

https://quickstats.censusdata.abs.gov.au/census_services/getproduct/census/2016/quickstat/6?opendocument

Note: proportions reported by the ABS involve some adjustments to account for sampling variability and small cell sizes.

Chapter 2: Overview of Suicides in Tasmania

Suicide Rates

Between 2012 and 2018, 72 Tasmanians on average have died by suicide annually (ranging from 61 to 87).

Table 5 presents numbers and rates of suicide in Tasmania by age group and sex between the years 2012 and 2018.

- Suicide rates were highest among the 35 to 44 year age group (22.3 per 100,000 population) followed by the 45 to 54 year age group (20.0 per 100,000 population)
- Lowest suicide rate was in the 14 – 24 year age group (11.3 per 100,000 population)
- Suicide rates were higher among males than females in all age groups

Table 5: Numbers and annual average suicide rates (per 100,000 population) by age group and sex, Tasmania 2012-2018

Age group	Females N (rate)^	Males N (rate)	Total N (rate)
14 - 24 years	13 (5.4)	43 (16.7)	56 (11.3)
25 - 34 years	7 (3.3)	53 (25.1)	60 (14.2)
35 - 44 years	26 (11.8)	71 (33.3)	97 (22.3)
45 - 54 years	19 (7.5)	80 (32.9)	99 (20.0)
55 - 64 years	20 (7.2)	71 (28.9)	91 (18.3)
65+	26 (7.4)	76 (24.1)	102 (15.2)
Total	111 (7.2)	394 (26.6)	505 (16.8)

Note: 2012-2018 ABS estimated residential population figures were used to calculate annual age-specific rates

^ Calculations in this group included numbers of less than 10 and should be interpreted with a degree of caution

Number of deaths by suicide by age group and year

Table 6 presents the number of suicide deaths by age group and by year between 2012 and 2018 in Tasmania. The data emphasises the year-to-year fluctuations in annual suicide numbers according to age group. Caution is required when interpreting year-to-year differences in numbers of suicides.

Table 6: Annual suicide numbers by age group, Tasmania 2012-2018 by year of death

Age group	2012	2013	2014	2015	2016	2017	2018	Total
14 - 24 years	6	11	7	13	7	7	5	56
25 - 34 years	7	6	9	10	9	12	7	60
35 - 44 years	13	15	9	16	12	14	18	97
45 - 54 years	14	15	14	11	23	14	8	99
55 - 64 years	12	11	14	15	17	11	11	91
65+	9	11	11	16	19	19	17	102
Total	61	69	64	81	87	77	66	505

A small number of suspected suicide cases were open and therefore not included at the time of reporting for the years 2016, 2017, and 2018

Residential Location

Suicide deaths occur at a range of locations throughout Tasmania. For reporting and statistical purposes, residential location was categorised into four standardised (SA4) boundaries (see Appendix 4 for a visual representation of SA4 locations).

The boundaries consist of the following Local Government Areas (LGA), noting that LGA may fall across more than one SA4 boundary.

1. Hobart: Brighton, Clarence City, Derwent Valley, Glenorchy City, Hobart City, Kingborough, Sorell

2. Launceston and North East: Break O'Day, Central Highlands, Dorset, Flinders, George Town, Launceston City, Meander Valley, Northern Highlands, West Tamar

3. South East: Brighton, Central Highlands, Derwent Valley, Huon Valley, Kingborough, Southern Midlands, Tasman

4. North and North West: Burnie City, Central Coast, Circular Head, Devonport City, Kentish, Latrobe, Waratah-Wynyard, West Coast.

The numbers and rates of suicides in Tasmania based on SA4 locations are presented in Tables 7 and 8 below. Data for males and females are presented separately.

Tables 7 and 8 show that between 2012 and 2018 in Tasmania:

- While Hobart had the highest percentage of suicides (41%), it had the second lowest total suicide rate (12.8 per 100,000 population)
- The highest rates of suicides for females occurred in the South East (11.6 per 100,000 population) whereas the highest rates of male suicides occurred in Launceston and North East (26.1 per 100,000 population).

Table 7: Number of suicides by residential location (SA4) and sex, Tasmania 2012-2018

Residential location	Females N (%)	Males N (%)	Total N (%)
Hobart	60 (55%)	143 (37%)	203 (41%)
Launceston and North East	22 (20%)	128 (33%)	150 (30%)
South East	15 (14%)	35 (9%)	50 (10%)
West and North West	13 (12%)	82 (21%)	95 (19%)

Note: Seven cases were unable to be classified due to no fixed address or residential location outside of Tasmania. Proportions are based on these excluded cases. Percentages may not add to one hundred due to rounding errors.

Table 8: Annual average suicide rates by residential location and sex (per 100,000 population), Tasmania 2012-2018

Residential location	Females (rate)	Males (rate)	Total (rate)
Hobart	7.5	18.2	12.8
Launceston and North East	4.3 [^]	26.1	15.0
South East	11.6 [^]	25.9	18.9
West and North West	3.3 [^]	21.5	12.2

Note: Seven cases were unable to be classified due to no fixed address or residential location outside of Tasmania.

ABS 2016 estimated resident population figures were used to calculate rates

[^] Calculations in this group included numbers less than 10 and should be interpreted with a degree of caution.

Incident Location

The actions of individuals that result in death by suicide can occur in either a residential or non-residential location.

