IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: **COR 2017 5305**

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
Section 67 of the Coroners Act 2008

Findings of:	**MR JOHN OLLE, CORONER**
Deceased:	**MR A***
Date of birth:	[redacted]
Date of death:	[redacted]
Cause of death:	**COMPRESSION OF THE NECK CONSEQUENT UPON HANGING**
Place of death:	[redacted]
Catch words:	**FAMILY VIOLENCE; SUICIDE; MENTAL HEALTH; SUBSTANCE USE; BEHAVIOUR CHANGE PROGRAM**

*The published version of this finding has been de-identified to preserve the privacy of the deceased's family.

TABLE OF CONTENTS

HIS HONOUR:

BACKGROUND

1. Mr A was aged [redacted] years at the time of his death. He lived at [redacted].

2. Mr A had three children with his wife of 44 years, Mrs A, however, the couple had recently separated. He was a carpenter by trade, but had been unemployed for two years after injuring his Achilles tendon. He experienced ongoing disability and pain related to the injury.

3. From the available medical records, it appeared Mr A had no formal or documented psychiatric condition or diagnosis.[1]

THE PURPOSE OF A CORONIAL INVESTIGATION

4. Mr A's death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic), as his death occurred in Victoria, and was both unexpected and unnatural.[2]

5. The jurisdiction of the Coroners Court of Victoria is inquisitorial[3]. The purpose of a coronial investigation is independently to investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.

6. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[4] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.

7. The "cause of death" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

8. For coronial purposes, the circumstances in which death occurred refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is

[1] Seaport Medical Centre and statement by general practitioner (GP) Dr Jesse Das. The focus was medical issues, most related to his January 2016 Achilles injury of which the care appears appropriate. His last consultation was with Dr Abraham Stephanson on 14 July 2017. Mr A was also referred to and assessed by an Epworth senior physiotherapist who recommended vocational rehabilitation and a return to work. Coronial brief of evidence, pages 15 – 27.
[2] Section 4, definition of 'Reportable death', *Coroners Act 2008.*
[3] Section 89(4) *Coroners Act 2008.*
[4] *Keown v Khan* (1999) 1 VR 69.

confined to those circumstances which are sufficiently proximate and causally relevant to the death.

9. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the 'prevention' role.

10. Coroners are also empowered:

    (a) to report to the Attorney-General on a death;

    (b) to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and

    (c) to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice. These powers are the vehicles by which the prevention role may be advanced.

11. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[5] The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

MATTERS IN WHICH THE CORONER MUST, IF POSSIBLE, MAKE A FINDING

Identity of the Deceased pursuant to section 67(1)(a) of the *Coroners Act 2008*

12. Mr A was visually identified by a long-term friend on 19 October 2017. Identity was not in issue and required no further investigation.

Medical cause of death pursuant to section 67(1)(b) of the *Coroners Act 2008*

13. On 20 October 2017, Dr Sarah Parsons, Forensic Pathologist at the Victorian Institute of Forensic Medicine, conducted an inspection on Mr A's body and provided a written report dated 24 October 2017, concluding a reasonable cause of death to be "I(a) Compression of

[5] (1938) 60 CLR 336.

the neck consequent upon hanging". I accept Dr Parsons' opinion in relation to the cause of death.

14. Post mortem toxicology recorded alcohol at 0.16 g/100mL.

Circumstances in which the death occurred pursuant to section 67(1)(c) of the *Coroners Act 2008*

15. My investigation revealed Mr A's death occurred in the context of psychosocial stressors, the consequences of perpetrating family violence, substance dependence, a possible emerging mental illness for which he did not seek help, and engagement with behaviour change services.

16. At the time of his death, Mr A and Mrs A had been separated for approximately five months. Mrs A noted a history of family violence with Mr A, and described her husband as "a little bit volatile". She stated he could be "physical" towards her, but only in private, and usually when consuming alcohol. Mrs A said she left the family home after an altercation in which Mr A told her to leave and had been physically aggressive.

17. Mr A struggled with the prospect of Mrs A not returning to the relationship and had voluntarily enrolled in a men's behaviour change program run by Brophy Family and Youth Services (**BFYS**) in Warrnambool. The program lasted 18 weeks and Mr A had completed 17 of 18 sessions at the time of his death. The last session was scheduled for 18 October 2017, however, he did not attend.

18. During the program, Mr A had admitted to using violence after five years of being in the relationship.[6] A Family Violence Intervention Order was in place at the time of Mr A's death, although Mr A had stated he was unaware of the conditions of any order because he had torn it up when he was at Court.[7]

19. Mr A's friend, Mr B, engaged him as a casual labourer, and they had a standing catch-up every Thursday and often on Sundays for coffee. Mr B described Mr A as upset "for the past few months" following his separation from Mrs A, and said he had encouraged Mr A to see a counsellor.

[6] Submission of Brophy Family and Youth Services assessment page 5.
[7] Submission of Brophy Family and Youth Services assessment page 5. Details of any order were not obtained.

20. Mrs A said Mr A was feeling down, was more withdrawn and that he often fluctuated in how he presented. Her last contact with him was via text message on 15 October 2017 while she was in Brisbane visiting their daughter.

21. On Monday 16 October 2017, Mr B said Mr A seemed "bloody good", but later in the day and after alcohol, Mr A had become tearful and upset about the loss of his relationship.

22. On the evening of Tuesday 17 October 2017, Mr A spoke with each of his three adult children and described future plans.

23. Mr B tried to contact Mr A by phone during the early evening on 18 October 2017, but received no response. According to Mr B, at about 7:00am on 19 October 2017, he attended Mr A's home as usual, and located Mr A hanging in the back yard.

24. Emergency services were contacted but Mr A was declared deceased at the scene. Mr A left suicide notes to five people. The note to Mrs A was bitter and accusatory and this information was included in his note to their son [redacted]. Notes written to friends and family were positive.

Review of Brophy Family and Youth Services

25. Ms Donna Wynters, Manager of Family and Individual Support Programs at BFYS provided a statement, attaching a copy of Mr A's participation forms in the behaviour change program. Ms Wynters described the behaviour change program as accessible, flexible and individualised in its response to assisting men who use violence against women, while maintaining the safety of women and children as paramount. In addition, Ms Wynter provided details of the evidence base for the model of service which included contact and voluntary participation by a partner. Mr A's attendance at the program was voluntary, whereas many participants, even if compelled, only attend the assessment appointment.

26. Mr A told group facilitators he drank alcohol most days of the week. He said he was angry about Mrs A telling friends they had volunteered for the Commonwealth Games and detailed the verbal and physical interaction that led to Mrs A leaving the family home. He expressed regret and shame at his behaviours and explained he was participating because his behaviours were not healthy for others and himself. However, Mr A's presentation within the group fluctuated, as did his level of engagement as opposed to attendance.

27. Mr A self-reported recent suicidal thoughts, and acknowledged an attempt 10 years prior. When this was explored, Mr A did not have current suicidal thoughts and was planning on taking the caravan and going away.

28. Mr A was expecting and hoping Mrs A would return to the marriage; that his participation in the behaviour change program was evidence of his commitment. However, he continued to blame Mrs A for his predicament – that she was not responding to his text messages as he wished. He believed he would lose everything in the event of a formal separation.

29. In June 2017, it was noted that Mr A was not coping with the separation and the idea of his abusive behaviours; that he had shut down within himself, and had suicidal thinking which staff would monitor.

30. In July 2017, Mr A was angry, felt sorry for himself, but was willing to look at his past behaviours in his relationship. At the end of July 2017, he had contacted his children, left voice messages for Mrs A and she had responded.

31. Around this time, Mrs A realised Mr A had controlled her throughout their relationship. In September 2017, it was noted Mr A expressed experiencing guilt and shame in the group, and that he should not be pushed any further.

32. There was no formal assessment or monitoring of Mr A's mood or suicidal thinking as a participant in the program. His program safety plan was focused on steps to take to avoid behaving violently.[8]

Internal review

33. BFYS completed an internal review and identified that the safety of participants in the context of the risks associated with ongoing and personally reflective programs, required a more formal response. Consequently, BFYS implemented the following:

    (a) All new program referrals have a weekly clinical review;

    (b) Participants with a past or current history of suicidal thinking at referral, have a suicide risk assessment commenced and documented in their file;

[8] Brophy Family and Youth Services participation notes from the program include the agreed action plan, assessment, individual briefing sheet, safety plan (focused on not behaving violently), records of in-house family violence meetings group records, participant agreement and a case note. The safety plan comprised the time-out/walk away strategy of which CPU advised there is limited evidence of effectiveness without other supports.

(c) Weekly clinical meetings to specifically include the identification of any participants with current risk indicators; and

(d) Participants with current risk indicators to have an alert noted on file.

Conclusion

34. I consider that these changes are appropriate, and will increase the opportunities for men participating in a program to identify and discuss suicidal thinking. It is likely that if such thinking is identified and there are safety concerns for the participant, that referral to an appropriate clinical service for follow-up would be made. Ultimately however, whether or not the participant agrees to a referral, or chooses to engage with an appropriate service after the referral is made, would likely be out of BFYS's control.

Coroners Prevention Unit review

35. As part of my investigation into Mr A's death, and in order to identify any prevention opportunities, I requested the Coroners Prevention Unit (**CPU**)[9] Mental Health Team, conduct a comprehensive review of the cohort of suicides into which Mr A's death fell. I requested CPU review the Victorian Suicide Register (**VSR**) for those aged 35 to 74, with a focus on males who had known anger and angry behaviours. I also sought submissions from organisations who provide services to these men.

36. The report was reviewed by the CPU Mental Health Investigators, CPU Family Violence Team, and CPU Manager Research and Data.

Trends identified by CPU

37. The CPU identified 2,554 relevant deaths for analysis, which included the following three cohorts (refer to Attachment A for data tables 1 - 35):

(a) All Relevant Deaths Cohort: 2,554 people (1,932 males and 622 females) aged 35 to 74 years who suicided in Victoria between 2009 and 2015.

(b) Anger/Angry Behaviours Cohort: 667 people (570 males and 97 females) among the 2,554 Victorian suicides, where there was explicit evidence they displayed anger and/or angry behaviours prior to death.

[9] The CPU assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the Coroner and is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

(c) Duration of anger/angry behaviours cohort: 229 people (205 males and 24 females) among the 667 suicides in the anger/angry behaviours cohort, where there was sufficient evidence available to establish the duration of the behaviours for more detailed analysis.

38. The process was not a comprehensive thematic analysis, rather, an identification of patterns in certain deaths. The narratives or stories that family, friends, employers, workmates and neighbours provided as part of the investigations into the deaths reviewed by CPU are documented throughout, providing a voice to those who knew the deceased in those cases.

39. Some of the repeated themes included:

(a) A high tolerance for anger/angry behaviours within a family(s) – for example:

> "It was the only time he was physical with me; during 18 years he'd only ever been insulting and verbally aggressive; It was always something that I did that he said made him hit me; When he started to tell my son again and again that it was his fault he had kicked or threatened me, I knew I needed to get out; I could tell when he was building up, when he was likely to explode, we all learned the signs."

(b) That many of the family relationships were complex – for example: "His Ex, the kids, his father and his work wanted him as much as me and I'm his fiancé and it was exhausting."

(c) That formal partner separation while sharing the same accommodation adds additional stressors – for example: "We couldn't afford the mortgage and rent for a second place plus needing more childcare so we just tried to stay apart under the same roof."

(d) Intergenerational trauma – for example: "An alcohol fuelled violent childhood; He was sexually abused by his brother for years;" and

(e) That the presence of alcohol was a constant.

(a) All Relevant Deaths Cohort

40. Among the deceased, 75.6% were males, of which 59.3% had at least one partner stressor, which was similar to the females at 57.7%. A higher proportion of males than females experienced partner separation (44.9% versus 38.3%) and partner conflict (35.5% versus

29.3%). This suggested an association between sex and partner stressors prior to suicide. Partner violence (perpetrator and/or victim) was identified in 16.2% of all deaths (males 15.7% versus females 17.7%).

