Coroners’ Recommendations and Suicide Prevention in Specialist Mental Health Services

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Abstract

Suicide is considered to be a serious health and social issue in need of further attention and the improvement of services that cater for those affected by mental disorder is one of the principal targets for suicide prevention. All cases of suspected suicide are investigated by a coroner in New Zealand and the key purposes of these inquiries is establishing the circumstances of death and making recommendations that may prevent a similar death occurring in the future. Specialist Mental Health Services (SMHS) are often involved in the inquiries and are recipients of the recommendations. However, to date there has been a very limited amount of research that has examined the impact of coronial recommendations on the delivery of SMHS.

A two phase qualitative dominant descriptive mixed method design was used to conduct the study. The first phase involved the retrieval and content analysis of 136 coroners’ recommendations directed to SMHS that relate to cases of suicide. The second phase of the study aim to gain an understanding of how the recommendations are handled by SMHS and to explore the first phase themes from the perspective of SMHS and individuals that work with families in SMHS. This was investigated with semi-structured interviews of SMHS leaders that are responsible for the implementation of the recommendations across 12 DHBs in New Zealand, as well as a local family and whänau worker focus group.

The first phase findings produced six major categories of coronial recommendations. These included communication, restrictive management, staff education, working with family, risk assessment, and service delivery. Further exploration of these categories from the perspective of SMHS leaders responsible for their implementation revealed that the majority of the recommendations were perceived as appropriate; however concerns were raised regarding recommendations in the risk assessment and restrictive management categories. Overall the SMHS leaders portrayed the perspective that the recommendations have a limited positive influence on the delivery of SMHS and suicide prevention. The family and whänau worker focus group findings corroborated that coroners are accurately identifying significant shortcomings in the way SMHS are including families in the treatment of mental health consumers.
The findings highlight that SMHS need to consider how they could improve their response to coronial recommendations that have clinical credibility, particularly in regard to communication, and family inclusive treatment. A starting point may be the promotion of a more positive, learning and transparent organisational culture. It is also essential that coroners promote organisational learning by consistently adopting a wider systematic focus during inquiries and avoid individual scrutiny of practice. Furthermore, better resourcing of Coronial Services of New Zealand may be required to ensure all recommendations have clinical relevance and take a more balanced and considered approach to risk, containment, and therapeutic autonomy. Further consideration may also be needed regarding how grieving families’ needs can be better met, alongside further contemplation of the statutory obligation of recipients to respond to recommendations.
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Abbreviations

SMHS  Specialist Mental Health Service
DHB  District Health Board
CSNZ  Coronal Services of New Zealand
CLU  Coronal Liaison Unit
CPU  Coroners Prevention Unit
EBP  Evidence-based practice
MHA  (The Mental Health [Compulsory Assessment and Treatment] Act, 1992)
OECD  Organisation for Economic Cooperation and Development
UK  United Kingdom
NCIS  Australian and New Zealand National Coronal Information System
SPCRIS  Specialist Mental Health Service Perspective of Coronal Recommendations
        Interview schedule
CADS  Community Alcohol and Drug Services
NGO  Non-government Organisation
GP  General Practitioner
CYF  Child, Youth and Family
CAT  Crisis, Assessment and Treatment Team
MDT  Multi-disciplinary Team
MOU  Memorandum of Understanding
Chapter 1: Introduction

Suicide is considered a serious health and social issue in New Zealand and internationally. All deaths that appear to be self-inflicted are investigated by a coroner in New Zealand, with the purposes of determining the circumstances of the death and making recommendations that may help prevent similar deaths occurring. Given a number of individuals that die from suicide have had previous contact with Specialist Mental Health Services (SMHS) in New Zealand, these organisations are often involved in coronial inquiries and are the recipients of coronial recommendations. However, the extent these recommendations contribute to the prevention of suicide in the mental health service context remains unclear.

The New Zealand Context

Every year there are more than 500 deaths that occur as a result of suicide in New Zealand (Ministry of Health, 2015b). This is higher than the rate of deaths that occur due to road traffic accidents and homicide combined (Beautrais, Collings, Ehrhardt, & Henare, 2005). Suicide is particularly concerning for Māori because they rank the highest in suicide statistics in New Zealand, and for youth (15-24) because it is the leading cause of death in this age group (Ministry of Health, 2015b). Attempt rates are estimated to be more than 8 to 25 times the rate of completed suicides (Beautrais et al., 2005), and the most recent data from 2012 indicated that there was 3031 intentional self-harm hospitalisations, two thirds of which were female (Ministry of Health, 2015b). The annual economic cost of suicidal behaviour in New Zealand is estimated to be around 1.4 billion dollars, which is made up of non-economic costs, lost production and health expenditure (O'Dea & Tucker, 2005). The impact is further reaching when considering the distress that is caused for bereaved families and the wider community (World Health Organization, 2014).

The presence of mental disorder is considered a significant risk factor for suicide (Windfuhr & Kapur, 2011b) and improving the care and treatment provided to individuals at risk is a key suicide prevention strategy (Collings & Beautrais, 2005). The New Zealand Suicide Prevention Strategy 2006-2016 provides a framework to co-ordinate a range of
prevention strategies to reduce suicide rates, the effects of suicide, and related inequalities (Associate Minister of Health, 2006). The strategy identifies seven goals, one of which is the improved care for people experiencing mental disorders or people who make non-fatal suicide attempts (Associate Minister of Health, 2006).