Table 9 shows that between 2012 and 2018 in Tasmania:

- 72% of deaths occurred in a residential setting, this proportion was higher among females (76%) than males (71%)
- In 68% of deaths the incident location was the same as the deceased's usual residence.

Table 9: Number of suicides by incident location description and sex, Tasmania 2012-2018

Incident setting	Females N (%)	Males N (%)	Total N (%)
Residential location	84 (76%)	279 (71%)	363 (72%)
Non-residential location	27 (24%)	115 (29%)	142 (28%)
Total	111 (100%)	394 (100%)	505 (100%)

Note: Residential setting includes a person's usual residence or temporary residence (such as short-term holiday stays, temporary housing or inpatient stays (women's shelters, detoxification programs, hospitals), or when residing temporarily with friends or family).

Non-residential location includes public places, or any other areas or places not generally used for residing (e.g., parks, bushland, workplaces, and schools).

Means of Suicide

Table 10 presents suicide numbers by means of suicide and sex between 2012 and 2018 in Tasmania.

- The most common means of suicide was hanging (45%)
- Among females, poisoning-drug was the most common means (35%) and for males the most common means was hanging (48%)
- The three most frequent methods (hanging, poisoning-drug, and firearm) accounted for 71% of all suicide deaths.

Table 10: Number of suicides by means of suicide and sex, Tasmania 2012-2018

Method	Females N (%)	Males N (%)	Total N (%)
Hanging	37 (33%)	189 (48%)	226 (45%)
Poisoning-drug (incl. alcohol)	39 (35%)	31 (8%)	70 (14%)
Firearms	NP	≥55 (≥14%)	59 (12%)
Carbon monoxide poisoning	NP	≥39 (≥10%)	43 (9%)
Falls	7 (6%)	21 (5%)	28 (6%)
Contact with sharp object	NP	≥19 (≥5%)	23 (5%)
Drowning and submersion	8 (7%)	8 (2%)	16 (3%)
Other (e.g. Poisoning non-drug, burns or fire)	13 (12%)	27 (7%)	40 (8%)
Total	111 (100%)	394 (100%)	505 (100%)

Toxicological Testing: Identified Substances

Testing for the presence of various substance groups is undertaken where possible for all suicide deaths. Toxicological reports indicate what substances may have been consumed before death and include (but are not limited to):

Pharmaceutical drugs: prescribed and over-the-counter medications such as anaesthetics, antidepressants, anti-epileptics, antihistamines, antipsychotics, benzodiazepines and sedatives/ hypnotics, cardiovascular medications, non-steroidal anti-inflammatory (NSAID) and simple analgesics, and opiates

Alcohol: includes ethanol levels of 0.01 g/100mL or greater

Illicit drugs: amphetamines (where not prescribed to the individual), cocaine, methyl-amphetamine, cannabis (tetrahydrocannabinol).

Table 11 shows that between 2012 and 2018 in Tasmania, analyses of toxicology reports indicate:

- 86% of persons who died by suicide had at least one substance identified, with 33% of individuals having more than one substance group identified
- The prevalence of pharmaceutical drugs was greater in females (87%) than males (69%) while illicit drugs were more common in males (15%) than females (9%)
- Alcohol was identified in a similar proportion of female (33%) and male (37%) suicides.

Table 11: Number of suicides with substances identified in toxicological testing by sex, Tasmania 2012-2018

Substance group	Females N (%)	Males N (%)	Total N (%)
Any substance identified	101 (93%)	319 (84%)	420 (86%)
Pharmaceutical drugs*	95 (87%)	262 (69%)	357 (73%)
Alcohol	36 (33%)	141 (37%)	177 (36%)
Illicit drugs	10 (9%)	58 (15%)	68 (14%)
More than one substance group identified	37 (34%)	122 (32%)	159 (33%)
No substances identified	8 (7%)	60 (16%)	68 (14%)

* For 21 cases (4.1%), the pharmaceutical drug category may include the presence of drugs as a result of post-incident medication and should be interpreted with a degree of caution.

Note: Where possible, toxicological testing is completed for all suicide-related deaths. In 3.4% cases (n=17) testing was unable to be completed. Proportions are calculated based on the exclusion of these cases.

Chapter 3: Mental and Physical Health and Access to Services

Mental Illness: Diagnosis

Diagnosed mental illness comprises cases where there is evidence of a formal diagnosis by a suitably qualified clinician (e.g. general practitioner, psychiatrist, or other medical officer). The presence of mental illness is categorised based on the International Classification of Diseases (ICD-10) coding (see Appendix 5 for category definitions). It is important to note that mental illness is often a chronic condition, and that an individual may be diagnosed with one or more mental illnesses at any one time.

Table 12 shows that in the population of Tasmanians who died by suicide between 2012 and 2018:

- Around two-thirds (64%) had at least one previous diagnosis of a mental illness. The prevalence was higher among females (70%) than males (62%)
- The most commonly identified mental illnesses were mood (affective) disorders (50%), followed by neurotic (anxiety), stress-related, and somatoform disorders (32%).