41. A higher proportion of females than males experienced family stressors (60.1% versus 50.9%) which included family death, family conflict, and family health issues. This was similarly seen in the non-family stressors (females 49.7% versus males 43.2%) which included non-family death, non-family conflict, and non-family health issues. This suggested an association between sex and family stressors prior to suicide.

42. Of the 2,554 deceased, 85.1% experienced one or more contextual stressor during their life including work, finance, legal, sexual, isolation, bullying, abuse[10] and substance use, with little difference between females and males.

43. Of the deceased who suicided, 57.4% had a documented mental disorder diagnosis, (females 71.7% versus males 52.8%) of which 47.7% were mood disorders. Of the 1,467 deceased with a documented mental health disorder, 83% had a mood disorder (females 85.6% versus males 81.9%). This suggested an association between sex and a mood disorder prior to suicide. The second frequent diagnosis was non-psychotic/mood which includes anxiety and stress related disorders at 20.2% (females 28.9% versus males 17.4%). Of these 517 deceased with a documented non-psychotic/mood mental health disorder, females had a higher proportion at 46.3% versus males 33%.

44. Of the 2,554 deceased who suicided, 64.1% had contact with at least one health service for a mental health related issue within the 12 months prior to their death (females 77.5% versus males 59.8%). Of the 1,637 deceased who had contact, 73.1% were with a general practitioner (females 74.6% versus males 72.5%), 49.4% with a psychiatrist (females 57.2% versus males 46.1%) and 37.1% with a mental health practitioner (females 40.6% versus males 35.6%). There was a higher proportion of females than males across contacts with psychiatrists, psychologists, mental health practitioners, emergency departments and crisis assessment and treatment teams. Of note, across all deaths, the frequency and proportion of contacts with addiction (substance use) services was small.

[10] Bullying and abuse included experience as perpetrator and/or victim.

(b) Anger/Angry Behaviours Cohort

45. The CPU analysed the VSR records for the 2,554 deceased aged 35 to 74 who suicided between 2009 and 2015, to identify any evidence of anger/angry behaviours. The use of the term anger/angry behaviours acknowledges the difference between feelings of anger and of behaviours that can be associated with anger. Coding included use of variants of words used in narratives including angry, aggressive, threatening, intimidating, argumentative, abusive, all abuse including sexual, physical, psychological, constraints and restrictive practices, financial, legal, systemic/services, all types of neglect, passive such as sulking, shouting, bickering, criticism, bullying, fighting, throwing things around, property damage etc. combined with evidence of orders or other activities related to aggression and violence.

46. The CPU found:

    (a) 463 (males 74.7% and females 25.3%) case narratives from family, friends, neighbours, practitioners etc. were considered as insufficient to assess presence or absence of anger/angry behaviours.

    (b) 1,424 (68%) of 2,091 remaining case narratives did not contain stated anger/angry behaviours associated with the deceased (males 71% and females 29%).

    (c) In 667 cases (32%), the case narratives contained explicit evidence of anger/angry behaviours associated with the deceased; 570 (85%) of the cases were deceased males and 97 (15%) were deceased females.

    (d) Across both males and females, the greater proportion of stated anger/angry behaviours occurred in the 35 to 44 and 45 to 54 age groups.

47. Among all the 667 deceased, 84.7% had at least one partner stressor (females 77% versus males 86%). A higher proportion of males than females experienced partner separation (57.2% versus 47.4%) and partner conflict (70.2% versus 53.6%). Partner violence (perpetrator and/or victim) was identified in 35.5% of the deaths (males 36% versus females 33%). Among the 565 deceased with at least one partner stressor, partner conflict was the higher proportion 80% (males 81.6% versus females 69.3%) and partner separation 65.8% (males 66.5% and females 61%).

48. A higher proportion of females than males experienced family stressors (79.4% versus 64%). Among the 442 deceased with at least one family stressor, family conflict had the

higher proportion at 66.9% (females 68.8% versus males 66.5%) and family death at 42.9% (males 41.6% and females 49.3%).

49. A higher proportion of females than males experienced non-family stressors (64.9% versus 56.7%). Among the 386 deceased with at least one non-family stressor, non-family conflict had a high proportion at 40.9% (females 49.2% versus males 39.3%).

50. Across both the All Deaths Cohort (35.2%) and all Anger/Angry Behaviours Cohort (40.8%), the higher proportion of non-family stressor among those with at least one non-family stressor was 'other' at 70.4% (females 69.8% versus males 70.5%). 'Other' included a specific identified interpersonal stressor not related to partner or family, for example, a one-off aggressive or violent incident.

51. Of the 667 deceased, 94.9% experienced one or more contextual stressors during their life, which is a higher proportion than the All Deaths Cohort (85.1%).

52. Of the 667 deceased, 53.4% had a documented mental disorder diagnosis, (females 74.2% versus males 49.8%) of which 45% were mood disorders. Of the 356 deceased with a documented mental health disorder, 84.2% had a mood disorder (females 83.3% versus males 84.5%). The second frequent diagnosis was non-psychotic/mood at 32.5% (females 30.5% versus males 33%). Of the 356 deceased, 23.8% had a substance use disorder (females 20.8% versus males 24.6%), which is higher than the proportion of the 1,467 All Deaths Cohort deceased with a mental health disorder diagnosis at 19.6% (females 16.3% versus males 21%).

53. Of the 667 deceased, 47.2% had contact with at least one health service for a mental health related issue within the 12 months prior to their death (females 69.1% versus males 43.5%), a lower proportion than the 64.1% of the All Deaths Cohort. Of the 315 deceased who had contact, 66% were with a general practitioner (females 67.1% versus males 65.7%), 37.1% with a psychiatrist (females 35.8% versus males 37.5%) and 27.3% with a mental health practitioner (females 28.3% versus males 27%). There was a higher proportion of females than males across contacts with mental health practitioners, crisis assessment and treatment services and general practitioners. There was a higher proportion of males than females for contact across psychiatrists, psychologists, emergency departments and addictions services.

54. Of the 326 deceased males who had experienced intimate partner separation, 151 narratives contained sufficient information to code for proximity of separation, proximity of conflict, proximate conflict with IVO where the deceased was the respondent, and any event which

could be reasonably considered as finalizing, including property settlement, refusal by partner to "try again", custody of children agreements, partner formalizing separation/divorce, and IVO initiation.

(c) Duration of Anger/Angry Behaviours Cohort

55. Of the 667 case narratives that contained stated anger/angry behaviours associated with the deceased, 229 (34.3%) contained enough evidence and information to code for the duration of anger/angry behaviours, of which 205 (89.5%) were males and 24 (10.5%) were females.

56. Further analysis focused on the male deaths in line with the scope of my request. From the 205 narratives associated with the deceased males, two groups emerged:

    (a) the deceased who had longstanding anger/angry behaviours – 119 (58%); and

    (b) those who had developed anger/angry behaviours in the months/year preceding their death – 86 (42%).

    These are referred to as the Longstanding Group and the Recent Group respectively.

57. Specific comparisons between the Longstanding and Recent Groups, and the broader Anger/Angry Behaviours Cohort in the context of all suicides is presented thematically under 'Discussion'.

<u>Submissions from service providers</u>

58. Organisations that provide services to men aged 35 to 74 years were invited to provide submissions to assist in understanding the vulnerability of males in circumstances similar to Mr A. Services were provided with a brief overview of the circumstances of Mr A's death and invited to provide their perspectives about what contributes to men over the age of 35 years suiciding in Victoria, including:

    (a) whether men access current mental health services;

    (b) whether the services are accessible to men;

    (c) whether there are any gaps or barriers; and

    (d) any recommendations about how to increase the engagement of men in such circumstances, with a focus on the prevention of suicide.

59. The following organisations provided a response:

(a) Relationships Australia – Victoria (**RAV**);

(b) No to Violence (**NTV**), Simone Tassone;

(c) Australian Psychological Society (**APS**), Dr Lyn O'Grady; and

(d) Royal Australian College of General Practitioners (**RACGP**), Dr Cameron Loy.

Of note was the high quality of submissions which were all referenced, evidence based and contained comprehensive critical analysis.

(a) Men and mental health service help-seeking

60. RAV restricted its response to its area of expertise in men's behavioural change clinical work specific to family violence including:

(a) the attitudes and behaviours contributing to the perpetration of family violence;

(b) the likely mental states of men using family violence upon presentation for assessment and throughout the program;

(c) factors that contribute to self-imposed isolation, family isolation, reduction in help seeking and sustained refusal to access social supports; and

(d) the strong correlation between family violence, suicide and homicide involving victims of the men using family violence.

61. RAV's submission was detailed and supported by references and clear analysis. RAV's submission included information regarding the likely mental states of men who participate in family violence group interventions, and highlighted that relationship separation is a dangerous time (for violence and perpetrator suicide). RAV also discussed perpetrator dangerous thinking and thought stacking.[11]

62. RAV also noted the use of the threat of suicide as a control strategy that is embedded in the man's coercive control pattern, both in the relationship and at the point of separation. RAV submitted that, when this is used in the post separation context as a threat, the separation

[11] A thinking pattern preceding an angry outburst most often has a build-up phase characterized by *thought stacking*. Following an initial trigger, the person becomes increasingly angry as they in quick succession dwell on one hostile thought then another that results in a chain of negative assumptions which can initially justify abusive behaviour and if substances are involved, excuse the behaviour on the basis of being substance affected.

violence escalates, and the coercive control pattern then changes to increased dangerous thinking. This then becomes a vulnerable context for the man where his thinking processes have narrowed down his options to carry out the threat as part of the control pattern. RAV noted that in the context of family violence this is significant because, where depression is a clinical presentation along with the attitudes of resentment, obsessive jealousy and the presence of alcohol use or substance use, it is likely that the man will be using a particularly dangerous and vulnerable pattern of thoughts that can lead to either impulsive or compulsive actions.

63. NTV's Ms Tassone noted that men are consistently less likely to help-seek for emotional distress, that men's ill-health may both exacerbate the frequency and severity of violence perpetrated against family members, and that such conditions may also create barriers for men in accessing available treatments. Ms Tassone detailed the Man Box Project which found:

> "The less respondents endorsed rules of the Man Box,[12] the more likely they were to seek help for feelings of sadness and depression from a wide variety of sources including romantic partners, male friends, female friends, and psychologists. Positively, over three quarters of participants disagreed with the Man Box rules of hypersexuality, rigid household roles, and men should use violence."

64. NTV provided extensive references of when and how men access and use health services and identified early intervention strategies as important. Ms Tassone also noted that men who sought help for mental health reasons tended to do so late in any illness, and once engaged in a service and/or treatment, that any masculine norms related to self-sufficiency could interfere with treatment processes. Ms Tassone stated that a client must believe that they cannot fix their problem alone as fundamental to treatment for men, however, ideals of invulnerability present particular challenges and threats to identity and self-concept.

65. APS's Dr O'Grady listed specific lifespan development stressors for men 35+ years, including a conflicting sense of identity, relationship difficulties (including social isolation), increased family demands, homelessness, bereavement because of suicide and pressures related to finances and employment. There is further detail specific to psychologists, their training and professional guidelines including the APS 2014 Ethical Guidelines relating to clients at risk of suicide and 2017 Ethical Guidelines for psychological practice with men

[12] The Man Box is a set of beliefs within and across society that place pressure on men to be a certain way – to be tough; not to show any emotions; to be the breadwinner, to always be in control, use violence to solve problems; and to have many sexual partners.

and boys which highlight how gender role socialisation can sometimes negatively impact on the psychological health of men and boys. Dr O'Grady noted that men's access to service has increased over the past decade and provided supporting evidence from 2011-2012.

