Australian Institute of Health and Welfare (AIHW) National Suicide and Self-harm Monitoring System data release

Released by AIHW on 4 November 2022

The latest data release occurred on **Friday, 4 November 2022**, and included an analysis of **patterns of health service use in the last year of life among those who died by suicide**.

A significant proportion of people who die by suicide have contact with the health system in their last year of life. This contact provides a potential touch point for suicide prevention activities.

The new report utilised the National Integrated Health Services Information Analysis Asset (NIHSI AA) version 0.5, which includes a number of linked datasets. This allowed analysis of health service use in the last year of life, including hospital admissions, emergency department (ED) presentations, health service visits billed under the Medicare Benefits Schedule (MBS), and medication prescriptions supplied under the Pharmaceutical Benefits Scheme (PBS).*

The analysis included those who had died between 1 July 2010 and 31 December 2017, and who were aged 15 to 64 years when they died. Health service use in the last year of life was compared between those who died by suicide to those who died from other causes.

Some of the key findings included:

- People who died by suicide accessed fewer health services overall in their last year of life than those who died from other causes.
- Just over half (51%) of people who died by suicide had contact with the hospital (either emergency department (ED) presentation or hospital separation), compared to 76% who died from other causes.
- However, a higher proportion of people who died by suicide had a hospital admission with any mental health, suicidal ideation or intentional self-harm hospital diagnosis (24%), or a mental health related ED presentation (7%) compared to people who died from other causes (19% and 2% respectively).
- People who died by suicide were more likely to access MBS services (82%) than hospital services (51%) in their last year of life.
- For those who died by suicide, 11% did not access any of the health services analysed in their last year of life.
- Females were more likely than males to access health services in their last year of life. For those who died by suicide:
    - A higher proportion of females (47%) were an admitted patient in hospital compared to males (32%). The highest proportion was for females aged 25–34 and 45–54 (49%) while the lowest proportion was for men aged 15–24 (26%).
    - A higher proportion of females (13%) were hospitalised for intentional self-harm than males (6%).
    - Females (30%) were more likely than males (19%) to have had a mental health hospital diagnosis (this excludes ED presentations) in their last year of life.
    - A higher proportion of females accessed any MBS service (90%), and MBS mental health services* (57%), compared to males (79% and 37% respectively).

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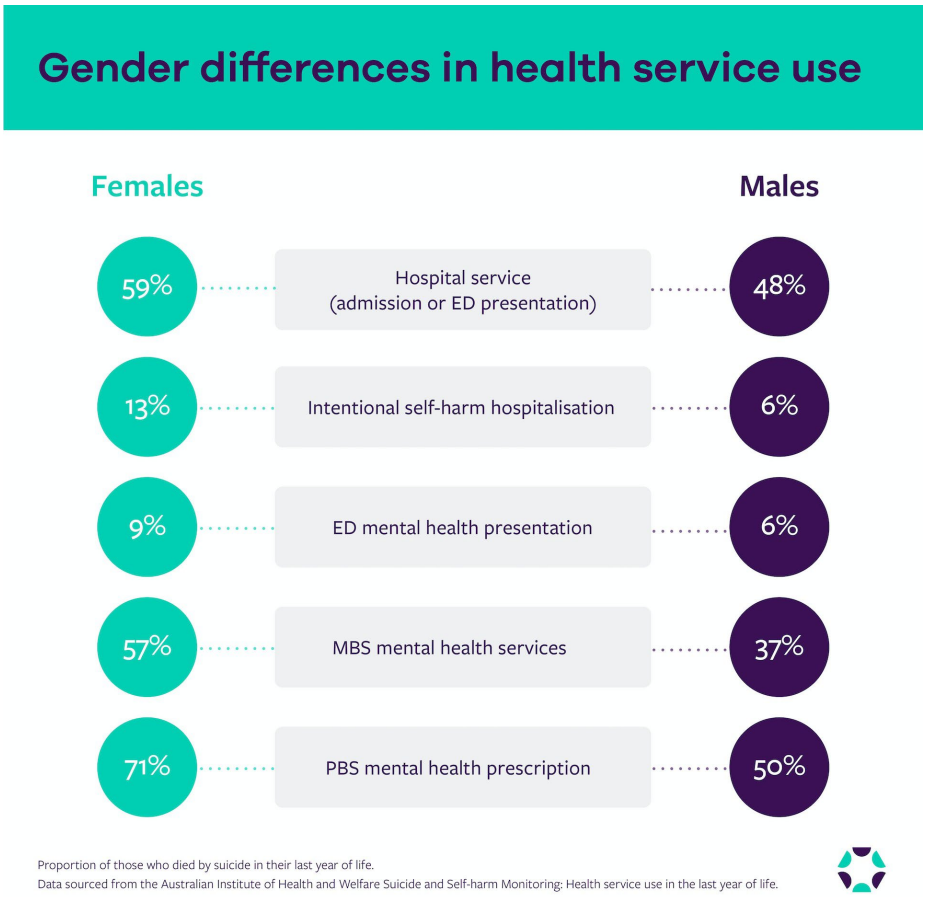
- The proportion of females accessing a PBS mental health prescription (71%) was higher than for males 50%.

- For those who died by suicide and had any hospital contact in their last year of life (including ED), 59% of those hospital contacts were by people in the 15–44 age group, compared to 17% of the same age who died of other causes. This makes sense given suicide is the leading cause of death for people aged 15-44 years.
- Most people who died by other causes and had a hospital contact were aged 45–64 (83%). Any mental health, suicidal ideation or intentional self-harm hospitalisations or ED mental health presentations also follow this pattern.

View the full report



***Please note when viewing this data:**

A number of limitations of the NIHSI AA v0.5 data asset exist and should be considered when interpreting this data, including:

- It does not include data from community or residential mental health.
- ED presentations for intentional self-harm are not reported as most states and territories do not effectively identify ED presentations for intentional self-harm in the data included in the NIHSI AA.
- Not all mental health services under the MBS are billed as specific mental health items – some may be billed under general GP items. Therefore, mental health GP services may be underreported.