All deaths that appear to be self-inflicted are investigated by a coroner in New Zealand. Coroners are qualified barristers or solicitors appointed as judicial officers. The primary role of coroners is to determine the cause and circumstances of these deaths as a means of promoting justice and preventing further deaths. The legislative framework that outlines these functions is The Coroners Act (2006). The three main purposes of this act include:

- The investigation and identification of the cause and circumstances of a sudden or unexplained death;
- To make specified recommendations that if drawn to public attention could help reduce a similar death occurring, and;
- To determine whether public interest would be served by the death being investigated by other investigating authorities and to refer to them (The Coroners Act, 2006).

Inquiries can be conducted by way of chamber findings or the coroner may decide to hold an inquest (public hearing). If the person was in formal custody at the time death an inquest must be held. At the conclusion of the inquiry and/or inquest, the coroner provides a certificate of and written reasons for their findings and recommendations. The coroner can comment on the conduct of any person in relation to the circumstances of the death concerned (The Coroners Act, 2006).

Of the approximate 500 suicides that are investigated by coroners each year in New Zealand a large number are connected with SMHS. Coroner office statistics indicate that between 2007 and 2010 annual rates of mental health related suicide cases, where the deceased was subject to a treatment order under the The Mental Health [Compulsory Assessment and Treatment] Act (1992) or had known involvement with mental health services, were just over 200 (Maclean, 2012). This is consistent with annual reports released from the office of the Director of Mental Health, which indicate around 40% of
those that die from suicide have been in contact with SMHS in the year prior to the date of
def (Ministry of Health, 2015a).

As a result SMHS are often involved in coronial inquiries and recipients of coronial
recommendations. The aim of these recommendations is the prevention of future suicides
in the SMHS context, which is fitting with the New Zealand Suicide Prevention Strategy
goal of improving the care provided by these services (Associate Minister of Health,
2006). However, there is no legal obligation for SMHS, or other recipients of coronial
recommendations, to respond to or implement proposed changes (The Coroners Act,
2006). This lack of obligation has led to claims that the prophylactic functions of coroners’
recommendations are not being maximised both in New Zealand (Mok, 2014; J. Moore,
2014b) and internationally (Freckelton & Ranson, 2006; Ranson, 2005). In addition to this,
concerns have also been raised about the quality of coronial recommendations, particularly
in regard to coroners making wide ranging recommendations that inform social and health
policy without the appropriate expertise (Freckelton & Ranson, 2006; Mok, 2014).

The coronial system has undergone a number of reforms since its conception in an attempt
to improve its outcomes. When New Zealand was first settled in the 1830’s, it came under
the jurisdiction of the Government of New South Wales. It was proclaimed a British
colony in 1840 and shortly after this the New South Wales laws were abolished. This
allowed for the colony’s creation of its own process of death investigation. The Coroners
Ordinance (1846, as cited in Freckelton & Ranson, 2006) outlined that every coroner in
New Zealand had the same powers, privileges, duties and responsibilities as the coroners in
England. Consequently, the New Zealand coronial system was very much based on the
English system at that time (Freckelton & Ranson, 2006).

Coronial law in New Zealand has undergone extensive reform since these earlier days, the
most recent occurring following the release of a review of the system in 1999 (The Law
Commission, 1999). Some of the issues that were identified during this reform included a
lack of supervision for coroners, a lack of consistency of coronial services throughout the
country, a failure of government departments to act on coronial recommendations, and
insensitive handling of cases including practices that did not take into account cultural
perspectives. Recommendations for change were made in a subsequent Law Commission
report (The Law Commission, 2000), which was the primary catalyst for The Coroners Act
This Act came into effect on the 1st of July 2007 and remains the current legislative frame work at this time. Some of the key changes in practice that occurred as a result of the revised legislation included the appointment of the Chief Coroner, the creation of a Coronial Service Unit within the Ministry of Justice and the improved collection of information (Ministry of Justice, n.d.).

Despite these improvements, in June 2013, a proposal was announced to reform the Coronal Services of New Zealand [CSNZ] and in 2016 The Coroners Amendment Act (2016) was introduced. This amendment act includes inserts that are specific to coroners’ roles in making recommendations. The changes include the stipulation that recommendations must be clearly linked to the case investigated and the evidence in the inquiry, alongside including an explanation from coroners about how their recommendation would prevent a similar death occurring in the future. In addition to this, the amendment act also specifies that coroners must consult with certain persons or organisations regarding the recommendations, and that the recipients of the recommendations are given 20 days to comment on the proposed recommendation (The Coroners Amendment Act, 2016). Recipient comment on proposed recommendations was not made mandatory.

Although these changes are considered to be an improvement, there remains concerns that the changes will not adequately address some of the perceived shortcomings of the system. In particular, the need to further enhance coroners’ preventative functions has been highlighted as an area in need of further attention (J. Moore, 2014b).