66. Dr Loy of the RACGP reported psychological issues as the most frequent health issue managed by general practitioners, and provided supporting data from the 2018 RACGP's General Practice Health of the Nation report. Most notable was that 80% of male participants had attended a general practitioner in the 12 months prior; and specific to males 45 years and older, 18% had spoken to a general practitioner about emotional and psychological health; and 8% indicated they had received emotional and psychological care from a practitioner/service other than a general practitioner. Dr Loy commented that general practitioners have the opportunities to establish lasting and effective clinical relationships, and that ongoing relationships between patients and the general practice team can facilitate early intervention for emerging mental health-related symptoms, assessment of suicide risk, and effective monitoring of chronic mental illness.

(b) Service accessibility for men

67. RAV identified the contributing factors to men not accessing services/support as associated with anxiety during the subsequent loss of control during separation and/or being vulnerable; not wanting to show weakness; concern about having a serious condition diagnosed and differing attitudes to help-seeking and shame. RAV also noted alcohol use and intoxication as a key risk factor to family violence and harmful behaviours.

> "What we now know in men's behaviour change work is that family violence in the context of separation is a risk factor for increased vulnerability to bitter thought processes; resentful beliefs and ideas that can lead to obsessive behaviours that isolate men from addressing their accountability."

68. RAV identified the barriers in change behaviour programs as:

> "The opportunity for self insight, self responsibility and increased ability to contemplate expansive ideas of seeing his life beyond separation is lost when this mental state is informed by a strong sense of male privilege, and the need to control (toxic masculinity) commonly associated with perpetrating family violence. These then act as immutable and emotive barriers to more positive perceptions of their circumstances that can then lead to long term acceptance of relationships ending where suicide is not a considered option."

69. NTV Ms Tassone believes that a lack of help-seeking amongst men is a contributor to mental illness and maladaptive coping, including the use of substances and violent crimes, and that regardless of the health concern, they are less likely to seek help, and that masculine norms increase the risks to men's overall health outcomes:

> "Awareness of these risk factors is critical to services' engagement of men in treatment or program interventions and informs suicide prevention strategies more broadly. As outlined above, particular attention must be paid to understanding that due to gender socialisation, men may be more reluctant to reveal internalising disorders, and may more readily report gender normative avoidance strategies such as substance abuse."

70. APS identified traditional masculine norms that have to be overcome by many men before accessing services, including self-stigma, discomfort and negative beliefs about help-seeking, and even when services are accessed, sustaining engagement is challenging.

71. Dr Loy noted general practitioners are equitably and easily accessible and without a referral. General practitioners can refer consumers to specialist practitioners such as psychologists using the general practitioner Mental Health Treatment Medicare items that provide a structured framework for early intervention, assessment and management of patients with a mental illness, including referral to specialist services. An example is the Access to Allied Psychological Services federal funding program (ATAPS). Dr Loy noted that in 2015-2016, almost 72,500 consumers used the Medicare items of which 94.6% were referred by general practitioners.

(c) Gaps and barriers

72. RAV highlighted the need for further research at the intersection of suicide and men perpetrating family violence, and the link between the presence of depression in men and family violence outcomes, identifying this group of men as vulnerable.

67. According to Ms Tassone, there is some evidence that the lack of knowledge about the specific points, places, and contexts in which opportunities to engage might exist for men who are at risk of using family violence impacts on them not help-seeking. In addition, a proportion of men are willing to access professional help, but how such help is presented to men is important.

68. APS's Dr O'Grady raised how the assessment of suicide risk is gender informed and that current ways of assessing risk in men may result in lower rates of detection and intervention.

Dr O'Grady noted that further detail about the signs of current suicidality in men are not always clear, with men's distress not always immediately recognised and consequently mental health difficulties and suicide risk remain undetected. Dr O'Grady stated:

> "Stoicism associated with avoidant, isolative coping strategies, including affective or substance abuse issues, are more prevalent among men. Accordingly, warning signs can take on more gender-specific forms, such as increased aggression and substance abuse, and may not be seen as warning signs related to suicide risk."

69. Dr O'Grady suggested mental health practitioners need to be sensitive to diverse masculinities, to detect and respond appropriately to distress, and noted that service provision for men needs to be provided differently in order for men to trust service providers and for interventions to be effective in meeting their needs.

70. Dr Loy noted the many psychobiological and cultural realities for men in Australian society that are necessary to understand men at risk of suicide. Dr Loy noted as most significant to men 35+ years are: unemployment, relationship breakdown, alcohol and substance use, rural locations, a diagnosis of major depression and sexuality. Dr Loy also identified gaps and barriers that apply across the population including: stigma and discrimination; fragmented state/federal funding systems; lack of community emotional literacy; rural and remote locations; lack of preventative strategies for vulnerable population groups; socioeconomic disadvantage; inadequate family and carer support; lack of integration of primary care and mental health providers; and general practitioner remuneration.

Discussion

71. The focus of the submissions was guided by the questions asked of the organisations which were informed by the Court's experience investigating suicide deaths of men with a history of anger/angry behaviours. There were strong correlations between the submissions. All agreed that men who engage in aggressive behaviours are a vulnerable group and that current service systems present barriers to help-seeking.

(a) Mood disorders

72. While all submissions noted mood disorders such as depression as potentially having an impact on the decision of a man in these circumstances to suicide, there is limited reliable evidence defining the relationship between them. However, in light of the VSR data, it required consideration.

73. Mental disorder diagnoses were present in over 50% of all male deaths aged 35 to 74 who suicided between 2009 and 2015, with 43.3% mood disorders. This increased slightly to 45% in the Anger/Angry Behaviours Cohort, 44.5% in the Longstanding Group, however, decreased to 38.4% in the Recent Group.

74. The narratives also supported that family and friends suspected some of the deceased had a type of mood disorder – for example:

> "Everything started to overwhelm him; He was grumpy and flat; Very down a lot; Marked deterioration in his outlook, he was depressed; Stopped enjoying everything; He would hibernate away for days regularly then he'd be OK with me going round and getting him up; Always sleeping, lost interest in work, just didn't care; Distant, uncommunicative, couldn't finish a day's work, negative and withdrawn; Low self-esteem, just not happy; Depressed after his partner's death; Became intense and moody; Lack of motivation; He had been depressed for years and now he couldn't hide it anymore; Never seen him like this before; His personality changed; I believed he would just snap out of it and be himself; His mind wasn't straight; Tired and out of character; On edge; and Mood swings."

75. In addition, the narratives referred to a deceased's poor sleep and the use of alcohol – for example:

> "He didn't sleep; He drank more to get to sleep; Said he needed it to stop his brain from running overtime; He moved onto the couch when he couldn't sleep and drank; Was so worried he couldn't sleep; He would just be exhausted and irritable and he saw his doctor about not sleeping but it didn't help and just said he had to stop drinking."

76. Of the 240 (84.5%) deceased in the Anger/Angry Behaviours Cohort with a formal mood disorder diagnosis: 141 (58.7%) had been prescribed an antidepressant proximate to their death, 25 (17.7%) were having a non-pharmacological therapy with either a psychiatrist, psychologist, general practitioner or other health discipline, and 46 (32.6%) had counselling from other counselling and social services.

77. Of the 53 (82.8%) deceased in the Longstanding Group with a formal mood disorder diagnosis: 35 (66%) had been prescribed an antidepressant proximate to their death, 4 (7.5%) had non-pharmacological therapy with either a psychiatrist, psychologist, general

practitioner or other health discipline proximate to death, and 13 (37.1%) had counselling from other counselling and social services proximate to death.

78. Of the 33 (66%) deceased in the Recent Group with a formal mood disorder diagnosis: 24 (72.7%) had been prescribed an antidepressant proximate to their death, 2 (6%) had non-pharmacological therapy with either a psychiatrist, psychologist, general practitioner or other health discipline proximate to death, and 5 (15.1%) had counselling from other counselling and social services proximate to death.

79. This raised questions about the knowledge of the clinical guidelines for the treatment of depression, including first and second line treatments,[13] whether referrals were offered to the deceased for non-pharmacological therapies and counselling and refused, were made and the deceased did not follow-up, or whether access to and wait times for appointments impacted on engagement. It also suggested that the deceased were more likely to engage with social services and counselling providers than health disciplines. This may be because access was more straightforward, faster, cheaper or it was the more appealing option to these men.

(b) Substances use

80. The VSR substance use data included a documented diagnosis, however, it was also coded as a contextual stressor which allowed for further analysis. Coding required positive evidence that substance use was a stressor for the deceased.

81. In the Anger/Angry Behaviours Cohort, substance use was identified as a stressor in 62.8% of deaths (males 63.7%) which increased to 77.3% in the Longstanding Group and was 61.6% across the Recent Group. Of the 363 males in the Anger/Angry Behaviours Cohort, 17.6% had a documented diagnosis of a substance disorder; of the 92 males in the Longstanding Group, 19.5% had a documented diagnosis of a substance disorder, compared to 13.2 % of the 53 males in the Recent Group.

82. Notable was the low proportion of deceased males with a substance use diagnosis who had contact with an addiction service, including the Anger/Angry Behaviours Cohort at 5.2%, Longstanding Group at 6.5%, and 3.7% of the Recent Group. The All Deaths Cohort also had a low proportion of contact by males with addiction services across the treating practitioner contacts (5.1%).

[13] Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines Mood Disorders; Australian and New Zealand Journal of Psychiatry 2015; 49 (12):1087-1206; Your Health In Mind – RANZCP – Depression. www.yourhealthinmind.org/mental-illnesses-disorders/depression; Therapeutic guidelines – Psychotropic – 2015. Principles for the Treatment of depression.

83. There is an increased rate of suicidal behaviour as well as completed suicide among individuals with an alcohol use disorder. The VSR data shows that alcohol is consistently detected during post-mortem examination in between 25% and 35% of all Victorian suicides each year. The association between alcohol consumption and self-harm/suicide is not entirely clear, however, substance misuse predisposes suicide by disinhibiting or providing "courage" to overcome resistance in carrying through the act, clouding one's ability to see alternatives, and worsening of mood disorders. Theoretically, consumption of alcohol may influence self-harm/suicide due to the depressant influence of the substance itself, or acute alcohol intoxication contributes to disinhibited and/or impulsive behaviours or alternatively, self-medicating with alcohol may prevent the individual from developing more functional coping strategies.

84. The submissions also supported that substance use plays a role in intimate partner violence (**IPV**), family and non-family violence. RAV noted:

> "In this particular death, the use of alcohol whilst not considered causation relevant to family violence, unaddressed intoxication and addiction is considered a 'key risk indicator' that contributes to high risk family violence behaviours underpinned by attitudes and beliefs that gives the man 'attitudinal permission' for violence to occur and to act in this way as an acceptable response to perceived or real losses of control (impending separation, ongoing non resolution of addressing his accountability, poor or no help seeking, etc)."

85. The narratives further supported that alcohol also played a role in the escalation of violence and aggression – for example: "He was always drunk after work and would go on about work and then have a go at me; He was consuming large amounts of alcohol and would get agitated; Drinking issues and would lash out; and Violent when he was drinking."

86. Post-mortem toxicology showed that, of the 469 deceased males with a substance detected post-mortem in the Anger/Angry Behaviours Cohort, 82.3% had substances detected, of which, 57.3% detected alcohol, 24.5% illicit substances and 71.2% prescription medicines. Post-mortem alcohol was detected in a greater proportion across the Recent Group at 74 (63.5%), compared with the Longstanding Group at 101 (49.5%), and both groups had a similar proportion of prescribed medicines (Recent Group 71.6% versus Longstanding Group 70.2%), but the Longstanding Group had a greater proportion of illicit substances (37.6% versus 20.2%).

87. Combined with the pervasive reference to alcohol use, in particular, by family, friends, and employers throughout the narratives, the VSR data supported minimal use of addiction services across all groups. This may be impacted by a view that alcohol consumption is a cultural norm and/or that an overuse of it is reasonable, for example, to obtain sleep and reduce stress, and therefore is not a problem to be addressed. Low access to or use of addiction services may also reflect a lack of knowledge of these services and how to access them and/or a reluctance by the deceased to engage. There is also an implication that practitioners do not recognise addiction services as specialised, or that the treatment of substance use when it is at the point of causing distress to a man may require more than the management of withdrawal, that substance use in combination with mood, sleep and anxiety disorders and/or contextual stressors will be controlled or contained when the underlying disorder or stressor is addressed, and that in the absence of positive change, there is a lack of willingness to advise and promote referral to addiction services.