Table 12: Number of suicides by diagnosed mental illness and sex, Tasmania 2012-2018

Mental illness	Female N (%)	Male N (%)	Total N (%)
Diagnosed (any mental illness)	78 (70%)	245 (62%)	323 (64%)
Mood (affective) disorders	64 (58%)	188 (48%)	252 (50%)
Neurotic (anxiety), stress-related and somatoform disorders	50 (45%)	112 (28%)	162 (32%)
Mental and behavioural disorders due to psychoactive substance use	16 (14%)	72 (18%)	88 (17%)
Disorders of adult personality and behaviour	17 (15%)	31 (8%)	48 (10%)
Schizophrenia, schizotypal and delusional disorders	6 (5%)	18 (5%)	24 (5%)
Other	10 (9%)	42 (11%)	52 (10%)
No diagnosed mental illness	33 (30%)	149 (38%)	182 (36%)
Total	111 (100%)	394 (100%)	505 (100%)

Note: An individual case may be diagnosed with more than one mental illness, therefore the subgroups may be greater than the parent group

Mental Health: Access to Treatment and Legal Status

A person suffering from mental illness can receive treatment as either a voluntary patient, or in times when decision-making capacity is substantially impaired, a person may be treated as an involuntary patient under the *Mental Health Act 2013*. The TSR collects and records data for persons who receive treatment within six weeks of death, and/or within 12 months of death.

Tables 13a and 13b show that between 2012 and 2018 in Tasmania:

- Two thirds (65%) of people who died by suicide received at least one episode of mental health care in the 12 months prior to death, and nearly half (47%) received treatment in the six-weeks prior to death
- 5% of those who died by suicide were treated as an involuntary patient in the 12 months prior to death.

Table 13a: Number of suicides by mental health treatment, accessed within 6 weeks and 12 months of suicide, by sex Tasmania 2012-2018

Proximity to death	Female N (%)	Male N (%)	Total N (%)
Treatment within six weeks	56 (50%)	183 (46%)	239 (47%)
Treatment within 12 months	80 (72%)	246 (62%)	326 (65%)
Total suicide deaths	111 (100%)	394 (100%)	505 (100%)

Table 13b: Number of suicides by legal status, within 6 weeks and 12 months of suicide, by sex Tasmania 2012-2018

Legal status	Female N (%)	Male N (%)	Total N (%)
Involuntary treatment within six weeks	NP	≥19 (≥5%)	23 (5%)
Involuntary treatment within 12 months	6 (5%)	21 (5%)	27 (5%)
Total suicide deaths	111 (100%)	394 (100%)	505 (100%)

Involuntary refers to treatment for those who lack decision-making capacity and are accordingly subject to the *Mental Health Act*. The *Mental Health Act 2013* commenced on 17 February 2014, replacing the *Mental Health Act 1996*. This category also includes persons receiving treatment outside of the *Mental Health Act*.

Mental Health: Treatment Provider

In Tasmania the provision of mental health treatment is undertaken by a range of medical professionals including psychiatrists, general practitioners, psychologists, and community-based mental health services (such as the Crisis Assessment and Treatment Team, CATT). While the majority of care is provided by registered health practitioners, other health and social service workers such as non-registered counsellors, may also be involved with an individual prior to their death (see Table 17: Access to Health and Social Services).

Table 14 shows that between 2012 and 2018 in Tasmania:

- Two-thirds (65%) of those who died by suicide had at least one episode of care from a mental health provider in the 12 months prior to death
- General practitioners, psychiatrists, and other mental health practitioners were the most commonly accessed care provider irrespective of proximity to death.

Table 14: Number of suicides by mental health treatment provider accessed within six weeks and 12 months of suicide, Tasmania 2012-2018

Mental health provider and proximity to death	Female N (%)	Male N (%)	Total N (%)
Treatment within six weeks	56 (50%)	183 (46%)	239 (47%)
General Practitioner	44 (40%)	137 (35%)	181 (36%)
Psychiatrist/Other medical specialist	26 (23%)	77 (20%)	103 (20%)
Other Mental Health Practitioner*	16 (14%)	55 (14%)	71 (14%)
Psychologist	15 (14%)	31 (8%)	46 (9%)
Emergency Department	11 (10%)	39 (10%)	50 (10%)
Crisis Assessment and Treatment Team (CATT)^	8 (7%)	20 (5%)	28 (6%)
Alcohol and Drug Services	NP	≥11 (≥3%)	15 (3%)
No treatment within six weeks	55 (50%)	211 (54%)	266 (53%)
Treatment within 12 months	80 (72%)	246 (62%)	326 (65%)
General Practitioner	69 (62%)	214 (54%)	283 (56%)
Psychiatrist/Other medical specialist	47 (42%)	127 (32%)	174 (34%)
Other Mental Health Practitioner	36 (32%)	93 (24%)	129 (26%)
Psychologist	32 (29%)	63 (16%)	95 (19%)
Emergency Department	31 (28%)	76 (19%)	107 (21%)

Mental health provider and proximity to death	Female N (%)	Male N (%)	Total N (%)
Crisis Assessment and Treatment Team (CATT) [^]	16 (14%)	38 (10%)	54 (11%)
Alcohol and Drug Services	NP	≥32 (≥8%)	36 (7%)
No treatment within 12 months	31 (28%)	148 (38%)	179 (35%)
Total	111 (100%)	394 (100%)	505 (100%)

Note: an individual may receive treatment from various providers within 12 months or six weeks of death; therefore the sum of the subsidiary groups may be greater than the overall group.