Further ambiguity remains regarding cases of suicide. A number of these cases result in recommendations being made to SMHS; however, the impact that these recommendations have on the delivery of SMHS is relatively unknown. This thesis aims to start to investigate this gap by determining what areas of SMHS delivery have been identified by coroners as requiring improvement as a means of suicide prevention and then exploring these findings from the perspective of SMHS and family and whānau workers employed to support families of mental health consumers.
Definitions of Key Terms

Internationally, there is a wide variety of terminology used to describe suicide and suicide behavior. For the purposes of this thesis, the definitions from the New Zealand Suicide Prevention Strategy (Associate Minister of Health, 2006) are used as follows:

1) Suicide is the act of intentionally killing oneself. The classification of suicide in New Zealand is determined by coroners.
2) Attempted suicide refers to all actions where a person has made attempts at suicide that are non-fatal.
3) Deliberate self-harm covers all behaviors that may or may not result in serious injury, but are not intentionally fatal.
4) Suicidal ideation refers to an individual having thoughts of suicide (Associate Minister of Health, 2006).

The term ‘consumer’ is used throughout this thesis and refers to individuals who receive treatment from SMHS. Alternatives to the term ‘patient’ came about during the consumer survivor movement that saw the rise of consumer rights and advocacy during the late 1960s and early 1970s (McLean, 1995). The wide adoption of the term ‘consumer’ was seen following this period. Those that identified as ‘consumers’ generally accepted traditional mental health treatments, but sought after system improvement and higher consumer participation (McLean, 1995). It is because of this historical context that it has been chosen for use in this study, alongside the fact that it is a widely used and understood term in contemporary mental health practice. The term ‘patient’ is still used in the context of mental health legislation as this remains the current legislative terminology.

‘Family and whānau workers’ refers to individuals that work in support and advisory roles with families of mental health consumers. These individuals often have personal experience of interacting with mental health services as family members of consumers and are usually employed by SMHS or mental health Non-Governmental Organisations [NGOs]. It also includes individuals that work with family members that identify with a specific culture.
Structure of the Thesis

This thesis is structured in eight chapters. This first chapter provides an introduction to the research by establishing the New Zealand context to suicide, background information pertaining to the coronial system and the rationale for the thesis.

Chapter two reviews the literature that is relevant to suicide, coronial inquiries and mental health service delivery. The first section explores the literature that is relevant to suicide by establishing what the extent of the problem is, followed by an overview of how suicide is conceptualised, and then more specifically reviewing the literature that is relevant to suicide in mental health consumer populations and the mental health service context. The second part of the literature review focuses on the research that is available regarding coronial recommendations.

Chapter three provides an overview of the methodology used to conduct the study. This includes an overview of the qualitative dominant mixed method design, as well as a description of the chosen qualitative and quantitative methods of the two phases of the study.

Chapter four presents the first phase findings. Background quantitative data that is relevant to the cohort of coronial cases that were included in the study is firstly reported on. The remainder of the chapter is structured around the six categories of coronial recommendations that emerged, which include: (1) communication, (2) restrictive management, (3) staff education, (4) working with family, (5) risk assessment, and (6) service delivery.

Chapter five reports on the SMHS leader participant response to the six categories described in chapter four. This includes a description of the participants’ perspectives regarding how appropriate the recommendations in each category are.

Chapter six describes the SMHS leader participants’ reports of the service level response to coronial recommendations. This includes a description of the participants’ perception of coronial inquiry processes, the perceived overall quality of the recommendations received,
the perceived impact that the recommendations have on SMHS delivery and how the recommendations are handled by SMHS once they are received.

Chapter seven is the final findings chapter. This chapter presents the findings of a family and whānau worker focus group. This focus group sought to explore the family and whānau worker perspective of the working with family category from chapter four. Three major categories are described including: (1) inadequate relationships with families, (2) privacy barriers, and (3) a lack of progress.

Chapter eight is the final chapter and discusses the findings in the context of the literature. This includes an exploration of the clinical credibility of the recommendations received by SMHS and discussion regarding the organisational learning that occurs as a result of the recommendations. The implications for SMHS delivery, CSNZ and coronial law are then provided, followed by the limitations and strengths of the study and implications for further research.
Chapter 2: Literature Review

Suicide is well recognised as a public health priority that requires further research. Mental disorder is considered a primary risk factor for suicide and relatively high rates of mental health service contact prior to suicide have been established with certain phases of treatment having an increased risk of suicide. It has also been recognised that different aspects of mental health service provision can affect suicide rates in mental health consumer populations. The improvement of mental health services is therefore supported by the evidence as an initiative that has the potential to reduce rates of suicide. Coronial recommendations that are directed to SMHS also have this objective; however, concerns have been raised that coronial recommendations in general are not meeting their preventative functions. The main concerns raised include the lack of obligation of recipients to respond and the overall quality and evidence base of the recommendations. A small number of studies have indicated moderate rates of implementation of recommendations across different settings. To date there is a paucity of literature that examines coronial recommendations regarding suicide and mental health service delivery.

This chapter will firstly review the literature that is relevant to suicide in mental health populations, followed by a review of the research that examines coroner recommendations.

Part One: Suicide

This section starts by providing a description of the extent of suicide internationally and within New Zealand, followed by an overview of the current explanations of suicide. This is followed by a review of the suicide literature that is more specific to mental health consumers, mental health service delivery, and suicide prevention strategies in this population.

The Extent of the Problem

Over 800,000 people worldwide die from suicide each year, which accounts for 1.4% of all deaths globally (Zalsman et al., 2016). This signifies an annual global age-standardised
rate of 11.4 per 100,000 population (World Health Organization, 2014). Suicide causes considerable burden, including economic, social and psychological disadvantage for individuals, families and communities (World Health Organization, 2014). The World Health Organisation (2014) reports that 75% of all suicides occur in low and middle income countries. Further disparities have been observed in certain ethnic groups and rates are particularly concerning for youth. Males are also known to be more likely to die from suicide, whilst females are more likely to make attempts (Beautrais & Fergusson, 2006; Hawton & Van Heeringen, 2009).