88. Consequently, in the context of the association between violence and suicide in this group of deceased, a more proactive approach to the assessment, impact and treatment of substance use provides an opportunity for prevention.

(c) Contact with services and help-seeking

89. 59.8% of all males aged 35 to 74 years who suicided between 2009 and 2015 had contacted a service that provides mental health care and for a mental health reason within 12 months of death. This decreased across the Anger/Angry Behaviours Cohort (43.5%), but increased in the Longstanding Group (48.7%) which had contact across most service types, and decreased in the Recent Group (39.5%). General practitioners were the most frequently contacted service for all male deaths and across all cohorts and groups.

90. Across the Recent Group, 60% did not have any contact, but when it occurred, 73.5% contacted general practitioners, which supported Dr Loy's submission. It also suggested that early intervention opportunities for men who have recently developed anger and angry behaviours might rest with general practitioners if contact was made.

91. Of note, 13.7% of the All Deaths Cohort had contact with psychologists; this decreased to 9.1% for the Anger/Angry Behaviours Cohort. Of the 248 deceased males in the Anger/Angry Behaviours Cohort who did make contact with a service, 20.9% had contact with a psychologist, this increased to 24.1% across the Longstanding Group, compared to 17.6% of the Recent Group. As stated by Dr Loy, the ATAPS program offers funded

sessions for therapies with private psychologists and general practitioners refer patients frequently. What is not known is the effectiveness and outcomes of such referrals, whether the deceased were referred but did not follow-up, how many sessions they attended if they did engage, and what was the outcome of attending sessions for these men.

92. It is unclear what interventions practitioners offer to men who do engage, and in particular, if these interventions are informed by a contemporary understanding of the evidence base for anger/angry behaviours and their association with increased risks of violence, homicide and suicide.

93. All submissions identified health seeking by men as low, that it may not happen until associated distress is high, and that retention is a challenge for men in this age group, and not just those with anger/angry behaviours. The narratives suggested many of the deceased males who were encouraged to seek help did not do so – for example:

> "I offered to go with him to see the doctor; He made a couple of appointments but didn't go; Said he would but I know he never got any help; I just wanted my husband back, he had changed and I knew something was wrong; I would say go see a doctor but he'd get so furious and tell me to mind my own business; and Mum pushed him to see a doctor and even made an appointment but he didn't."

94. The VSR data revealed that, across the Anger/Angry Behaviours Cohort and Longstanding Group, nearly half the deceased males did have contact with health services about a mental health related issue. While this is less than the 59.8% of the All Deaths Cohort, it is perhaps higher than expected given the apparent barriers to access and engagement for these men.

95. It supported the submissions regarding the apparent lack of knowledge and service systems, where to find the information, what they offer and how to access them. APS noted:

> "The researchers concluded that public health campaigns that promote service use among vulnerable groups at times of crisis might usefully be targeted at those likely to be experiencing financial and relationship issues."

96. The VSR data also supported that general practitioners are most often the initial help-seeking contact for men in similar circumstances to those like Mr A. Dr Loy commented that a streamlined mental health approach that addresses all the social determinants of health, and includes the integration of mental, medical, substance use and social care would increase the engagement of men in help-services.

97. Consequently, this revealed some prevention opportunities including:

(a) public education for men to what services are available, what they offer and how to access them;

(b) changing the services offered to men to improve retention and outcomes; and

(c) education for practitioners about contemporary thinking for interventions for men who have anger and angry behaviours.

(d) Exploration of anger as an indicator of illness

98. APS's Dr O'Grady suggested men's distress may not always be recognised, and consequently, mental health difficulties and warning signs such as substance use and change in behaviours related to suicide risk are not identified. NTV also noted the point regarding practitioner stereotyping – that men externalise emotional distress, for example as anger, which could explain some under-recognition of internalising disorders such as depression.

99. This was particularly relevant to the Recent Group, whose stories from their family and friends suggested that anger/angry behaviours prior to their death were unusual – for example:

> "It came out of nowhere; I was terrified when he just up and threw things around the lounge; He's never even yelled before, it was completely out of character; Never ever been violent but started about two months ago; Uncharacteristic aggression; Following his accident he started to criticise me and the children; Never seen him this angry before; and Following his workplace injury he got angry about everything."

100. It is reasonable to consider that this type of unusual behaviour may be associated with increased use of substances, but also the result of feeling overwhelmed, of losing any sense of control from the impact of psychosocial and interpersonal stressors. This is supported by 43% of the deceased experiencing three or more stressors across the domains of work, finance, legal, sexuality, isolation, education, substance abuse/use, combined with poor distress tolerance and emotional regulation, and are attempts to regain control by controlling others.

101. Nonetheless, it would be short sighted not to consider that for some, the changes may be associated with an emerging mental disorder. Anger and aggression are often central to practitioner risk assessments, but with a focus more often on the prevention of harm to

others. Accepting that behaviours can be new, it raises the question for services and practitioners whether routine exploration of a man's angry behaviours as being recent or longstanding patterns of behaviour, might improve the individuality of approach to each man's needs. This type of focus on the behaviour may also offer opportunities for practitioners to engage directly with men about anger and angry behaviours, to reinforce the unacceptability of aggression and violent behaviours, the potential consequences of their use, options for early intervention for help to manage anger and to treat any emerging mental disorders and/or substance use.

(e) Conflict, separation and relationships

102. All of the deceased males in the Anger/Angry Behaviours Cohort had experience with partner violence, and 92.3% of the Longstanding Group and 94.1% of the Recent Group had conflict across all three domains of partner, family and non-family, suggesting the behaviours were not always discriminatory.

103. Separation was identified in the submissions as a high-risk time for men and their partners and children, and the narratives supported the deceased's difficulties in coming to terms with the relationship breakdown, loss of relationship or separation, and a reluctance to participate in options to repair a relationship if it was a possibility – for example:

> "I wanted him to get help to manage his anger, then we'd see; He would not accept the end of our marriage; It didn't sink in, no matter what I said; I wanted to work to fix our relationship but he refused any counselling; I said I had no intention of staying separated, I was just desperate for him to stop his drinking and I never thought our marriage was over, I just wanted him to stop hurting us."

104. The VSR data showed that 44.9% of males in the All Deaths Cohort were separated, compared to 57.2% of the Anger/Angry Behaviours Cohort. Further analysis of the 93 cases of the Longstanding Group and 58 cases of the Recent Groups who were separated showed proportions of proximate partner conflict above 97% in both groups. 61.5% of the Longstanding Group and 44.6% in the Recent Group were respondents in an intervention order. The most notable difference between the two groups was whether the separation was within weeks/months/year before death or longer (remote). The Longstanding Group separations were nearly all remote, while the Recent Group were nearly all within the year prior to death.

105. Although the sample was comparatively small (151), the narratives suggested the risk of suicide increased when associated with what the CPU referred to as 'finalising events'. These were events that could be interpreted by the deceased as decisive, of removing further choice and/or control which included property settlement, refusal by a partner to "try again" when asked, custody of children arrangements, partner formalizing separation/divorce, and IVO initiation. Finalising events were associated with 46.2% of the Longstanding Group and 36.2% of the Recent Group deaths of males who had separated.

106. Although this data was not interrogated extensively, it did suggest that exploration of the details of when an intimate partner separation occurred, and what events related to that separation were currently contributing to levels of anger, may be useful in assessing risk.

(f) Intergenerational trauma

107. Intergenerational trauma was evident in the stories of family, friends and in the documented medical records of the deceased – for example: "Our father was a violent alcoholic; Beaten up by his brother for years; Violent upbringing; Traumatic childhood; Abusive mother, Childhood was frightening; Violent father; Alcoholic father; Physical and emotionally abusive parents; and Raised in a violent setting."

108. NTV noted suicide rates are higher for individuals who have experienced or witnessed abuse as a child. While acknowledging this intergenerational trauma was not further explored, and with respect to the evidence base for family violence and men's health services, it is unclear if there is any conflict between a focus on shame as a pathway to change and reparation, and that of the evidence-base for the treatment of the effects of developmental trauma such as trauma-informed practice. NTV stated:

> "Trauma-informed services do no harm i.e. they do not re-traumatise or blame victims for their efforts to manage their traumatic reactions, and they embrace a message of hope and optimism that recovery is possible. In trauma-informed services, trauma survivors are seen as unique individuals who have experienced extremely abnormal situations and have managed as best they could."

109. It is unclear if the two are balanced by behaviour change services and if, within a group environment, that an expectation of such a balance is possible or even reasonable. Nonetheless, it is appropriate that behaviour change services are confident the content of the programs do not re-traumatise, and that the assessment of participants includes the

identification of their history of trauma and this is considered in the program they are offered.

110. As stated by RAV, behaviour change programs move men through a group process aimed at accountability, self-responsibility, self-insight and self-reflection which can result in a man actively changing how he thinks while he recognises he has choices over his own perceptions which can result in him making better choices about interpersonal relationships and himself. RAV, NTV and APS provided comprehensive references for the evidence bases supporting this approach, however, it is unclear how much of the focus is on the learning of new ways to self-regulate their emotional responses and what are more appropriate behaviours.

111. The group behaviour change programs run for many weeks however, the ability of participants to embed lifetime positive change to thinking and resultant behaviours is unclear, for example, are new behaviours and strategies resistive to the effects of substance use. The VSR Longstanding Group data supported that the anger/angry behaviours for many of the deceased had been repeated over many years and may often have been learned while young and/or during exposure to developmental or other trauma. RAV and NTV noted referral to post-program supports if needed, but this was not explored further.

(g) Lack of insight into the effects of anger/angry behaviours on children

112. Men who use anger/angry behaviours often lack insight into the impacts of their behaviours on their children, and the trauma it can cause. According to the stories of the deceased's family, friends and their medical records, many did not accept there was a link between their use of anger/angry behaviours and their relationships with their children, especially older children, who described their own reasons for not having a relationship with their father included their experience of anger and angry behaviours – for example:

> "My dad texted me that he loved me, wanted to see me but really I was too scared of him; Kept saying he loved his kids but they were older now and wanted nothing to do with him; He blamed me for his son not talking to him. He always hit him and bullied him and seemed to enjoy it; Stopped work so he didn't have to pay for the kids then tell 'em it was their mother's fault; and He would yell at me and say he was my father and I had to see him when he said."

113. There were also stories that the deceased missed their children and vice versa, and of isolation from family and friends, which, as noted in the submissions, was often self-imposed – for example:

> "He was a great Dad, always taking me to footy and netball; The kids are devastated; I don't understand why he left us, he should've got help; Since he had to leave it was all about getting custody of the kids and he was worried he wouldn't get to be with them; He was fighting for custody but he wouldn't see the kids. He could have; I know Dad got angry at Mum, but I really miss him; When he moved in with us, all he thought about was the kids and I worried too because they're my grandkids and I saw them all the time, but not now, not at all; At work he just went on and on about the kids, like how much he missed them, if they were alright, how he reckon'd he'd let them down. I couldn't help him; and He used to take the kids boating when we all stayed at the park every Christmas since we were at uni, but when they spilt up he wouldn't come at all, wouldn't bring the kids."

(h) Contingent suicidality

114. As noted by RAV, threats to suicide are sometimes used by men to control. Contingent suicidality is a threat to suicide dependent on a desired response by the person the threat is directed to. These were not restricted to proximity to death, but had often occurred throughout a relationship or in circumstances related to separation – For example:

> "I wanted to go on a holiday with my sister and he said he'd kill himself while I was away but he didn't; I stayed because each time I talked about leaving he threatened to kill himself. It took me years to realise it was emotional blackmail; He told me a lot that if he did drive his car into a tree without his seatbelt it'd be because I made him; and I went to Mum's but he texted me over 120 times that he'd kill himself if I didn't go home. I couldn't handle it, so I went back."