Other medical specialist comprises medical specialists involved in the mental health care of a patient such as Geriatricians, Neurologists, and other physicians specialising in illnesses such as Parkinson's disease.

Other Mental Health Practitioner comprises practitioners involved in the mental health care of a patient such as mental health nurses, occupational therapists and physiotherapists.

[^]CATT is included only when contact is made outside of the hospital setting.

Physical Health: Diagnosis

In addition to mental illness (Table 12) an individual may have also suffered from physical illness, physical injury, pain, or a terminal illness prior to death. Evidence of a relevant physical health diagnosis relies on medical records.

Table 15 shows that between 2012 and 2018 in Tasmania:

- Approximately two-thirds (65%) of those who died by suicide had at least one reported physical illness, and nearly half (46%) experienced acute, chronic or cancer-related pain prior to death
- Females had a higher prevalence of physical illness (76%) and pain (63%) than males (62% and 41% respectively)
- 2% of cases had a reported terminal illness at the time of death.

Table 15: Number of suicides by physical illness, injury, pain and terminal illness and sex, Tasmania 2012-2018

Physical health issue:	Female N (%)	Male N (%)	Total N (%)
Physical illness	84 (76%)	243 (62%)	327 (65%)
Pain (chronic, acute or cancer-related)	70 (63%)	163 (41%)	233 (46%)
Physical injury	24 (22%)	94 (24%)	118 (23%)
Terminal illness	NP	NP	10 (2%)
Total	111 (100%)	394 (100%)	505 (100%)

Terminal illness comprises cases where there is supporting medical records to confirm that an individual is deemed to be terminally ill.

Physical Health: Treatment Provider

Medical records were used to identify episodes of care provided to those who died by suicide in the 12 months prior to death, and in the six-weeks before death. No distinction was made between public and private hospital settings (see Table 17: Access to Health and Social Services), and treatment included services provided by allied health professionals in community settings.

Table 16 below shows that between 2012 and 2018 in Tasmania:

- 83% of persons who died by suicide had at least one episode of care for a physical health complaint prior to death
- General practitioners were the most common treatment providers (78%) followed by specialist outpatient practitioners (30%).

Table 16: Number of suicides by physical health treatment provider accessed within six weeks or outside of six weeks of suicide, by sex Tasmania 2012-2018

Physical health provider and proximity to death	Female N (%)	Male N (%)	Total N (%)
Any provider: Ever	104 (94%)	315 (80%)	419 (83%)
Treatment within six weeks	61 (55%)	179 (45%)	240 (48%)
General practitioner	59 (53%)	161 (41%)	220 (44%)
Specialist outpatient practitioner	7 (6%)	27 (7%)	34 (7%)
Inpatient (admitted to hospital)	9 (8%)	20 (5%)	29 (6%)
Emergency Department	8 (7%)	16 (4%)	24 (5%)
Allied health professionals	NP	≥8 (≥2%)	12 (2%)
No treatment within six weeks	50 (45%)	215 (55%)	265 (52%)
Treatment outside of six weeks	102 (92%)	310 (79%)	412 (82%)
General practitioner	102 (92%)	294 (75%)	396 (78%)
Specialist outpatient practitioner	46 (41%)	107 (27%)	153 (30%)
Inpatient (admitted to hospital)	29 (26%)	101 (26%)	130 (26%)
Emergency Department	23 (21%)	77 (20%)	100 (20%)
Allied health professionals	12 (11%)	36 (9%)	48 (10%)
No treatment outside of six weeks	9 (8%)	84 (21%)	93 (18%)

Note: an individual may receive treatment from various providers within or outside six weeks of death; therefore the sum of the subsidiary groups may be greater than the overall group

Access to Health and Social Services

People who died by suicide may have accessed a range of government and non-government health services prior to death. While there is no timeframe for when access was made to these services, inclusion in Table 17 was considered on the basis of relevance to the individual at the time of death (for example, proximity of service access to death and consideration of current social, mental and physical health status).

Table 17 shows that between 2012 and 2018 in Tasmania:

- The most commonly used health and social service contacts involved other non-government community services (including general practitioners) (96% of females, 89% of males)
- Around two-thirds (59%) had engaged with a Tasmanian Government health service (excluding Alcohol and Drug Services, Housing services).

Table 17: Number of suicides by health and social service contacts accessed, by sex Tasmania 2012-2018

Health and social service contacts	Female N (%)	Male N (%)	Total N (%)
Other non-government community services and private providers	107 (96%)	350 (89%)	457 (90%)
Tasmanian Government health services	76 (68%)	220 (56%)	296 (59%)
Centrelink	45 (41%)	159 (40%)	204 (40%)
Other government services	51 (46%)	123 (31%)	174 (34%)
Alcohol and drug services	10 (9%)	62 (16%)	72 (14%)
Housing	8 (7%)	27 (7%)	35 (7%)
Known to Child Protection Services (as a child or adult):	11 (10%)	18 (5%)	29 (6%)
Total suicide deaths	111 (100%)	394 (100%)	505 (100%)

Other non-government community services comprise treatment and support services for physical and mental health care, aged-care, financial and legal services. This group includes general practitioners.

Housing comprises government and non-government services that assist with temporary and long-term housing issues such as Housing Tasmania, Colony 47.

Alcohol and drug services comprises government and non-government service providers.