New Zealand has comparatively high rates of suicide. Although rates have shown an overall decrease since a peak in 1996 (Ministry of Health, 2015b), a comparison between New Zealand’s 2012 suicide data and other Organisation for Economic Co-operation and Development (OECD) countries most recent data shows that New Zealand suicide rates for both female and males is just above the median (age standardised rate of 12.2 per 100,000 population) (Ministry of Health, 2015b). This is a similar ranking to previous years (Ministry of Health, 2012, 2014). Data from Te Rau Hinengaro: The New Zealand Mental Health Survey, indicated that the lifetime prevalence for suicidal ideation was 15.7%, 5.5% for suicidal plan and 4.5% for suicidal attempt (Oakley Browne & Wells, 2006).

Variations in rates of suicide are seen in different ethnic groups in different countries (Hawton & Van Heeringen, 2009). For example, the rate of suicide in African Americans has historically been higher than that of White Americans (Windfuhr & Kapur, 2011a), or in the UK, young Indian women have higher rates than other women, whilst young Afro-Caribbean women have very low rates (Hawton & Van Heeringen, 2009). Factors such as religion, spirituality and greater familial and social ties have been associated with the lower rates in some ethnic groups (Windfuhr & Kapur, 2011a). Whereas, factors such as stigma of mental illness, low contact with mental health services (Windfuhr & Kapur, 2011a), marginalisation and disintegration of traditional social support and cultural values (Hawton & Van Heeringen, 2009), and the impact of colonisation (Lawson-Te Aho & Liu, 2010) are thought to contribute to the higher rates in other ethnic groups.

Indigenous populations in a number of countries have higher rates of suicide that non-indigenous populations (Clifford, Doran, & Tsey, 2013; Maskill, Hodges, McClellan, & Collings, 2005). This is the case for Aboriginal people in Australia, Native American
people in the USA, Māori in New Zealand (Clifford et al., 2013; Hawton & Van Heeringen, 2009), and Canadian First people in Canada (Clifford et al., 2013). Exposure to multiple risk factors in indigenous populations is thought to be the rationale for the increased suicide rates in these populations, including higher rates of social disadvantage, mental disorder, stressful life events and disadvantaged historical contexts (Clifford et al., 2013).

In New Zealand Māori have ranked the highest in suicide rates since the 1980s (Robson & Harris, 2007). The national mental health survey indicated that Māori populations also have a higher prevalence of mental disorder, suicidal ideation, suicide plans, and suicide attempts (Oakley Browne & Wells, 2006). Furthermore, this survey also indicated that Māori are less likely to make contact with health services than other ethnic groups (Oakley Browne & Wells, 2006). There have been different perspectives on why Māori suicide rates are generally higher than non-Māori. The most obvious is the impact of colonisation, which is widely acknowledged as a factor in New Zealand suicide statistics (Beautrais & Fergusson, 2006; Hirini & Collings, 2005; Lawson-Te Aho & Liu, 2010). The segregation of Māori youth from their culture and identity has also been considered as a factor (Hirini & Collings, 2005; Skegg, Cox, & Broughton, 1995). Some additional explanations were identified in a qualitative study that explored Māori perspectives on increased suicide rates (Hirini & Collings, 2005). The explanations included the rapid change in social values and norms for Māori, the influence of modern international youth culture, the impact of negative social constructions of Māori, and the systematic bias against Māori in modern society. Increased Māori suicide statistics have also been identified as a reflection of the overall disadvantaged status of Māori in other statistics such as health, justice and education (Beautrais & Fergusson, 2006). However, Lawson (1998) argues that such a perspective on its own is limited in that it fails to recognise the original cause of the disadvantage.

Suicide can occur at any time during the lifespan (Zalsman et al., 2016). Suicide rates are generally lowest in individuals under the age of 15 and highest in those aged over 70 in most regions of the world (World Health Organization, 2014). Suicide is the second leading cause, and in some countries the leading cause, of death in young people aged 15-24 (Zalsman et al., 2016). However, significant variability is seen in the age patterns in different regions and different countries (World Health Organization, 2014).
New Zealand’s youth (15-24) rates are particularly concerning. They ranked the highest amongst the OECD countries in the most recent 2012 comparison (23.4 deaths per 100,000 population) (Ministry of Health, 2015b), and have ranked highly in previous years comparisons (Ministry of Health, 2012, 2014). The reasons for the high youth suicide rate in New Zealand remains relatively unknown (Beautrais, 2003a). The economic crisis that occurred in the 1980s and 1990s was considered to have potential relevance because suicide rates were at their peak for this age group when youth were entering their earning years (Weaver, 2014). However, Beautrais (2003a) points out that the association between economic factors and youth suicide are fairly modest. This author suggests that explanations made in other countries, such as the increased rates of alcohol and drug use, increased rates of depression, and the changes in social, societal, and family models, are likely circumstances that are related to the increased rates of youth suicide in New Zealand (Beautrais, 2003a).

