MINISTRY OF HEALTH
MANATŪ HAUORA

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9 December 2021

Paul Lynch

By email: fyi-request-17551-af39a229@requests.fyi.org.nz
Ref: H202116171

Tēnā koe Paul

Response to your request for official information

Thank you for your request under the Official Information Act 1982 (the Act) to the Ministry of Health (the Ministry) on 13 November 2021 for:

> *"…information on the number of people who have died in New Zealand by suicide or suspected suicide over the past decade while in residential mental health care."*

On 26 November 2021, you clarified 'residential health care' to mean:

> *"Instances of suicide or suspected suicide while the people resident, as in living in a residential facility either voluntarily or otherwise. My interest in the number of people who manage to take their own lives while they are living in/are patients in mental health facilities 24/7, that are staffed 24/7."*

The Ministry has attempted to extract data from our databases to assist with your clarified request, however our systems do not code data in a manner that fully answers your question.

The Programme for the Integration of Mental Health Data (PRIMHD) and the Ministry's Mortality Collection are only able to provide information on whether a person committed suicide on the same day they saw an inpatient mental health team. Due to the way the data is structured, it is not possible to state whether the death occurred during the event or after they saw the team.

Producing the information in its requested form would require the Ministry to manually cross-reference and link existing data sets and doing so would also involve substantial collation. The Ministry would therefore consider refusing under section 18(f) and section 18(g) of the Act. As the Ministry does not wish to refuse your request outright, we have provided information which closely relates to the information you have requested.

Between 2009 and 2018, there were 49 deaths due to suicide or of undetermined intent where the deceased saw an inpatient mental health team on the day of death. We are only able to provide this up to 2018, as it can take some years for Coroners to confirm whether the death was due to suicide or of undetermined intent. This data only covers people aged 10 to 64 at the time of the event.

The Office of the Director of Mental Health and Addiction Services' (ODMHAS) annual reports provide information on adverse events, including those reported by the Health Quality and Safety Commission (HQSC) and those that are mandatory to report under section 132 of the

Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Mental Health Act). Section 132 of the Mental Health Act provides for the reporting to the Director of Mental Health of all deaths of those who are subject to compulsory assessment and treatment under the Mental Health Act. This can include those who are receiving this treatment in the community. Thus, while we are able to provide this information, it is important to note that it covers more than just those in inpatient mental health services. For a fulsome understanding of this information, you can find the ODMHAS reports at: www.health.govt.nz/our-work/mental-health-and-addiction/mental-health-and-addiction-monitoring-reporting-and-data.

The following tables contain a collation of the data in those reports. This data is at the time of the publishing of these reports.

Table 1: Suspected suicides reported by the HQSC, by year, collated from the ODMHAS Annual Reports

	Suspected suicide			
Year	Inpatient	Inpatient - AWOL	On approved leave	Total
2013	3	3	3	9
2014	6	-	2	8
2015	3	-	1	4
2016	4	-	4	8
2017	10	-	2	12
2018	7	4	0	11
2019	6	4	5	15
2020	3	1	2	6
Total	42	12	19	73

Note: This data was not collected in this way prior to 2013. 'AWOL' means the event occurred while the person was an 'inpatient' however had absconded from the service without approved leave.
Source: ODMHAS Annual Reports 2013–2020.

Table 2: Suspected and confirmed suicides reported under section 132 of the Mental Health Act, by year, collated from the ODMHAS Annual Reports

Year	Suspected suicide	Confirmed suicide	Total
2010	8	4	12
2011	5	5	10
2012	16	4	20
2013	7	2	9
2014	12	1	13
2015	9	-	9
2016	11	-	11
2017	16	-	16
2018	19	-	19
2019	17	-	17
2020	11	-	11
Total	131	16	147

Note: This data includes those who are subject to compulsory assessment and treatment under the Mental Health Act but living in the community. 'Confirmed suicides' are deaths which, at the time of the report's publication, have been determined by a Coroner to be a death by suicide.

Source: ODMHAS Annual Reports 2010–2020.

As part of reporting a section 132 death to the Director of Mental Health, services are asked to include the location where the death occurred. The following data in Table 3 is based off information in the ODMHAS Reportable Events database.

Table 3: Suspected and confirmed suicides reported under section 132 of the Mental Health Act, by location of event, from 1 January 2011 to 31 December 2020

	Hospital premises	Inpatient Unit	Supported accommodation	Prison	Total
Suspected suicide	5	14	3	1	23
Suicide	-	3	1	-	4
Total	5	17	4	1	27

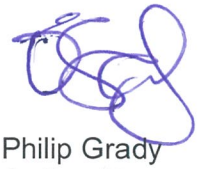
Note: This information is based on the initial reporting template submitted by the services. Some of these may have involved the individual being AWOL at the time of event.
Source: ODMHAS Reportable Events database.

You may also be interested in the Health Quality and Safety Commission New Zealand's (HSSC) adverse events quarterly reporting for quarter 1 of 2021/2022 at: www.reports.hqsc.govt.nz/AdverseEventsQuarterly/#!/quarterly-snapshot.

Under section 28(3) of the Act, you have the right to ask the Ombudsman to review any decisions made under this request. The Ombudsman may be contacted by email at: info@ombudsman.parliament.nz or by calling 0800 802 602.

Please note that this response, with your personal details removed, may be published on the Ministry of Health website at: www.health.govt.nz/about-ministry/information-releases.

Nāku noa, nā



Philip Grady
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Mental Health and Addiction