Tasmanian Government Health Services includes any health services provided by any of the Tasmanian Department of Health, the Tasmanian Health Service, the Department of Communities Tasmania, a Tasmanian Health Organisation or the Department of Health and Human Services as each entity or agency was established at the time the service was provided. This group *excludes* Centrelink, Child Protection, Housing, Alcohol and Drug Services.

Contact with the Legal System

Contact with the legal system was recorded for times within six-weeks of death or outside of six-weeks of death. An individual may have had contact with more than one element of the legal system during this time.

Tables 18a and 18b shows that between 2012 and 2018 in Tasmania:

- Nearly half (48%) of those who died by suicide had contact with police, courts, or corrections during their lifetime, occurring more commonly among males (50%) than females (39%)
- Police were the most common contact for both males and females.

Table 18a: Number of suicides by legal contact, by sex 2012-2018 Tasmania

Legal contacts and proximity to death	Female N (%)	Male N (%)	Total N (%)
Any legal contact: Ever	43 (39%)	198 (50%)	241 (48%)
No legal contact: Ever	68 (61%)	196 (50%)	264 (52%)
Total	111 (100%)	394 (100%)	505 (100%)

Note: An individual may have contact with more than one legal service within a given time period, therefore the sum of the subsidiary groups may be greater than the overall group.

Table 18b: Number of suicides by legal contact (within or outside of six weeks) and proximity to date of death, by sex 2012-2018 Tasmania

Legal contacts and proximity to death	Female N (%)	Male N (%)	Total N (%)
Contact within six weeks	15 (14%)	99 (25%)	114 (23%)
Police	14 (13%)	85 (22%)	99 (20%)
Courts	NP	≥24 (≥6%)	28 (6%)
Corrections	NP	NP	8 (2%)
Contact outside of six weeks	37 (33%)	159 (40%)	196 (39%)
Police	36 (32%)	156 (40%)	192 (38%)
Courts	10 (9%)	79 (20%)	89 (18%)
Corrections	NP	≥44 (≥11%)	48 (10%)
Total suicide deaths	111 (100%)	394 (100%)	505 (100%)

Police contact comprises contact with police; including speaking to police on the street, neighbourhood disputes, welfare checks instigated by family/friend/peers, through to arrest and custody in police cells. Court contact comprises criminal, civil, and family matters that involves contact with the courts. Corrections contact comprises imprisonment, community corrections orders and remand while facing charges.

Chapter 4: Identified Stressors

Interpersonal and Family

There are many interpersonal and contextual stressors that can be present in an individual's life prior to death. The recording of stressors relies on medical records and accurate accounts (sworn statements) from family members, friends and peers who knew the deceased prior to death. While particular attention is paid to recent events, any stressor occurring outside 12 months of death, if deemed relevant at the time of death, may also be included (e.g. the death of a partner).

Table 19 (overleaf) shows that between 2012 and 2018 in Tasmania:

- The majority (91%) of those who died by suicide had experienced at least one interpersonal and/or family stressor, with both males and females similarly affected
- Similar proportions of stressors involved either the deceased's partner (71%) or family member (71%)
- Separation from a partner, (whether actual or threatened) was the most common identified stressor (55%) followed by death of a family member (48%) and conflict with partner/ family member (42% and 40% respectively).

Table 19: Number of suicides by identified interpersonal stressors and sex, Tasmania 2012-2018*

Interpersonal and Family stressors	Female N (%)	Male N (%)	Total N (%)
Any identified stressor	104 (94%)	355 (90%)	459 (91%)
Partner related	82 (74%)	276 (70%)	358 (71%)
Separation from partner (threat or actual)	52 (47%)	224 (57%)	276 (55%)
Conflict with partner	45 (41%)	168 (43%)	213 (42%)
Violence* involving partner	25 (23%)	72 (18%)	97 (19%)
Death of partner	20 (18%)	35 (9%)	55 (11%)
Partner health issues	10 (9%)	21 (5%)	31 (6%)
Other family member related	89 (80%)	271 (69%)	360 (71%)
Death of family member	61 (55%)	180 (46%)	241 (48%)
Conflict with family member	53 (48%)	151 (38%)	204 (40%)
Family health issues	29 (26%)	68 (17%)	97 (19%)
Violence* involving family	26 (23%)	75 (19%)	101 (20%)
Acquaintance related	28 (25%)	98 (25%)	126 (25%)
Conflict with acquaintance	18 (16%)	57 (14%)	75 (15%)
Death of acquaintance	12 (11%)	44 (11%)	56 (11%)
Acquaintance health issues	NP	NP	8 (2%)
Total suicide deaths	111 (100%)	394 (100%)	505 (100%)

*Violence refers to any of the following: physical, verbal, financial, psychological, emotional, neglect, sexual and or spiritual/cultural violence but does not include self-inflicted violence. When reporting on violence, the deceased may be the perpetrator, victim, or both.

Contextual and Situational

Contextual / situational stressors may also be identified in people who die by suicide. In addition to recent events, an identified stressor may include historical events (outside 12 months) if they are considered relevant at the time of death. The presence of contextual and situational stressors relies on medical records and accurate accounts (sworn statements) from family, friends, and peers known to the deceased.

Table 20 shows that between 2012 and 2018 in Tasmania:

- The majority (94%) of people who died by suicide had at least one contextual or situational stressor, with males and females similarly affected
- The two most common stressors were substance use or misuse (55%) and experience of abuse or violence (48%).

