Suicide Mortality Review Feasibility Study

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Aim
Test a suicide mortality review mechanism to improve knowledge of contributing factors and patterns of suicidal behaviour

Sample Frame
All Suicides in New Zealand 2007-2011

Sub-group focus

Men working age
Mental health consumers
Māori youth

Methods and Data

Health and Census data
Government agency data
Hospital files/coronal records
Interviews with bereaved family

Tier 1: High level demographic overview
Tier 2: Sub-group detail
Tier 3: Systems review
Tier 4: Family storytelling

Sub-group findings (examples)

• 50% had accessed mental health services
• 30% were unemployed
• More suicides in 'construction and trade' and the 'farm and forestry' industries

• 50% known to Police
• 48% had contact with mental health services in 7 days prior to death
• 31% had a file with Corrections

• 40% had files with government youth services
• >50% had accessed specialist mental health services
• >50% had an argument with partner or a relationship termination immediately prior
• in the short time prior to death, youth became settled and calm, mended relationships and tidied up personal spaces

Results
• Additional opportunities for intervention outside the health system were identified
• Mental health services need to practice critically and reflexively within a recovery framework
• Systems review and suicide story telling provide unique data and have the potential to strengthen conventional mortality review

Recommendations
Recommend government set up and fund a permanent statutory suicide mortality review committee at arm’s length from government.

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