(i) Death of family and non-family as a stressor

115. The VSR data showed that across all deaths (2,554) in the All Deaths Cohort, 27.1% (524) of males had a family death as a stressor. Of the 983 deceased males who had at least one identified family stressor, 53.3% (524) had a family death as a stressor. Across all deaths (667) in the Anger/Angry Behaviours Cohort, 26.7% (152) of males had a family death as a stressor. Of the 365 deceased males in this cohort who had at least one identified family stressor, 41.6% (152) had a family death as a stressor.

116. Across all deaths (2,554) in the All Deaths Cohort, 5% (97) males had a non-family death as a stressor. Of the 835 deceased males who had at least one identified non-family stressor, 11.6% (97) had a non-family death as a stressor. Across all deaths (667) in the Anger/Angry Behaviours Cohort, 6.5% (37) males had a non-family death as a stressor. Of the 323 deceased males who had at least one identified non-family stressor, 11.4% (37) had a non-family death as a stressor.

117. This was not explored in depth, however, suggested grief, loss and the importance of friendships outside of and especially within families have an impact on the risk of suicides in men.

(j) Physical health stressors

118. 46% of males in the Anger/Angry Behaviours Cohort had at least one physical health stressor. Of the 262 males with at least one physical health stressor, 62.2% had an illness, 41.6% an injury, and 45% had pain. Across the Longstanding and Recent Groups, the proportions were lower for injury and pain, however, 72.7% of Recent Group deceased males had a physical illness as a stressor which was not associated with any specific age group. This was not further explored, and the numbers are small (n=24), however, this may suggest physical illness may impact on the risk of suicide in men who have recently developed anger and angry behaviours.

Submission recommendations

119. RAV, NTV, RACGP and APS were invited to suggest recommendations with a focus on the prevention of suicide deaths in males aged 35 to 74 years. Their recommendations shared similar themes including: how services are delivered to men; practitioner knowledge including assessing risk of suicide for men and evidence-based interventions; public campaigns that promote help-seeking amongst men; and the need for further research. Their recommendations were valuable and were based on their experiences and knowledge of the organisations and practitioners who provide services to these men.

120. RAV's Ms Tassone, and Ms Wynters of Brophy Family and Youth Services provided the evidence base, purpose and goals for behaviour change programs. The behaviour change program elements of thought stacking and dangerous thinking are logical and relatable, and provide a framework to challenge thinking and promote recognition by a man that what he thinks is a normal thinking pattern, is not.

121. However, although information on thought stacking and tips for controlling anger are available, it is not overt. In the experiences of the submitting organisations and the Court, this information is not readily understood or utilised by many of the practitioners and services who are often the initial contacts for men in this age group. This is particularly so for those men whose behaviours are new and out of character, when early intervention is likely to be most effective. To identify these men would require a deliberate discussion about his behaviours with an emphasis on anger and angry behaviours, but it is not clear this would occur routinely when a man seeks help from primary care or other practitioners, and, if this did occur, what an appropriate intervention would be.

122. Notwithstanding, aggression and violence were factors identified in the stories from family, friends and others, and evident in the VSR data and in the circumstances of Mr A's death. Consequently, prevention opportunities associated with the VSR cohorts discussed above would ideally start before the development of sustained and patterned angry behaviours and violence.

CONCLUSION

123. Mr A had a 42-year-history of intimate partner violence including verbal and physical aggression to his wife, which was often associated with his consuming alcohol. He reported some suicidal ideation and a lowered mood when asked, and that he was concerned he was at risk of losing everything if Mrs A did not return home. The realisation that his hope of Mrs A returning to the marriage and his status quo, mixed with periods of insight documented as guilt and shame, potentially impacted his mental state. Notes he left for his wife and family suggested that any insight into the nexus of his aggressive and angry behaviours experienced during the behaviour change program was fleeting, or was not forefront in his mind when affected by alcohol. He did not seek help for his lowered mood, for the grief he experienced at the loss of the relationship with Mrs A, or suicidal thinking, despite the encouragement of his friend Mr B to seek counselling.

124. The coronial experience as illustrated by Mr A's death bears out NTV's conclusion that:

> "If men are left alone, they pose a risk both to themselves and their families as they are more likely to be living with untreated mental illness, be coping through the use of drugs and alcohol, and are more likely to externalise their symptoms by blaming their partners, families, or society more broadly."

125. There is some suggestion that focus on men who are angry should begin especially early after the act of IPV, however, the VSR data suggested there may be opportunities to intervene still earlier, and the ability to intervene lies not with specialist behaviour change services or specialist family violence services, but with primary care services.

126. The Department of Health and Human Services has comprehensive family violence workforce development plans which rightly focus on the victims of family violence. There also exists however, missed opportunities to focus on the prevention of violence perpetrated by men who are angry/exhibit angry behaviours, and the prevention of their suicide deaths. The VSR data supported a high proportion of mood disorders across the deceased males, but little is known about the relationship with the anger/angry behaviours of the deceased, or if it was an indicator of increased risk.

127. Men whose behaviours have recently changed to include anger/angry behaviours which is noticed by partners, family and friends, may be the group most receptive to intervention. These men are more likely to access a social service or general practitioner in the first instance, and the development of skills in working with these men would be appropriate. This should include information for primary healthcare providers and other associated services about what services are available for men who require specialist input for any current or escalating anger and associated behaviours that may or may not be associated with a mental disorder or current interpersonal or contextual stressors.

128. Violence and aggression were factors associated with Mr A's death, and this reflects the experience of many partners, families and friends, in similar circumstances – there is distress and trauma before and after the death. What was reassuring from the submissions provided, was that these organisations have identified strategies and options to reduce both the violence and aggression, but also the suicide of these men. Nonetheless, the VSR data revealed there are further opportunities to enhance the prevention of suicide in such cases.

129. I wish to acknowledge the significant efforts of the CPU Mental Health Team in conducting the considered research and data analysis for this investigation. Their findings, coupled with the firsthand knowledge and experience offered by the submitting organisations, have greatly assisted my ability to identify prevention opportunities and frame my recommendations.

FINDINGS

130. Having investigated the death of Mr A, and having considered all of the available evidence, I am satisfied that no further investigation is required.

131. On the basis of the available evidence, I am satisfied to the requisite standard that Mr A intentionally ended his own life.

132. I make the following findings, pursuant to section 67(1) of the *Coroners Act 2008*:

(a) that the identity of the deceased was Mr A, born [redacted];

(b) that Mr A died between [redacted], at [redacted], from compression of the neck consequent upon hanging; and

(c) that the death occurred in the circumstances described in the paragraphs above.

COMMENTS

133. Pursuant to section 67(3) of the *Coroners Act 2008*, I make the following comments connected with the death:

(a) It is not within the scope of the Coroner to recommend service delivery pathways and innovations, however, encouragement is given to funding bodies, organisations, practitioners and social services that concerted consultation and involvement of men as service providers and service users, is undertaken as part of the design and development of such pathways and service innovations.

RECOMMENDATIONS

134. Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendations connected with the death:

Family Safety Victoria

(a) Family Safety Victoria work with the Blue Knot Foundation to review the behaviour change program for opportunities to embed trauma-informed principles and practices;

(b) To improve the safety of the men who engage in family violence behaviour change programs, the Family Safety Victoria Minimum Standards should include:

i. Active and explicit discussion about suicidal thinking in the program interventions and material;

ii. Assessment for suicide risk at entry and regular review throughout the program;

iii. Use of a screening tool for a mood disorder as part of assessment; and

iv. Include as part of the program, a mental and physical health focus with connection to a participant's local general practitioner.

Department of Health and Human Services

(a) To reduce the suicide of men through the promotion of help-seeking, develop public awareness raising strategies that:

i. Are inclusive of all men and promote early help-seeking as normal and appropriate;

ii. Target times in a man's life when he is likely more vulnerable, including relationship breakdowns, and advice of what services are available and how to access them;

iii. Explore the problems associated with a reliance on alcohol to manage distress and such things as sadness, poor sleep and increased stress; and

iv. Promote addiction services to men as an accessible and appropriate option in circumstances when substance use is contributing to anger, aggression and violence.

(b) To increase the engagement of men with social services and practitioners, develop advice for the community of ways to increase both the appeal of, and engagement with services by men.

Department of Health and Human Services and Family Safety Victoria

(a) The Department of Health and Human Services and Family Safety Victoria work together with organisations who provide behaviour change programs for men, professional bodies, social services, mental health services, and with particular emphasis on involvement of general practitioners and addiction services, develop practical information about the relationship between angry behaviours, violence and

associated suicide risk. The information should focus on practical interventions and strategies for men who have anger and/or with angry behaviours, and include when and where to seek specialist advice.

135. I convey my sincerest sympathy to Mr A's family and friends.

136. Pursuant to section 73(1A) of the *Coroners Act 2008*, I order that this Finding be published on the internet.

137. I direct that a copy of this finding be provided to the following:

(a) Mr A's family, senior next of kin;

(b) Investigating Member, Victoria Police; and

(c) Interested Parties:

i. The Department of Health and Human Services;

ii. Family Safety Victoria;

iii. Dr Cameron Loy – Royal Australian College of General Practitioners;

iv. Dr Lyn O'Grady – Australian Psychology Society;

v. Simone Tassone – No to Violence;

vi. Relationships Australia – Victoria;

vii. Royal Commission on Mental Health Services in Victoria;

viii. The Hon. Martin Foley MP, Minister for Mental Health;

ix. The Hon. Jenny Mikakos, Minister for the Coordination of Health and Human Services;

x. Chief Psychiatrist, Dr Neil Coventry, and Chief Mental Health Nurse, Ms Anna Love;

xi. Blue Knot Foundation; and

xii. National Health and Medical Research Council.

Signature:

MR JOHN OLLE

CORONER

Date: 2 September 2020

Attachment A: Victoria Suicide Register Data Tables

1. Case identification

The CPU searched the VSR to identify every suicide investigated by a Victorian Coroner between 2009 and 2015 where the deceased age was between 35 and 74.[14]

For each relevant death, the CPU recorded the local case number, case year, deceased sex and age, interpersonal stressors, contextual stressors, evidence of exposure to suicide and evidence of the deceased's contact with health services for treatment of mental health related issues within 12 months of death.

The search strategy used by the CPU was reliant on thorough and accurate coding in the VSR. Therefore, it is possible that the CPU did not identify all relevant deaths. Further to this point, the amount of information contained in the VSR can vary significantly between deaths, depending on a range of factors including the thoroughness and focus of the coronial investigation, and the material that is available for coding into the VSR.

1.2 Relevant deaths - All Deaths Cohort

The CPU identified 2554 relevant deaths for analysis as extracted from the VSR in January 2020. Among the deceased, 1932 (75.6%) were males.

1.3 Data tables for suicides 2009 to 2015 with age between 35 and 74

Table 1: Frequency and proportion by sex of the All Sex Cohort for experience of partner stressors, Victoria 2009-2015

Partner stressors*	Male		Female		All	
	N	%	N	%	N	%
Evidence of stressors	**1146**	**59.3**	**359**	**57.7**	**1505**	**58.9**
Partner death	71	3.7	50	8.0	121	4.7
Partner separation	867	44.9	238	38.3	1105	43.3
Partner conflict	685	35.5	182	29.3	867	33.9
Partner health issues	83	4.3	48	7.7	131	5.1
Partner FV	304	15.7	110	17.7	414	16.2
No evidence of stressors	**786**	**40.7**	**263**	**42.3**	**1049**	**41.1**
Total	**1932**	**100.0**	**622**	**100.0**	**2554**	**100.0**

*Please note a deceased may have experienced multiple partner stressors.

[14] Data between 2009 and 2015 was extracted as these are the years for which enhanced data entry was complete in the VSR.

Table 2: Frequency and proportion by sex of the All Sex Cohort for experience of family stressors, Victoria 2009-2015.