Available rates of suicide are alarming and yet they are most probably underestimates because of issues with misclassification and under reporting (Freckelton & Ranson, 2006; Shah, Bhandarkar, & Bhatia, 2010; Walker, Chen, & Madden, 2008). One of the identified issues is that countries differ in the way they classify and record suicide. For example the responsibility for classification is held by the police in India (Freckelton & Ranson, 2006), and by the coroner in England, New Zealand and Australia (Hawton & Van Heeringen, 2009). The different procedures, practices and cultural values are thought to have a considerable impact on how suicide is classified (Hawton & Van Heeringen, 2009). This is particularly pertinent when a finding of suicide potentially has religious, economic or social consequences (Hawton & Van Heeringen, 2009). For example, in India suicide is illegal and independent investigations have uncovered profoundly underestimated rates (Hawton & Van Heeringen, 2009). It has also been questioned by some authors if the potential impact of making a suicide finding on the bereaved family influences coroners decisions (Walker et al., 2008). Having a high legal threshold for making a finding of suicide is also a factor that can lead to misclassification (Shah et al., 2010). Determining intent can be a very complex matter, particularly in mental health related cases given the doubt that can remain about a person’s state of mind at the time of the act (Maclean, 2012). Further classification issues can arise from the variation in terminology used in different classification systems, countries and by individuals (Silverman, 2011). An example of this, is the use of the term ‘deliberate self-harm’ being used interchangeably with the term
‘suicide’. Variation in wording has particular relevance because it limits the comparison of suicide rates internationally (Silverman, 2011).

Regardless of classification issues, rates both internationally and in New Zealand demonstrate that suicide is a significant health and social issue that requires attention, particularly for vulnerable populations. It is therefore well recognised as a public health priority that requires further research (Zalsman et al., 2016).

**Current Explanations of Suicide**

Suicide is a complex and multifaceted phenomenon that occurs because of a combination of psychological, genetic, social, and cultural risk factors, combined with individual circumstances (Zalsman et al., 2016). Current models of suicide demonstrate the interactions between these factors in an attempt to explain the occurrence of suicide. This section of the review provides a brief overview of the main theories of suicide including psychological and psychiatric, pathophysiological, and sociological, and then describes how frameworks conceptualise suicide through the interactions between each of these paradigms.

Psychological and psychiatric theories focus on disturbances in a person’s temperament, personality, feelings, and cognitions (Maskill et al., 2005). The main rationale for psychological theories is the belief that disturbances in personality traits can lead to a person being vulnerable to suicide if they are predisposed to cope in a negative way to stressful situations (Beautrais et al., 2005; Windfuhr & Kapur, 2011a). A factor that sits inside this theme, is the link between suicide and childhood adversity, such as a history of sexual, physical and emotional abuse or neglect. Such adversity is thought to lead to an increased risk of adjustment problems and in some cases negatively impact on a person’s coping style (Beautrais et al., 2005).

Studies that have explored the relationship between mental illness and suicide show a clear correlation between the two (Hawton & Van Heeringen, 2009; Windfuhr & Kapur, 2011b). Psychological autopsy studies, which involve interviews with informants and reviews of records, examine individual characteristics of people who have died from suicide. This approach has shown estimates rates of mental disorder occurring as high as 90% in those
that die from suicide (Hawton & Van Heeringen, 2009). For example, a systematic review of psychological autopsy studies found that mental disorder was the most strongly related variable in suicide cases (Cavanagh, Carson, Sharpe, & Lawrie, 2003). A similar study that reviewed 27 studies comprising of 3275 suicides, found that mental disorder was diagnosed prior to death in 87.3% of the cases (Arsenault-Lapierre, Kim, & Turecki, 2004).

Pathophysiological research considers the biochemical and genetic factors that make a person vulnerable to suicide (Hawton & Van Heeringen, 2009). This includes studies that examine the relationship between suicide and genetics, chemical imbalances, abnormal levels of neurotransmitters, neurological damage and nutritional disorders (Maskill et al., 2005). For instance, adoption studies have demonstrated genetic links through the increased incidence of suicide in adoptees that have biological relatives who have died by suicide (Beautrais et al., 2005), or post-mortem studies that have shown associations with suicide and central neurotransmission functions particularly in regard to serotonin and noradrenalin (Hawton & Van Heeringen, 2009).

The final paradigm concentrates on the social context of suicide such as a person’s demographic profile, environment, relationships, and culture (Maskill et al., 2005). Some examples of social factors that have been associated with suicide include the presence of social isolation, poor support networks, limited access to crisis intervention (Maskill et al., 2005), and the presence of physical illness (Hawton & Van Heeringen, 2009). Furthermore, inequalities in the economic conditions that affect health have also been linked, such as financial status, unemployment, and educational achievement (Maskill et al., 2005). Groups who are vulnerable to discrimination also demonstrate higher rates of suicide, for example refugees and migrants; lesbian, gay, bisexual, transgender persons; indigenous people; or prisoners (World Health Organization, 2014). Temporal factors, such as seasonality, personally significant dates and public holidays may also have significance (Maskill et al., 2005; Windfuhr & Kapur, 2011a). However, the impact of these factors on suicide has not been conclusively established (Windfuhr & Kapur, 2011a).

Current models of suicide integrate the influences from each of the above paradigms in an attempt to explain suicide. An example of one of these frameworks is provided by Beautrais (2003b). This model conceptualises that there are six domains that contribute to
suicide that include: genetic and biologic factors; social and demographic background; childhood adversity; personality characteristics; life stresses; and mental health factors. This model assumes that four sets of factors (pathophysiological, social, family, and personality characteristics) are distal factors that contribute to a person’s vulnerability to suicide, whereas the remaining factors, mental illness and exposure to stress, are the more dominant and immediate causes of suicide (Beautrais, 2003b).