Table 20: Number of suicides by identified contextual and/or situational stressors and sex, Tasmania 2012-2018

Contextual and situational stressors	Female N (%)	Male N (%)	Total N (%)
Any identified stressor	107 (96%)	368 (93%)	475 (94%)
Substance use or misuse	51 (46%)	225 (57%)	276 (55%)
Experience of abuse/violence*	56 (50%)	184 (47%)	240 (48%)
Work-related	35 (32%)	170 (43%)	205 (41%)
Isolation (social or physical)	45 (41%)	148 (38%)	193 (38%)
Financial	40 (36%)	137 (35%)	177 (35%)
Legal issues	19 (17%)	106 (27%)	125 (25%)
Experience of bullying*	11 (10%)	43 (11%)	54 (11%)
Education-related	7 (6%)	30 (8%)	37 (7%)
Sexuality and gender	NP	≥13 (≥3%)	17 (3%)
Exposure to suicide^:			
Family/friend/peer/acquaintance	22 (20%)	76 (19%)	98 (19%)
Stranger	NP	NP	5 (1%)

Note: an individual may experience one or more of the listed stressors and therefore the sum of the subsidiary groups may be greater than the overall group.

*Violence refers to any of the following: physical, verbal, financial, psychological, emotional, neglect, sexual and or spiritual/cultural violence but does not include self-inflicted violence. When reporting on violence or bullying, the deceased may be the perpetrator, victim, or both.

^Exposure to suicide comprises experiencing or witnessing another person's death by suicide and/or a serious suicide attempt.

Appendix

Appendix I: Mindframe Media Guidelines – Communicating about Suicide

Mindframe is a national program supporting safe media reporting, portrayal and communication about suicide, mental ill-health and alcohol and other drugs. The following advice has been drawn from Mindframe resources.

When communicating about suicide, it's important to remember that suicide is a complex issue and is often not preceded by a single event or condition. Suicide can arise from an interaction between many vulnerabilities and risk factors in a person's life. However, suicide may also be influenced by social and economic circumstances and differences between cultures and individuals' experiences within society (Mindframe, 2021).

Discussing method and location

When it comes to communication which references suicide, it is important to minimise details about method and location. Studies indicate that content, which includes explicit or technical descriptions and images of methods or locations used for suicide, have been linked to increased rates of suicide. The considerations below will reduce risk on vulnerable people, limit graphic information being shared, and present alternate ways to communicate about a location in a safe way.

Issue	Options to consider
Reporting explicit detail about method has been linked to increases in use of that method and overall suicide rates.	If it is important to mention method, discuss in general terms e.g. 'mix of drugs' instead of detailing type and quantity.
Reporting uncommon or new methods of suicide can lead to imitation as well as a lasting impact on rates.	Remove specific details about new or unusual methods of suicide and reference ways further information can be found e.g. online
Describing locations of suicide may promote these to vulnerable people and increase frequency of attempts at these sites.	If referring to a location, describe this in general terms only e.g. use 'at a nearby park' instead of detailing the exact location.
Images or footage depicting method or location of a suicide can lead to imitation by vulnerable people.	Avoid using detailed or dramatic photographs or footage e.g. images of people standing at ledges or of implements used in a suicide attempt

Other issues of importance include use of safe language, story context, accuracy and balance, and cultural considerations. For further detail, consult the [Mindframe guidelines](https://mindframemedia.imgix.net/assets/src/uploads/MF-Media-Professionals-DP-LR.pdf)⁸

⁸ <https://mindframemedia.imgix.net/assets/src/uploads/MF-Media-Professionals-DP-LR.pdf>

Appendix 2: Overview of Socio-Economic Indexes for Areas (SEIFA)

Developed by the Australian Bureau of Statistics (ABS), SEIFA is a classification system that ranks areas in Australia according to relative socio-economic advantage and/or disadvantage. Rankings are available at a National or State/Territory level. The ABS broadly defines relative socio-economic advantage and disadvantage in terms of:

“people’s access to material and social resources, and their ability to participate in society”

For this report, the Index of Relative Social Disadvantage (IRSD) is used which ranks areas based only on relative disadvantage within Tasmania. The indexes are based on information from the five-yearly Census. The SEIFA 2016 is based on Census 2016 data.

[More information about SEIFA and IRSD is available through the ABS⁹](#)

⁹ <http://www.abs.gov.au/websitedbs/censushome.nsf/home/seifa>

Appendix 3: Overview of Occupational Categories

Table IA: Summary of the Major categories and sub-categories of the Australian and New Zealand Standard Classification of Occupations (ANZSCO), First Edition.