Family stressors	Male		Female		All	
	N	%	N	%	N	%
Evidence of stressors	**983**	**50.9**	**374**	**60.1**	**1357**	**53.1**
Family death	524	27.1	196	31.5	720	28.2
Family conflict	523	27.1	217	34.9	740	29.0
Family health issues	248	12.8	124	19.9	372	14.6
Family FV	213	11.0	97	15.6	310	12.1
No evidence of stressors	**949**	**49.1**	**248**	**39.9**	**1197**	**46.9**
Total	**1932**	**100.0**	**622**	**100.0**	**2554**	**100.0**

*Please note a deceased may have experienced multiple family stressors.

Table 3: Frequency and proportion by sex of the All Sex Cohort for experience of non-family stressors, Victoria 2009-2015.

Non-family stressors	Male		Female		All	
	N	%	N	%	N	%
Evidence of stressors	**835**	**43.2**	**309**	**49.7**	**1144**	**44.8**
Non-family death	97	5.0	42	6.8	139	5.4
Non-family conflict	253	13.1	101	16.2	354	13.9
Non-family health issues	12	0.6	7	1.1	19	0.7
Fam-friends other	668	34.6	230	37.0	898	35.2
No evidence of stressors	**1097**	**56.8**	**313**	**50.3**	**1410**	**55.2**
Total	**1932**	**100.0**	**622**	**100.0**	**2554**	**100.0**

*Please note a deceased may have experienced multiple non-family stressors.

Table 4: Frequency and proportion by sex of the All Sex Cohort for experience of contextual stressors, Victoria 2009-2015.

Contextual Stressors*	Male		Female		All	
	N	%	N	%	N	%
Evidence of stressors	**1670**	**86.4**	**504**	**81.0**	**2174**	**85.1**
Work	796	41.2	186	29.9	982	38.4
Financial	762	39.4	203	32.6	965	37.8
Legal	556	28.8	123	19.8	679	26.6
Sexuality	58	3.0	14	2.3	72	2.8
Isolation	308	15.9	134	21.5	442	17.3
Abuse**	584	30.2	233	37.5	817	32.0
Education	55	2.8	21	3.4	76	3.0
Bullying**	206	10.7	77	12.4	283	11.1
Substance abuse/use	941	48.7	247	39.7	1188	46.5
Other stressors	419	21.7	84	13.5	503	19.7
No evidence of stressors	**262**	**13.6**	**118**	**19.0**	**380**	**14.9**
Total	**1932**	**100.0**	**622**	**100.0**	**2554**	**100.0**

*Please note a deceased may have experienced multiple contextual stressors.

**Abuse and Bullying coding included experience as perpetrator and/or victim.

Table 5: Frequency and proportion by sex of the All Sex Cohort for a documented mental disorder diagnosis coded to ICD-10 Classification of Mental and Behavioural Disorders, Victoria 2009-2015.*

Mental disorders formal diagnosis**	Male		Female		All	
	N	%	N	%	N	%
Documented diagnosis* **	**1,021**	**52.8**	**446**	**71.7**	**1,467**	**57.4**
F01-F09 - Physiological	21	1.1	4	0.6	25	1.0
F10-F19 - Substances	215	11.1	73	11.7	288	11.3
F20-F29 - Non-mood psychotic	119	6.2	60	9.6	179	7.0
F30-F39 - Mood	837	43.3	382	61.4	1,219	47.7
F40-F49 - Non-psychotic/mood	337	17.4	180	28.9	517	20.2
F50-F59 - Physiological/physical	18	0.9	20	3.2	38	1.5
F60-F69 - Personality	83	4.3	83	13.3	166	6.5
F70-F79 - Intellectual disabilities	2	0.1	0	0.0	2	0.1
F80-F89 - Developmental	9	0.5	1	0.2	10	0.4
F90-F98 - Child/adolescent onset	12	0.6	3	0.5	15	0.6
F99-F99 - Unspecified	6	0.3	1	0.2	7	0.3
No documented diagnosis	**912**	**47.2**	**176**	**28.3**	**1,088**	**42.6**
Total	**1,933**	**100.0**	**622**	**100.0**	**2,555***	**100.0**

*Data extracted 4 June 2020.

**The proximity of the formal diagnosis to the death was not explored for the purposes of this report.

***Deceased may have had multiple diagnoses.

Table 6: Frequency and proportion by sex and involved clinician of the All Sex Cohort for experience of contact with a treating practitioner for a mental health reason within 12 months of death, Victoria 2009-2015.

Treating	Male		Female		All	
practitioner	**N**	**%**	**N**	**%**	**N**	**%**
Treatment within 12 Months*	**1155**	**59.8**	**482**	**77.5**	**1637**	**64.1**
Psychiatrist	533	27.6	276	44.4	809	31.7
Psychologist	264	13.7	118	19.0	382	15.0
Mental Health Practitioner	412	21.3	196	31.5	608	23.8
General Practitioner	838	43.4	360	57.9	1198	46.9
Emergency Department Clinician	273	14.1	122	19.6	395	15.5
CATT	170	8.8	94	15.1	264	10.3
Drug and Alcohol Clinician	99	5.1	23	3.7	122	4.8
No Treatment within 12 months	**777**	**40.2**	**140**	**22.5**	**917**	**35.9**
Total	**1932**	**100.0**	**622**	**100.0**	**2554**	**100.0**

*Please note a deceased may consulted more than one practitioner type/discipline.

2. Anger/Angry Behaviour Cohort Data Tables

The CPU VSR Anger/Angry Behaviour Cohort data summary utilised the dataset from the CPU All Deaths Cohort, tables 1 – 6. The same caveats and notations apply. Using the existing VSR coded datasets completed on the 2554 deceased who suicided between 2009 and 2015, combined with the narratives of family, friends, employers and others, further coding was completed for the presence of stated anger/angry behaviours[15]. These deaths were further coded for information about the duration of such behaviours.

Coding included use of variants of words used in narratives including angry, aggressive, threatening, intimidating, argumentative, abusive, all abuse including sexual, physical, psychological, constraints and restrictive practices, financial, legal, systemic/services, all types of neglect, passive such a sulking, shouting, bickering, criticism, bullying, fighting, throwing things around, property damage etc. combined with evidence of orders or other activities related to aggression and violence.

463 (males 74.7% and females 25.3%) case narratives from family, friends, neighbours, practitioners etc were considered as insufficient to assess presence or absence of anger/angry behaviours.

1424 (68%) of 2091 remaining case narratives did not contain stated anger/angry behaviours associated with the deceased (males 71% and females 29%).

2.1. Relevant deaths

In 667 (32%) the case narratives contained explicit evidence of anger/angry behaviours associated with the deceased; 570 of the deceased (85%) were males and 97 (15%) were female.

Across both male and female deceased the greater proportion of stated anger/angry behaviours occurred in the 35 - 44 and 45 - 54 age groups 507 (76%).

2.2 Data tables for Anger/Angry Behaviour Cohort

Table 7: Frequency and proportion by sex of the Anger/angry Behaviour Cohort for experience of partner stressors, Victoria 2009-2015.

Partner stressors*	Male		Female		All	
	N	%	N	%	N	%
Evidence of stressors	**490**	**86.0**	**75**	**77.3**	**565**	**84.7**
Partner death	23	4.0	6	6.2	29	4.3
Partner separation	326	57.2	46	47.4	372	55.8
Partner conflict	400	70.2	52	53.6	452	67.8
Partner health issues	25	4.4	5	5.2	30	4.5
Partner FV	205	36.0	32	33.0	237	35.5
No evidence of stressors	**80**	**14.0**	**22**	**22.7**	**102**	**15.3**
Total	**570**	**100.0**	**97**	**100.0**	**667**	**100.0**

*Please note a deceased may have experienced multiple partner stressors.

[15] Analysis included the use of variants of words including “angry”, “aggressive”, “threatening”, “intimidating”, “argumentative”, and “abusive”.

Table 8: Frequency and proportion by sex of the Anger/angry Behaviour Cohort (Table 7) with at least one partner stressor, Victoria 2009-2015.

Partner stressors*	Male		Female		All	
	N	%	N	%	N	%
Partner stressors	**490**	**100**	**75**	**100**	**565**	**100**
Partner death	23	4.7	6	8.0	29	5.1
Partner separation	326	66.5	46	61.0	372	65.8
Partner conflict	400	81.6	52	69.3	452	80.0
Partner health issues	25	5.1	5	6.6	30	5.3
Partner FV	205	41.8	32	42.6	237	41.9
Total	**490**	**100**	**75**	**100**	**565**	**100**

*Please note a deceased may have experienced multiple partner stressors.

Table 9: Frequency and proportion by sex of the Anger/angry Behaviour Cohort for experience of family stressors, Victoria 2009-2015.

Family stressors*	Male		Female		All	
	N	%	N	%	N	%
Evidence of stressors	**365**	**64.0**	**77**	**79.4**	**442**	**66.3**
Family death	152	26.7	38	39.2	190	28.5
Family conflict	243	42.6	53	54.6	296	44.4
Family health issues	69	12.1	20	20.6	89	13.3
Family FV	105	18.4	26	26.8	131	19.6
No evidence of stressors	**205**	**36.0**	**20**	**20.6**	**225**	**33.7**
Total	**570**	**100.0**	**97**	**100.0**	**667**	**100.0**

*Please note a deceased may have experienced multiple family stressors.

Table 10: Frequency and proportion by sex of the Anger/angry Behaviour Cohort (Table 9) with at least one family stressor, Victoria 2009-2015.

Family stressors*	Male		Female		All	
	N	%	N	%	N	%
Family stressors	**365**	**100.0**	**77**	**100.0**	**442**	**100.0**
Family death	152	41.6	38	49.3	190	42.9
Family conflict	243	66.5	53	68.8	296	66.9
Family health issues	69	18.9	20	25.9	89	20.1
Family FV	105	28.7	26	33.7	131	29.6
Total	**365**	**100.0**	**77**	**100.0**	**442**	**100.0**

*Please note a deceased may have experienced multiple family stressors.

Table 11: Frequency and proportion by sex of the Anger/angry Behaviour Cohort for experience of non-family stressors, Victoria 2009-2015.

Non-family stressors*	Male		Female		All	
	N	%	N	%	N	%
Evidence of stressors	**323**	**56.7**	**63**	**64.9**	**386**	**57.9**
Non-family death	37	6.5	9	9.3	46	6.9
Non-family conflict	127	22.3	31	32.0	158	23.7
Non-family health issues	2	0.4	0	0.0	2	0.3
Fam-friends other**	228	40.0	44	45.4	272	40.8
No evidence of stressors	**247**	**43.3**	**34**	**35.1**	**281**	**42.1**
Total	**570**	**100.0**	**97**	**100.0**	**667**	**100.0**

*Please note a deceased may have experienced multiple non-family stressors.

**Family-Friends – Other includes a specific identified stressor, for example, a one-off aggressive or violent incident (king-hit in a bar or verbal abuse from a passenger on a train).

Table 12: Frequency and proportion by sex of the Anger/angry Behaviour Cohort (Table 11) with at least one non-family stressor, Victoria 2009-2015.

Non-family stressors*	Male		Female		All	
	N	%	N	%	N	%
Non-family stressors	**323**	**100.0**	**63**	**100.0**	**386**	**100.0**
Non-family death	37	11.4	9	14.2	46	11.9
Non-family conflict	127	39.3	31	49.2	158	40.9
Non-family health issues	2	0.6	0	0	2	0.5
Fam-friends other**	228	70.5	44	69.8	272	70.4
Total	**323**	**100.0**	**63**	**100.0**	**386**	**100.0**

*Please note a deceased may have experienced multiple non-family stressors.

**Family-Friends – Other includes a specific identified stressor, for example, a one-off aggressive or violent incident (king-hit in a bar or verbal abuse from a passenger on a train).

Table 13: Frequency and proportion by sex of the Anger/angry Behaviour Cohort for experience of contextual stressors, Victoria 2009-2015.