Overtime, a number of theories and frameworks have sought to explain why people take their own lives. Whilst some frameworks give certain paradigms more dominance, other authors considered the importance of the various factors to differ between individuals and different population groups (Maskill et al., 2005). What is generally accepted is that no one factor or theory adequately explains the aetiology of suicide on its own. Rather, each case is individual, with different combinations of contributing factors that interact with each other in very complex ways (Maskill et al., 2005; Mishara & Chagnon, 2011).

**Suicide in Mental Health Consumer Populations**

A number of suicide research studies have focused on mental health explanations for suicide because mental illness is considered a significant risk factor (Collings & Beautrais, 2005; Windfuhr & Kapur, 2011a). The prevalence of mental disorders in New Zealand is relatively common, with a large scale survey showing that 39.5% of New Zealanders have met the criteria for mental disorder at some point in their life (Oakley Browne & Wells, 2006). In New Zealand SMHS users are considered to have 25 times the rate of suicide compared with non-services users (Ministry of Health, 2015a). Although it is well recognised that suicide risk is elevated in those who suffer from mental disorder (Beautrais, Wells, McGee, & Oakley Browne, 2006; Hawton & Van Heeringen, 2009; Windfuhr & Kapur, 2011b), different diagnoses are associated with different rates and risk factors (Windfuhr & Kapur, 2011b). The following will review this more specific evidence.

The rate of suicide in those diagnosed with depression at some time in their lives is estimated to be around 6%, and rates of attempted suicide in people with major depressive disorders have been estimated as high as 25-50% (Royal Australian and New Zealand College of Psychiatrists, 2004). Depressive symptoms identified as having increased
relevance to cases of suicide include weight and appetite loss, insomnia, feelings of worthlessness and excessive guilt (McGirr et al., 2007). Those who die by suicide with a depressive diagnosis are more likely to be male, have a family history of psychiatric illness and have comorbid disorders including anxiety and alcohol and drug use (Hawton, Comabella, Haw, & Saunders, 2013). They are also more likely to have a history of previous attempts (Hawton et al., 2013), and inpatient admission (Coryell & Young, 2005).

Suicide risk is also considered elevated in persons with a diagnosis of bipolar affective disorder (Hawton, Sutton, Haw, Sinclair, & Harriss, 2005). Research suggests that there is no significant difference in the rate of suicide attempts in the different subtypes of bipolar affective disorder (Novick, Swartz, & Frank, 2010). However, previous attempts, hopelessness (Hawton, Sutton, Haw, Sinclair, & Harriss, 2005), male gender, and co-morbid anxiety (Simon, Hunkeler, Fireman, Lee, & Savarino, 2007) have been identified as risk factors for completed suicide in this population. Further risk factors that have been identified include early onset of the illness, severity of depressive symptoms, and the presence of mixed states and rapid cycling (Hawton, Sutton, Haw, Sinclair, & Harriss, 2005).

People with schizophrenia are known to have a shorter life expectancy than the general population and one of the leading reasons for premature death in this population group is suicide (Hor & Tayler, 2010). A systematic review of suicide risk in schizophrenia showed a general consensus that the lifetime risk of suicide in this population is around 5 percent (Hor & Tayler, 2010). Risk factors in this population are largely similar to other populations, including being young, male, having had prior suicide attempts, and having co-morbid depressive and substance abuse disorders (Hor & Tayler, 2010). However, there are some indicators that are unique, which include having a higher educational history, varying levels of insight (Hawton, Sutton, Haw, Sinclair, & Deeks, 2005; Hor & Tayler, 2010), and the presence of internalised stigma (Sharaf, Ossman, & Lachine, 2012). Adequate delivery of and adherence to treatment for the illness and related co-morbid problems has been found to be the main protective factor for suicide for persons with schizophrenia (Hawton, Sutton, Haw, Sinclair, & Deeks, 2005; Hor & Tayler, 2010).

Substance use disorders, including alcohol abuse and dependence and other specific drug use disorders, are also known to be associated with suicidal behaviour (Conner & Ilgen,
A meta-analysis conducted by Wilcox et al. (2004) demonstrated that individuals with alcohol dependence were approximately 9.8 times more likely to die from suicide compared with the general population. This study also indicated that individuals with opioid use disorders and mixed intravenous drug use were at elevated risk. Specific risk factors for individuals diagnosed with substance use disorders include aggression and impulsivity, acute substance use, comorbid depressive disorders, interpersonal stress (Conner & Ilgen, 2011; Sher, 2006), and affect negativity (Conner & Ilgen, 2011). Conner and Ilgen (2011) suggest that the severity of the substance use disorder, an individual’s temperament including aggression and impulsivity and the presence of a negative affect are distal risk factors for suicide in persons with substance use disorders, and when combined with proximal factors including active substance use, interpersonal stress and depressive symptoms the risk of suicidal behaviour is heightened.