Major category	Sub-category
MANAGERS	Chief Executives, General Managers and Legislators Farmers and Farm Managers Specialist Managers Hospitality, Retail and Service Managers
PROFESSIONALS	Arts and Media Professionals, Business, Human Resource and Marketing Professionals Design, Engineering, Science and Transport Professionals Education Professionals Health Professionals ICT Professionals Legal, Social and Welfare Professionals
TECHNICIANS AND TRADE WORKERS	Engineering, ICT and Science Technicians Automotive and Engineering Trades Workers Construction Trades Workers Electro technology and Telecommunications Trades Workers Food Trades Workers Skilled Animal and Horticultural Workers Other Technicians and Trades Workers
COMMUNITY AND PERSONAL SERVICE WORKERS	Health and Welfare Support Workers Carers and Aides Hospitality Workers Protective Service Workers Sports and Personal Service Workers

Major category	Sub-category
CLERICAL AND ADMINISTRATIVE WORKERS	<ul style="list-style-type: none"> Other Clerical and Administrative Workers Clerical and Office Support Workers Numerical Clerks Inquiry Clerks and Receptionists General Clerical Workers Personal Assistants and Secretaries
SALES WORKERS	<ul style="list-style-type: none"> Sales Representatives and Agents Sales Assistants and Salespersons Sales Support Workers
MACHINERY OPERATORS & DRIVERS	<ul style="list-style-type: none"> Machine and Stationary Plant Operators Mobile Plant Operators Road and Rail Drivers Storepersons
LABOURERS	<ul style="list-style-type: none"> Cleaners and Laundry Workers Construction and Mining Labourers Factory Process Workers Farm, Forestry and Garden Workers Food Preparation Assistants Other Labourers

Full category descriptions available:

[http://www.ausstats.abs.gov.au/ausstats/subscriber.nsf/0/B4B626DEB4A0C558CA2571E600092D5A/\\$File/12200_2006.pdf](http://www.ausstats.abs.gov.au/ausstats/subscriber.nsf/0/B4B626DEB4A0C558CA2571E600092D5A/$File/12200_2006.pdf)

Appendix 4: Representation of Statistical Boundaries

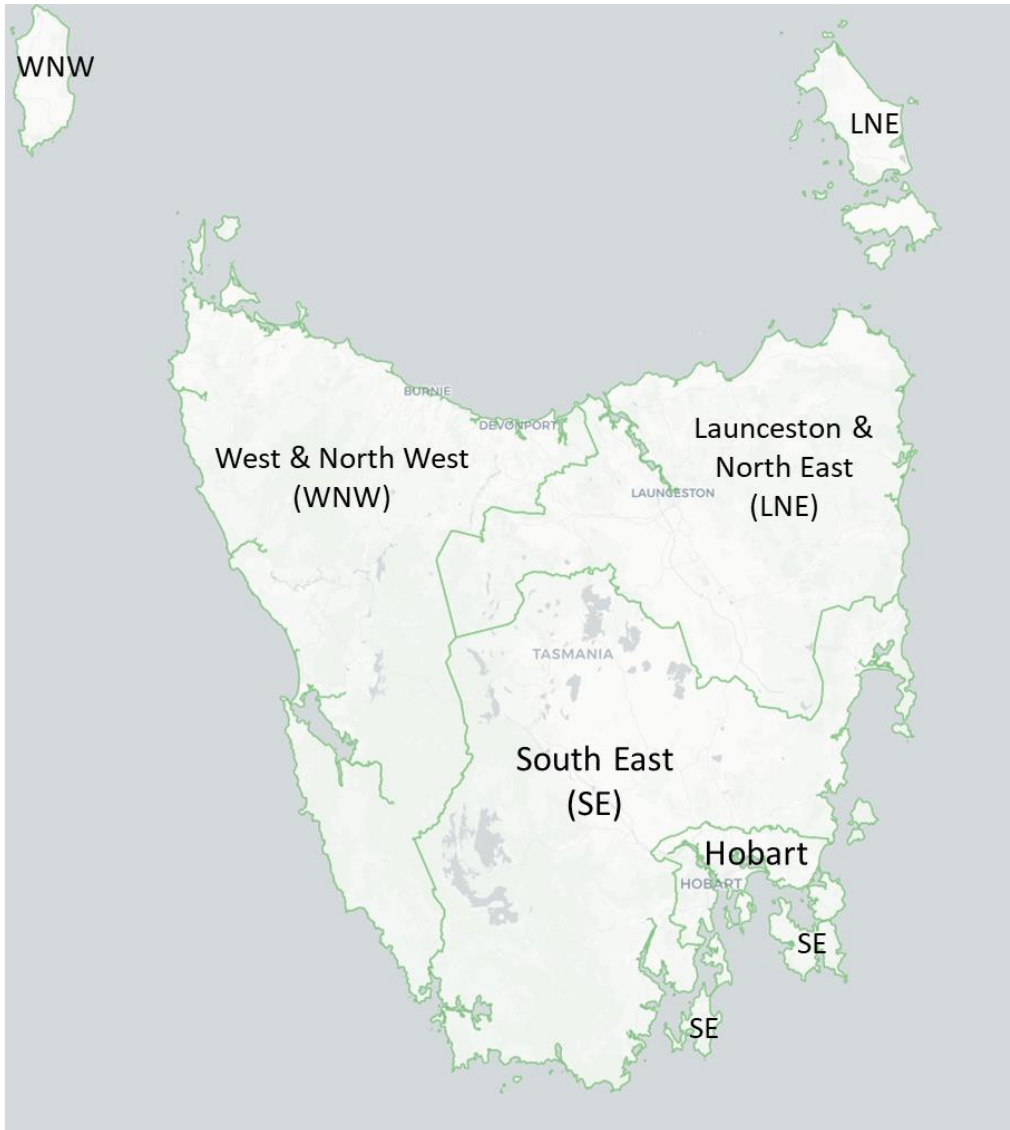


Figure 1A: Statistical Area Level 4 (SA4) boundary map, Tasmania

SA4 boundaries were designed by the Australian Bureau of Statistics (ABS), and form part of the Australian Statistical Geography Standard (ASGS). For more information visit the [ABS](https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/1270.0.55.001~July%202016~Main%20Features~Statistical%20Area%20Level%204%20(SA4)~10016)¹⁰

