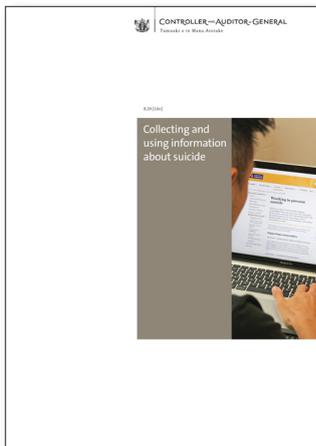




Summary of our report

Collecting and using information about suicide



Suicide is a tragedy for everyone involved, and is difficult to discuss. In 2013, it was the third leading cause of premature death in New Zealand. There are many potential pathways to suicide, and the reasons for it may be complex and particular to each person. This makes it difficult to determine what can increase or reduce the risk of suicide, and means that there is no single solution for preventing suicide. Therefore, it is important that public agencies in New Zealand collect and use good information about suicide to help them find ways to prevent it. This report looks at how well agencies collect and use information about suicide to understand it and, where possible, to prevent it.

In general, some information is collected and used well. However, there are gaps – most of which agencies have identified and are taking steps to fill. They include inconsistency in the information collected and delays in collecting it and sharing it, which in turn affects the timely analysis of this information for preventative purposes.

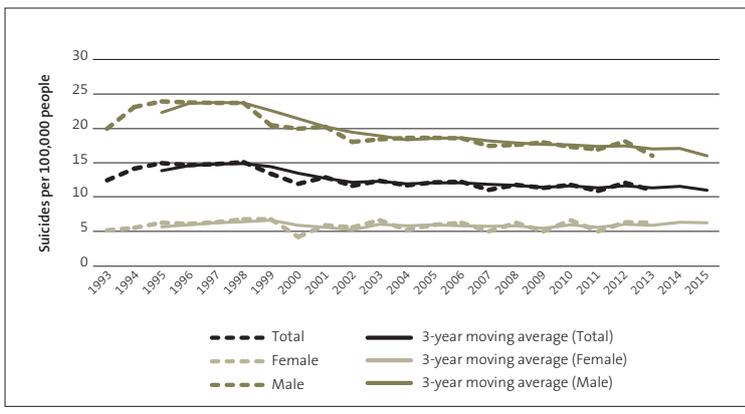
Suspected suicides are notified to a duty coroner. Some early information about suspected suicides is shared with district health boards (DHBs) shortly after a duty coroner is notified. One reason for doing this is to provide support to the bereaved, and to consider whether any immediate actions are needed to reduce the risk that someone else might take their life in similar circumstances. This early information is also used to spot any emerging trends and respond to them, and correct any misunderstandings in the community about recent suspected suicides. The Ministry of Health has not yet got assurance that DHBs are responding appropriately to the information they get from the coroner.

Two mortality review committees review about 30% of suicides – mostly child, youth, and maternal suicides. This means that about 70% of suicides – mostly of people aged 25 years and older – are not reviewed by a mortality committee. The Ministry of Health has trialled mortality review methods with a focus on suicide. The trial was completed in late 2015, and a decision about whether a suicide mortality committee will be established is expected in 2016/17. The Health Quality and Safety Commission and Ministry of Health have told us that, if a suicide mortality committee is not established, they will look at other ways of reviewing adult suicides in more depth.

Vital statistics:

- 42 pages
- Presented to Parliament on Thursday 16 June 2016
- Contact: reports@oag.govt.nz

New Zealand's suicide rate for every 100,000 people, 1993-2013



The Child and Youth Committee's process for collecting and considering information is systematic, but is not described clearly or implemented fully. However, the Health Quality and Safety Commission is in the process of ensuring that data collection is consistent and that reviews of suspected suicides are completed within 12 months of a coroner's decision on the cause of death. Until these aims are

achieved, the Child and Youth Committee will get partial information, making its analysis and reporting less effective. The Perinatal and Maternal Mortality Review Committee's approach to collecting and considering information is clearly described and systematic.

Agencies should work together to give coroners more consistent and comprehensive information. This would help the coroners in their work and help with suicide prevention measures.

We found that the average time for coroners to complete suicide inquiries increased between 2010/11 and 2014/15, from an average of 318 days to 509 days for inquiries without an inquest, and 676 days to 778 days for inquiries with an inquest.

Nearly all coronial inquiries need to be completed for the year being reported on before the Ministry of Health can release the latest statistics, which is why reports are published between two and three years later. The Ministry of Justice is aiming to complete all coronial inquiries within 300 days, so that families get decisions sooner. This will also mean that statistics can be published sooner.

Information about suicides is used to form plans and strategies to prevent suicide in New Zealand. For example, the Ministry of Health used information about suicide from a wide range of sources to inform the 2006-16 national suicide prevention strategy, which will be updated in 2016/17. The Ministry plans to release a new national suicide prevention action plan at the same time.

The Ministry of Health uses some information about suicide to identify the groups that are affected more by suicide than others. This information has influenced the strategy and the action plan's priorities, and it forms the basis of guidance for DHBs on preparing local suicide prevention action plans. The DHBs' plans will run from July 2015 to June 2017, and DHBs will report on their implementation to the Ministry.

Population statistics about suicide are valuable for looking at changes in suicide rates over periods of 20 years or longer, but they are not useful for assessing the effectiveness of suicide prevention actions in the shorter term. For this reason, the Ministry of Health is creating a suicide prevention outcomes framework and is selecting indicators for it, in the hope that they will help assess the effectiveness of suicide prevention actions in the short and medium terms.

It is too early to tell whether the agencies' planned improvements in their collecting and use of information will be effective. The next one to two years are important. Agencies need to carry out their plans and report whether they are working as well as expected toward preventing suicide.