Contextual Stressors*	Male		Female		All	
	N	%	N	%	N	%
Evidence of stressors	**544**	**95.4**	**89**	**91.8**	**633**	**94.9**
Work	265	46.5	25	25.8	290	43.5
Financial	260	45.6	33	34.0	293	43.9
Legal	218	38.2	37	38.1	255	38.2
Sexuality	10	1.8	2	2.1	12	1.8
Isolation	67	11.8	23	23.7	90	13.5
Abuse**	292	51.2	61	62.9	355	53.2
Education	18	3.2	3	3.1	21	3.1
Bullying**	120	21.1	18	18.6	138	20.7
Substance abuse/use	363	63.7	56	57.7	419	62.8
Other stressors	140	24.6	19	19.6	159	23.8
No evidence of stressors	**26**	**4.6**	**8**	**8.2**	**34**	**5.1**
Total	**570**	**100.0**	**97**	**100.0**	**667**	**100.0**

*Please note a deceased may have experienced multiple contextual stressors.

**Abuse and Bullying coding included experience as perpetrator and/or victim.

Unemployment as a stressor across all deaths was 208 (31.1%).

Isolation as a stressor was most frequent for males 67 (70.1%) in the 34 – 44 and 45 – 54 age groups and most frequent for females 23 (73.9%) in 45 – 54 and 55 – 64 age groups.

Table 14: Frequency and proportion by sex and involved clinician of the Anger/angry Behaviour Cohort for experience of contact with a treating practitioner for a mental health reason within 12 months of death, Victoria 2009-2015.

Treating	Male		Female		All	
Practitioner*	**N**	**%**	**N**	**%**	**N**	**%**
Treatment within 12 Months	**248**	**43.5**	**67**	**69.1**	**315**	**47.2**
Psychiatrist	93	16.3	24	24.7	117	17.5
Psychologist	52	9.1	6	6.2	58	8.7
Mental Health Practitioner	67	11.8	19	19.6	86	12.9
General Practitioner	163	28.6	45	46.4	208	31.2
Emergency Department Clinician	53	9.3	13	13.4	66	9.9
CATT	23	4.0	9	9.3	32	4.8
Drug and Alcohol Clinician	20	3.5	4	4.1	24	3.6
No Treatment within 12 months	**322**	**56.5**	**30**	**30.9**	**352**	**52.8**
Total	**570**	**100.0**	**97**	**100.0**	**667**	**100.0**

*Please note that a deceased person may have been treated by multiple practitioners within 12 months prior to their death.

Table 15: Frequency and proportion by sex and involved clinician of the Anger/angry Behaviour Cohort (Table 14) with at least one contact with a treating practitioner for a mental health reason within 12 months of death, Victoria 2009-2015.

Treating	Male		Female		All	
Practitioner*	**N**	**%**	**N**	**%**	**N**	**%**
Treatment within 12 Months	**248**	**100.0**	**67**	**100.0**	**315**	**100.0**
Psychiatrist	93	37.5	24	35.8	117	37.1
Psychologist	52	20.9	6	8.9	58	18.4
Mental Health Practitioner	67	27.0	19	28.3	86	27.3
General Practitioner	163	65.7	45	67.1	208	66.0
Emergency Department Clinician	53	21.3	13	19.4	66	20.9
CATT	23	9.2	9	13.4	32	10.1
Drug and Alcohol Clinician	20	8.0	4	5.9	24	7.6
Total	**248**	**100.0**	**67**	**100.0**	**315**	**100.0**

*Please note that a deceased person may have been treated by multiple practitioners within 12 months prior to their death.

Table 16: Frequency and proportion by sex of the Anger/angry Behaviour Cohort for evidence of a documented mental disorder diagnosis coded to ICD-10 Classification of Mental and Behavioural Disorders, Victoria 2009-2015.

Mental disorders	Male		Female		All	
Formal Diagnosis*	**N**	**%**	**N**	**%**	**N**	**%**
Documented diagnosis**	**284**	**49.8**	**72**	**74.2**	**356**	**53.4**
F01-F09 - Physiological	7	1.2	1	1.0	8	1.2
F10-F19 - Substances	70	12.3	15	15.5	85	12.7
F20-F29 - Non-mood psychotic	19	3.3	9	9.3	28	4.2
F30-F39 - Mood	240	42.1	60	61.9	300	45.0
F40-F49 - Non-psychotic/mood	94	16.5	22	22.7	116	17.4
F50-F59 - Physiological/physical	3	0.5	0	0.0	3	0.4
F60-F69 – Personality	32	5.6	18	18.6	50	7.5
F70-F79 - Intellectual disabilities	0	0.0	0	0.0	0	0.0
F80-F89 - Developmental	1	0.2	1	1.0	2	0.3
F90-F98 - Child/adolescent onset	4	0.7	1	1.0	5	0.7
F99-F99 - Unspecified	4	0.7	0	0.0	4	0.6
No documented diagnosis	**286**	**50.2**	**25**	**25.8**	**311**	**46.6**
Total	**570**	**100.0**	**97**	**100.0**	**667**	**100.0**

*The proximity of the diagnosis to the death was not explored for the purposes of this report.

**Deceased may have had multiple diagnoses.

Table 17: Frequency and proportion by sex of the Anger/angry Behaviour Cohort (Table 16) with a documented mental disorder diagnosis coded to ICD-10 Classification of Mental and Behavioural Disorders, Victoria 2009-2015.

Mental disorders	Male		Female		All	
Formal Diagnosis*	**N**	**%**	**N**	**%**	**N**	**%**
Documented diagnosis**	**284**	**100.0**	**72**	**100.0**	**356**	**100.0**
F01-F09 - Physiological	7	2.4	1	1.3	8	2.1
F10-F19 - Substances	70	24.6	15	20.8	85	23.8
F20-F29 - Non-mood psychotic	19	6.6	9	12.5	28	7.8
F30-F39 - Mood	240	84.5	60	83.3	300	84.2
F40-F49 - Non-psychotic/mood	94	33	22	30.5	116	32.5
F50-F59 - Physiological/physical	3	1.0	0	0.0	3	0.8
F60-F69 – Personality	32	11.2	18	25.0	50	14.0
F70-F79 - Intellectual disabilities	0	0.0	0	0.0	0	0.0
F80-F89 - Developmental	1	0.3	1	1.3	2	0.5
F90-F98 - Child/adolescent onset	4	1.4	1	1.3	5	1.4
F99-F99 - Unspecified	4	1.4	0	0.0	4	1.4
Total	**284**	**100.0**	**72**	**100.0**	**356**	**100.0**

*The proximity of the diagnosis to the death was not explored for the purposes of this report.

**Deceased may have had multiple diagnoses.

Table 18: Frequency and proportion by sex of the Anger/angry Behaviour Cohort for experience of physical illness, physical injury and/or pain present proximate to death, Victoria 2009-2015.

Physical health stressors*	Male		Female		All	
	N	**%**	**N**	**%**	**N**	**%**
Evidence of stressors	**262**	**46.0**	**48**	**49.5**	**310**	**46.5**
Physical illness	163	28.6	39	40.2	202	30.3
Physical injury	109	19.1	9	9.3	118	17.7
Pain	118	20.7	24	24.7	142	21.3
No evidence of stressor	**308**	**54.0**	**49**	**50.5**	**357**	**53.5**
Total	**570**	**100.0**	**97**	**100.0**	**667**	**100.0**

*Deceased may have experienced multiple physical health stressors.

Table 19: Frequency and proportion by sex of the Anger/angry Behaviour Cohort (Table 18) with a documented physical illness, physical injury and/or pain present proximate to death, Victoria 2009-2015.

Physical health related	Male		Female		All	
	N	%	N	%	N	%
Physical health stressors*	**262**	**100.00**	**48**	**100.00**	**310**	**100.0**
Physical illness	163	62.2	39	81.2	202	65.1
Physical injury	109	41.6	9	18.7	118	38.0
Pain	118	45.0	24	50	142	45.8
Total	**262**	**100.00**	**48**	**100.00**	**310**	**100.0**

*Deceased may have experienced multiple physical health stressors.

Table 20: Frequency and proportion by sex of the Anger/angry Behaviour Cohort for experience of substance use as a stressor and/or a formal substance use diagnosis and/or evidence of specialist addiction service contact Victoria 2009-2015.

Substance related stressor*	Male		Female		All	
	N	%	N	%	N	%
Evidence of stressor	**363**	**63.7**	**56**	**57.7**	**419**	**62.8**
Formal diagnosis	64	11.2	15	15.5	79	11.8
Addiction service contact	19	3.3	4	4.1	23	3.4
No evidence of stressor	**207**	**36.3**	**41**	**42.3**	**248**	**37.2**
Total	**570**	**100.0**	**97**	**100.0**	**667**	**100.0**

*Substance use requires evidence of impact of the substance use as a stressor.

Table 21: Frequency and proportion by sex of the Anger/angry Behaviour Cohort (Table 20) with a substance use stressor for formal substance use diagnosis and/or evidence of specialist addiction service contact Victoria 2009-2015.

Substance related	Male		Female		All	
	N	%	N	%	N	%
Substance related stressor*	**363**	**100.00**	**56**	**100.00**	**419**	**100.0**
Formal diagnosis	64	17.6	15	26.7	79	18.8
Addiction service contact	19	5.2	4	7.1	23	5.4
Total	**363**	**100.00**	**56**	**100.00**	**419**	**100.0**

*Substance use requires evidence of impact of the substance use as a stressor.

Table 22: Frequency and proportion by sex of the Anger/angry Behaviour Cohort for evidence of substances detected by type in post-mortem toxicology Victoria 2009-2015.

Post-mortem toxicology	Male		Female		All	
	N	%	N	%	N	%
Toxicology	**570**	**100.0**	**97**	**100.0**	**667**	**100.0**
Substance detected	**469**	**82.3**	**81**	**83.5**	**550**	**82.5**
Alcohol	269	47.2	34	35.1	303	45.4
Illicit drugs	115	20.2	14	14.4	129	19.3
Prescription medicines	334	58.6	76	78.4	410	61.5
Nil detected	**101**	**17.7**	**16**	**16.5**	**117**	**17.5**
Total	**570**	**100.0**	**97**	**100.0**	**667**	**100.0**

Table 23: Frequency and proportion by sex of the Anger/angry Behaviour Cohort (Table 22) with detected substances by type in post-mortem toxicology Victoria 2009-2015.

Post-mortem toxicology	Male		Female		All	
	N	%	N	%	N	%
Substance detected	**469**	**100.00**	**81**	**100.00**	**550**	**100.0**
Alcohol	269	57.3	34	41.9	303	55.0
Illicit drugs	115	24.5	14	17.2	129	23.4
Prescription medicines	334	71.2	76	93.8	410	74.5
Total	**469**	**100.00**	**81**	**100.00**	**550**	**100.0**

3. Duration of Anger/angry Behaviours Cohort

3.1 Relevant deaths

Of the 667 case narratives that contained stated anger/angry behaviours associated with the deceased, 229 (34.3%) contained enough evidence and information to code for the duration of anger/angry behaviours of which 205 (89.5%) males and 24 (10.5%).

Further analysis focused on the male deaths in line with the scope of the Coroner's request.

From the 205 narratives associated with the deceased males, two groups emerged, a) the deceased who had longstanding anger/angry behaviours 119 (58%) and b) those who had developed anger/angry behaviours in the months/year preceding their death 86 (42%). These are referred to as Longstanding Group and Recent Group respectively, refer tables 24 - 34.

3.2 Data tables for the Duration of Anger/angry Behaviours Cohort

Table 24: Frequency and proportion by Longstanding and Recent groups of the Duration of Anger/angry Behaviours Cohort for experience of contextual stressors, Victoria 2009-2015.