¹⁰

[https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/1270.0.55.001~July%202016~Main%20Features~Statistical%20Area%20Level%204%20\(SA4\)~10016](https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/1270.0.55.001~July%202016~Main%20Features~Statistical%20Area%20Level%204%20(SA4)~10016)

Appendix 5: Overview of ICD-10 Coding Classifications

Table 2A: International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10) - Definitions of Mental and behavioural disorders

Classification	Description
Organic, including symptomatic, mental disorders	Comprises a range of mental disorders grouped together on the basis of their having in common a demonstrable etiology in cerebral disease, brain injury, or other insult leading to cerebral dysfunction. The dysfunction may be primary, as in diseases, injuries, and insults that affect the brain directly and selectively; or secondary, as in systemic diseases and disorders that attack the brain only as one of the multiple organs or systems of the body that are involved.
Mental and behavioural disorders due to psychoactive substance use	A wide variety of disorders that differ in severity and clinical form but that are all attributable to the use of one or more psychoactive substances, which may or may not have been medically prescribed. Severity categories include: acute intoxication, harmful use, dependence syndrome, withdrawal state, withdrawal state with delirium, psychotic disorder, amnesic syndrome, residual and late-onset psychotic disorder.
Schizophrenia, schizotypal and delusional disorders	This group includes schizophrenia, schizotypal disorder, schizoaffective disorders, persistent delusional disorders, and a larger group of acute and transient psychotic disorders.
Mood (affective) disorders	Disorders in which the fundamental disturbance is a change in affect or mood to depression (with or without associated anxiety) or to elation. The mood change is usually accompanied by a change in the overall level of activity; most of the other symptoms are either secondary to, or easily understood in the context of, the change in mood and activity. Most of these disorders tend to be recurrent and the onset of individual episodes can often be related to stressful events or situations.
Neurotic (anxiety), stress-related and somatoform disorders	This group includes phobic anxiety disorders, other anxiety disorders (such as panic disorder, generalised anxiety disorder), obsessive-compulsive disorder, reaction to severe stress, and adjustment disorders, dissociative (conversion) disorders, somatoform disorders and other neurotic disorders.

Classification	Description
Behavioural syndromes associated with physiological disturbances and physical factors	<p>This group includes eating disorders, nonorganic sleep disorders, sexual dysfunction (non-organic cause), abuse of non-dependence-producing substances and unspecified behavioural syndromes associated with physiological disturbances and physical factors.</p>
Disorders of adult personality and behaviour	<p>A variety of conditions and behaviour patterns of clinical significance which tend to be persistent and appear to be the expression of the individual's characteristic lifestyle and mode of relating to himself or herself and others. Some of these conditions and patterns of behaviour emerge early in the course of individual development, as a result of both constitutional factors and social experience, while others are acquired later in life. Specific personality disorders, mixed and other personality disorders, and enduring personality changes are deeply ingrained and enduring behaviour patterns, manifesting as inflexible responses to a broad range of personal and social situations. They represent extreme or significant deviations from the way in which the average individual in a given culture perceives, thinks, feels and, particularly, relates to others. Such behaviour patterns tend to be stable and to encompass multiple domains of behaviour and psychological functioning.</p>
Mental retardation	<p>A condition of arrested or incomplete development of the mind, which is especially characterized by impairment of skills manifested during the developmental period, skills which contribute to the overall level of intelligence, i.e. cognitive, language, motor, and social abilities.</p> <p>Degrees of mental retardation are estimated by standardized intelligence tests and can be supplemented by scales assessing social adaptation in a given environment.</p>
Disorders of psychological development	<p>The disorders included in this group have in common: (a) onset invariably during infancy or childhood; (b) impairment or delay in development of functions that are strongly related to biological maturation of the central nervous system; and (c) a steady course without remissions and relapses. In most cases, the functions affected include language, visuo-spatial skills, and motor coordination. Usually, the delay or impairment has been present from as early as it could be detected reliably and will diminish progressively as the child grows older, although milder deficits often remain in adult life.</p>

Classification	Description
Behavioural and emotional disorders with onset usually occurring in childhood and adolescence	This group includes hyperkinetic disorders, conduct disorders, mixed disorders of conduct and emotions, emotional disorders with onset specific to childhood, disorders of social functioning with onset specific to childhood and adolescence, tic disorders and other behavioural and emotional disorders with onset usually occurring in childhood and adolescence.

For [full outline of categories](#)¹¹

¹¹ <https://icd.who.int/browse10/2010/en%23/V>

Appendix 6: Toxicology Testing

In Tasmania toxicological testing is undertaken by Forensic Science Service Tasmania for all suicide-related deaths. This testing may be conducted on blood, or other tissue samples that were collected ante-mortem (before death), post-mortem (after death), or both. Testing of samples prior to death can occur when an incident does not cause immediate death.



Tasmanian
Government

Department of Health

Mental Health, Alcohol and Drug Directorate

Phone:

(03) 6166 0778

Email:

director.mhadd@health.tas.gov.au

www.health.tas.gov.au