Personality disorders have also been shown to be closely linked to suicidal behaviour and deliberate self-harm. The nature of these disorders lead to difficulties in social functioning, poor communication, decreased understanding of non-verbal communication, and identity confusion (Krysinska, Heller, & De Leo, 2006). These characteristics alone increase the risk of suicidal behaviour based on the sociological and psychological explanations of suicide. The diagnostic criteria for borderline personality disorder includes suicidal and deliberate self-harming behaviours. Given the chronic nature of risk in these populations traditional treatments and interventions adopted in short term acute risk situations are not usually suitable (Krysinska et al., 2006). Hospitalisation, for example, is not proven to have suicide preventative effects for persons with a borderline personality disorder diagnosis and have in fact been proven to produce negative outcomes such as increased rates of deliberate self-harming behaviour (Paris, 2004). An alternative approach of professionally indicated short-term risk taking is often appropriate in the context of this personality disorder (Krysinska et al., 2006).

Anxiety disorders (generalized anxiety disorder, agoraphobia, simple phobia, social phobia, posttraumatic stress disorder (PTSD) and panic disorder) have also been associated with suicide and suicide attempts (Nepon, Belik, Bolton, & Sareen, 2010; Sareen, Houlahan, Cox, & Asmundson, 2005); however, there remains some controversy if the association is independent of other variables, in particular comorbid psychiatric disorders
such as depression (Sareen et al., 2005). Nepon et al. (2010) investigated the relationship between anxiety disorders and suicide attempt using a large nationally representative sample and controlled for comorbid diagnosis. Having an anxiety disorder, particularly panic disorder and PTSD, were found to be significantly associated with the incidence of suicide attempt. Sareen et al. (2005) ran a similar large scale study and found only PTSD was connected. Similarly, a systematic review of the evidence controlling for other psychiatric disorders conducted by Krysinska and Lester (2010) also found there to be an association between PTSD and suicide attempt but not completed suicide.

It has been clearly established that mental disorder is associated with suicide; however, which specific disorders are most closely related remains somewhat unclear because many studies examine individual disorders in isolation (Nock, Hwang, Sampson, & Kessler, 2010). A review of the evidence for suicide prevention conducted by Beautrais et al. (2005), found that mood disorders, substance abuse disorders and anti-social behaviours are the most closely linked mental disorders to suicide. The World Health Organization (2014) also identifies mood and substance abuse disorders as having particular relevance.

Some of the ambiguity around what specific disorders are unique to suicide is because of the high rate of comorbidity (co-occurrence of two or more disorders in individuals) (Beautrais et al., 2005; Nock et al., 2010). High rates of comorbidity are found in individuals who attempt or complete suicide and the risk of suicidal behaviour increases with the number of comorbid mental disorders (Beautrais et al., 2005). Nock et al. (2010) examined the relationship between individual disorders in relation to suicidal behaviour from a national survey in the USA. Depression was found to best predict the onset of suicidal ideation but depression did not necessarily predict suicide attempt. Rather, disorders characterized by anxiety and agitation, (such as PTSD), and poor impulse control (such as conduct disorder or substance use disorder) were the strongest predictors of suicidal ideation progressing to suicide attempt. This study also found that every mental disorder predicts the onset of suicidal ideation. In interpreting these results the authors consider the explanation that the pattern of suicidal behaviour in people experiencing mental disorder may not be about the individual illnesses, but rather factors that are common to all mental disorders such as the distress and impairment that they cause (Nock et al., 2010).
In summary, suicide has been clearly linked with mental disorder, in particular mood disorders, schizophrenia, substance use disorders, personality disorders, and PTSD have been identified as having specific importance or individual associated risk factors. Comorbid mental disorder has also been shown to be a strong predictor of suicide, with the incidence of suicide increasing exponentially with the increased incidence of comorbidity. Given this understanding, a number of authors support the need to focus on the adequate treatment of mental disorder as a way of mitigating suicide (Arsenault-Lapierre et al., 2004; Cavanagh et al., 2003; Hawton, Sutton, Haw, Sinclair, & Deeks, 2005; Hor & Tayler, 2010).

**Mental Health Service Delivery and Suicide**

Adequate access to appropriate treatment for mental health disorder is considered a key suicide prevention strategy both internationally (World Health Organisation, 2013) and in New Zealand (Ministry of Health, 2013). This section of the review will consider the literature that examines the association between mental health service provision and suicide. This includes studies that identify the rates, phases and types of mental health service provision that are associated with suicide, alongside a smaller number of studies that identify more specific service delivery factors that may have potential relevance.

Relatively high rates of mental health service contact prior to suicide have been shown in the research (Pirkis & Burgess, 1998; Windfuhr & Kapur, 2011b). As previously described, around 40% of suicide victims have had known contact with SMHS in the year prior to death in New Zealand (Ministry of Health, 2015a). In comparison, data from the UK shows a lower rate of 25% (Windfuhr & Kapur, 2011b) and a systematic review conducted by Luoma, Martin, and Pearson (2002), that reviewed studies across countries, estimated a rate of one third of people having contact with mental health services in the year prior to suicide.

Certain phases in mental health treatment have been shown to be higher risk periods for suicide, in particular a number of studies have shown the period following discharge from inpatient treatment as being of concern (Appleby et al., 1999; Meehan et al., 2006; Pirkis & Burgess, 1998). The risk of suicide at this time has been reported to be as much as 100 times than that of the general population, with a high percentage of suicides occurring
before the first follow-up appointment (Windfuhr & Kapur, 2011b). A systematic meta-analysis of risk factors for suicide following discharge from a hospital found that no factor or combination of factors was strongly associated with the risk of suicide during this period, which suggests limited predictability of suicide during this phase of illness (Large, Smith, Sharma, Nielssen, & Singh, 2011).