Contextual Stressors*	Longstanding		Recent		All	
	N	%	N	%	N	%
Evidence of Stressors	**119**	**100.0**	**86**	**100.0**	**205**	**100.0**
Work	48	40.3	42	48.8	90	43.9
Financial	59	49.6	44	51.2	103	50.2
Legal	78	65.5	38	44.2	116	56.6
Sexuality	2	1.7	1	1.2	3	1.5
Isolation	14	11.8	6	7.0	20	9.8
Abuse**	107	89.9	76	88.4	183	89.3
Education	5	4.2	2	2.3	7	3.4
Bullying**	55	46.2	25	29.1	80	39.0
Substance abuse/use	92	77.3	53	61.6	145	70.7
Other stressors	32	26.9	20	23.3	52	25.4
No evidence of stressors	**0**	**0.0**	**0**	**0.0**	**0**	**0.0**
Total	**119**	**100.0**	**86**	**100.0**	**205**	**100.0**

*Deceased may have experienced multiple stressors.

***Abuse* and *Bullying* coding included experience as perpetrator and/or victim.

Table 25: Frequency and proportion by Longstanding and Recent groups of the Duration of Anger/angry Behaviours Cohort for evidence of experience of physical illness, physical injury and/or pain present proximate to death, Victoria 2009-2015.

Physical health stressors*	Longstanding		Recent		All	
	N	%	N	%	N	%
Evidence of stressors**	**57**	**47.9**	**33**	**38.4**	**90**	**43.9**
Physical illness	32	26.9	24	27.9	56	27.3
Physical injury	23	19.3	14	16.3	37	18.0
Pain	21	17.6	13	15.1	34	16.6
No evidence of stressor	**62**	**52.1**	**53**	**61.6**	**115**	**56.1**
Total	**119**	**100.0**	**86**	**100.0**	**205**	**100.0**

*Deceased may have experienced multiple physical health stressors.

**Coding required the illness, injury or pain evidence of impact of it as a stressor.

Table 26: Frequency and proportion by Longstanding and Recent groups of the Duration of Anger/angry Behaviours Cohort (Table 25) with a documented physical illness, physical injury and/or pain present proximate to death, Victoria 2009-2015.

Physical health*	Longstanding		Recent		All	
	N	%	N	%	N	%
Physical health stressors**	**57**	**100.00**	**33**	**100.00**	**90**	**100.0**
Physical illness	32	56.1	24	72.7	56	62.2
Physical injury	23	40.3	14	42.4	37	41.1
Pain	21	36.8	13	39.3	34	37.7
Total	**57**	**100.00**	**33**	**100.00**	**90**	**100.0**

*Deceased may have experienced multiple physical health stressors.

**Coding required the illness, injury or pain evidence of impact of it as a stressor.

Table 27: Frequency and proportion and involved clinician by Longstanding and Recent groups of the Duration of Anger/angry Behaviours Cohort for evidence of contact with a treating practitioner for a mental health reason within 12 months of death, Victoria 2009-2015.

Treating	Longstanding		Recent		All	
Practitioner*	**N**	**%**	**N**	**%**	**N**	**%**
Treatment within 12 Months	**58**	**48.7**	**34**	**39.5**	**92**	**44.9**
Psychiatrist	19	16.0	10	11.6	29	14.1
Psychologist	14	11.8	6	7.0	20	9.8
Mental Health Practitioner	13	10.9	8	9.3	21	10.2
General Practitioner	40	33.6	25	29.1	65	31.7
Emergency Department Clinician	13	10.9	3	3.5	16	7.8
CATT	8	6.7	2	2.3	10	4.9
Drug and Alcohol Clinician	6	5.0	2	2.3	8	3.9
No Treatment within 12 months	**61**	**51.3**	**52**	**60.5**	**113**	**55.1**
Total	**119**	**100.0**	**86**	**100.0**	**205**	**100.0**

*Please note that a deceased person may have been treated by multiple practitioners within 12 months prior to their death.

Table 28: Frequency and proportion and involved clinician by Longstanding and Recent groups of the Duration of Anger/angry Behaviours Cohort (Table 27) with at least one contact with a treating practitioner for a mental health reason within 12 months of death Victoria 2009-2015.

Treating	Longstanding		Recent		All	
Practitioner*	**N**	**%**	**N**	**%**	**N**	**%**
Treatment within 12 Months	**58**	**100.0**	**34**	**100.0**	**92**	**100**
Psychiatrist	19	32.7	10	29.4	29	31.5
Psychologist	14	24.1	6	17.6	20	21.7
Mental Health Practitioner	13	22.4	8	23.5	21	22.8
General Practitioner	40	68.9	25	73.5	65	70.6
Emergency Department Clinician	13	22.4	3	8.8	16	17.3
CATT	8	13.7	2	5.8	10	10.8
Drug and Alcohol Clinician	6	10.3	2	5.8	8	8.6
Total	**58**	**100.0**	**34**	**100.0**	**92**	**100**

*Please note that a deceased person may have been treated by multiple practitioners within 12 months prior to their death.

Table 29: Frequency and proportion by Longstanding and Recent groups of the Duration of Anger/angry Behaviours Cohort for evidence of a documented mental disorder diagnosis coded to ICD-10 Classification of Mental and Behavioural Disorders.

Mental disorders	**Longstanding**		**Recent**		**All**	
Diagnosis*	**N**	**%**	**N**	**%**	**N**	**%**
Documented diagnosis**	**64**	**53.8**	**50**	**58.1**	**114**	**55.6**
F01-F09 - Physiological	1	0.8	2	2.3	3	1.5
F10-F19 - Substances	18	15.1	7	8.1	25	12.2
F20-F29 - Non-mood psychotic	5	4.2	0	0.0	5	2.4
F30-F39 - Mood	53	44.5	33	38.4	86	42.0
F40-F49 - Non-psychotic/mood	25	21.0	12	14.0	37	18.0
F50-F59 - Physiological/physical	1	0.8	0	0.0	1	0.5
F60-F69 – Personality	10	8.4	4	4.7	14	6.8
F70-F79 - Intellectual disabilities	0	0.0	0	0.0	0	0.0
F80-F89 - Developmental	0	0.0	0	0.0	0	0.0
F90-F98 - Child/adolescent onset	2	1.7	0	0.0	2	1.0
F99-F99 - Unspecified	1	0.8	1	1.2	2	1.0
No Formal diagnosis	**55**	**46.2**	**36**	**41.9**	**91**	**44.4**
Total	**119**	**100.0**	**86**	**100.0**	**205**	**100.0**

*The proximity of the formal diagnosis to the death was not explored for the purposes of this report.

**Deceased may have had multiple diagnoses.

Table 30: Frequency and proportion by Longstanding and Recent groups of the Duration of Anger/angry Behaviours Cohort (Table 29) with a documented mental disorder diagnosis coded to ICD-10 Classification of Mental and Behavioural Disorders.

Mental disorders	**Longstanding**		**Recent**		**All**	
Diagnosis*	**N**	**%**	**N**	**%**	**N**	**%**
Documented diagnosis**	**64**	**100.0**	**50**	**100.0**	**114**	**100**
F01-F09 - Physiological	1	1.5	2	4.0	3	2.6
F10-F19 - Substances	18	28.1	7	14.0	25	21.9
F20-F29 - Non-mood psychotic	5	7.8	0	0.0	5	4.3
F30-F39 - Mood	53	82.8	33	66.0	86	75.4
F40-F49 - Non-psychotic/mood	25	39.0	12	24.0	37	32.4
F50-F59 - Physiological/physical	1	1.5	0	0.0	1	0.8
F60-F69 – Personality	10	15.6	4	8.0	14	12.2
F70-F79 - Intellectual disabilities	0	0.0	0	0.0	0	0.0
F80-F89 - Developmental	0	0.0	0	0.0	0	0.0
F90-F98 - Child/adolescent onset	2	3.1	0	0.0	2	1.7
F99-F99 - Unspecified	1	1.5	1	2.0	2	1.7
Total	**64**	**100.0**	**50**	**100.0**	**114**	**100**

*The proximity of the formal diagnosis to the death was not explored for the purposes of this report.

**Deceased may have had multiple diagnoses.

Table 31: Frequency and proportion by Longstanding and Recent groups of the Duration of Anger/angry Behaviours Cohort for evidence of a substance use stressor and/or a formal substance use diagnosis and/or evidence of specialist addiction service contact Victoria 2009-2015.

Substance related stressors*	Longstanding		Recent		All	
	N	%	N	%	N	%
Evidence of stressor	**92**	**77.3**	**53**	**61.6**	**145**	**70.7**
Formal diagnosis	18	15.1	7	8.1	25	12.2
Addiction service contact	6	5.0	2	2.3	8	3.9
No evidence of stressor	**27**	**22.7**	**33**	**38.4**	**60**	**29.3**
Total	**119**	**100.00**	**86**	**100.00**	**205**	**100.0**

*Substance use requires evidence of impact of the substance use as a stressor.

Table 32: Frequency and proportion by Longstanding and Recent groups of the Duration of Anger/angry Behaviours Cohort (Table 31) with a substance use stressor and with a formal substance use diagnosis and/or evidence of specialist addiction service contact Victoria 2009-2015.

Substance related	Longstanding		Recent		All	
	N	%	N	%	N	%
Substance related stressor*	**92**	**100.00**	**53**	**100.00**	**145**	**100.00**
Formal diagnosis	18	19.5	7	13.2	25	17.2
Addiction service contact	6	6.5	2	3.7	8	5.5
Total	**92**	**100.00**	**53**	**100.00**	**145**	**100.0**

*Substance use requires evidence of impact of the substance use as a stressor.

Table 33: Frequency and proportion by Longstanding and Recent groups of the Duration of Anger/angry Behaviours Cohort with evidence of substances in post-mortem toxicology Victoria 2009-2015.

Post-mortem toxicology	Longstanding		Recent		All	
	N	%	N	%	N	%
Toxicology	**119**	**100.0**	**86**	**100.0**	**205**	**100.0**
Substance detected	**101**	**84.9**	**74**	**86.0**	**175**	**85.4**
Alcohol	50	42.0	47	54.7	97	47.3
Illicit drugs	38	31.9	15	17.4	53	25.9
Prescription medicines	71	59.7	53	61.6	124	60.5
Nil detected	**18**	**15.1**	**12**	**14.0**	**30**	**14.6**
Total	**119**	**100.0**	**86**	**100.0**	**205**	**100.0**

Table 34: Frequency and proportion by Longstanding and Recent groups of the Duration of Anger/angry Behaviours Cohort (Table 33) with a substance detected in post-mortem toxicology Victoria 2009-2015.

Post-mortem toxicology	Longstanding		Recent		All	
	N	%	N	%	N	%
Substance detected	**101**	**100.00**	**74**	**100.00**	**175**	**100.0**
Alcohol	50	49.5	47	63.5	97	55.4
Illicit drugs	38	37.6	15	20.2	53	30.2
Prescription medicines	71	70.2	53	71.6	124	70.8
Total	**101**	**100.00**	**74**	**100.00**	**175**	**100.0**

Of the 326 deceased males of the Anger/angry Behaviour Cohort who had experienced intimidate partner separation, refer table 7, 151 narratives contained enough information to code for proximity of separation, proximity of conflict, proximate conflict with IVO where the deceased was the respondent and any event which could be reasonably considered as finalizing, including property settlement, refusal by partner to "try again", custody of children arrangements, partner formalizing separation/divorce, and IVO initiation.

Table 35: Frequency and proportion by Longstanding and Recent groups who experienced partner separation for proximity of separation, proximity of conflict, proximate conflict with IVO where the deceased was the respondent and any *final event*, Victoria 2009-2015.

Partner stressor	Longstanding		Recent		All	
	N	%	N	%	N	%
Evidence of separation	**93**	**100.0**	**58**	**100.0**	**151**	**100.0**
Proximate separation*	2	2.2	56	96.6	58	38.4
Remote separation**	91	97.8	2	3.4	93	61.6
Proximate conflict***	91	97.8	56	96.6	147	97.4
…Proximate conflict + IVO	56 (91)	61.5	25 (56)	44.6	81 (147)	55.1
Finalizing event	43	46.2	21	36.2	64	42.4
Total	**93**	**100.0**	**58**	**100.0**	**151**	**100.0**

*Separation occurred within a year/months/weeks before death.

**Separation occurred greater than one year before death.

***Conflict with partner/ex-partner.