Inpatient treatment has also been associated with higher rates of suicide (Kapur et al., 2013; Madsen, Agerbo, Mortensen, & Nordentoft, 2011). A study conducted in Denmark that examined all inpatient admissions over a ten year period found that the rate of suicide in this population was high, with a rate of 860 suicide per 100,000 inpatients (Madsen et al., 2011). Furthermore, inpatient suicide rates in England have been shown to be 60 times that of the general population (Kapur et al., 2013). Studies have also found that patients are particularly vulnerable to suicide during the initial stages of inpatient treatment (Meehan et al., 2006), whilst on approved leave and following absconding from inpatient wards (Meehan et al., 2006; Shah & Ganesvaran, 1997). Furthermore, a study from the United States that reviewed data from a prospective mortality study of psychiatric inpatients, found that a length of inpatient stay less than 14 days and a lack of re-admission within six months was associated with a higher risk of suicide (Desai, Dausey, & Rosenheck, 2005). A systematic review of clinical factors associated with the risk of suicide in inpatient settings, conducted by Large, Smith, et al. (2011), identified a history of self-harm, hopelessness, feelings of guilt, depressed mood, suicidal ideation and family history of suicide as being the risk factors associated with suicide in the inpatient setting. Furthermore, having comorbid diagnoses of depression and schizophrenia were also linked (Large, Smith, et al., 2011).

Consumers receiving treatment from crisis resolution services have also more recently been connected with higher rates of suicide (Hunt et al., 2014; Kapur et al., 2013). A longitudinal analysis of adults that died by suicide whilst under the care of crisis resolution home treatment showed higher rates of suicide compared to those that occur in inpatient settings (Hunt et al., 2014). Particular risk factors that were identified in this study included people who lived alone or had recent adverse life circumstances (Hunt et al., 2014).
Other mental health service delivery factors have been associated with consumer suicides. A study that reviewed 10,040 cases of suicide including 358 inpatient deaths, identified difficulties with observation due to ward design, and nursing shortages, as being common factors in cases of inpatient suicide (Appleby et al., 1999). Another perspective is provided with a comprehensive audit that was undertaken of the clinical files of mental health service users who committed suicide (Burgess, Pirkis, Morton, & Croke, 2000). This study considered that 20% of the cases were preventable. The main areas of preventability included poor therapeutic relationships with the deceased, incomplete or inadequate assessments, poor treatment of depressive and psychological problems, and poor continuity of care (Burgess et al., 2000). Poor continuity of care was also shown to be associated with an increased risk of suicide in a US study conducted by (Desai et al., 2005). However, variations in service delivery at the systems levels were not shown to be as closely connected (Desai et al., 2005; Zahl & Hawton, 2004). For example, the size of facilities (Desai et al., 2005) and overall resourcing available (Johannessen, Dieserud, Claussen, & Zahl, 2011; Shah et al., 2010) have been shown to not be significant.

The United Kingdom (UK) has produced extensive research in the area of suicide and mental health service contact as part of a National Confidential Inquiry into suicide and homicide by people with mental illness (While et al., 2012; Windfuhr & Kapur, 2011b). This inquiry is a national database of all suicide cases in contact with mental health services in the 12 months preceding suicide. One of the aims of the inquiry is to make recommendations about clinical practice and policy based on the research. While et al. (2012) compared suicide rates for services before and after the implementation of the inquiry recommendations and found that the implementation of the recommendations was associated with decreased suicide rates. The services that did not implement the recommendations did not have the same reduction in suicide. The implementation of recommendations that were most closely associated with a decrease in suicide rates included the provision of 24hr crisis care, local policy on dual diagnosis and multidisciplinary team review after suicide. The authors conclude that aspects of mental health service provision can affect suicide rates in mental health consumer populations (While et al., 2012).

This section of the review has established that there is relatively high rates of mental health service contact prior to suicide, and that certain phases of treatment, including the period
following discharge from inpatient treatment, inpatient care and crisis resolution treatment, have been connected with higher rates of suicide. A number of studies have also established that different aspects of mental health service provision are considered to affect suicide rates in mental health consumer populations.

**Suicide Prevention Strategies in Mental Health Consumer Populations**

To address suicide prevention many countries have developed suicide prevention strategies, as a way of mitigating the incidence of suicide and suicide attempts (Beautrais et al., 2005; Zalsman et al., 2016). However, concerns have been raised by some authors about the limited evidence and lack of evaluation of suicide prevention strategies (Beautrais et al., 2007; Mann et al., 2005). As a consequence, recent research has aimed to gain an understanding of what has positive and negative influences on the prevention of suicide. This section of the review considers the literature that examines suicide prevention interventions that are associated with mental health consumer populations.

Suicide is thought to be often an impulsive act, therefore the easy availability of means can alter the potential outcome of suicide (World Health Organization, 2014). A number of studies that examine the evidence for suicide prevention strategies have identified restricting access to means of suicide as having a high level of proof for the prevention of suicide (Beautrais et al., 2007; Mann et al., 2005; World Health Organization, 2014; Zalsman et al., 2016). Mann and colleague’s (2005) systematic review concluded restricted accessing to means decreases suicide, alongside a New Zealand review that also supported reducing access to means as an effective suicide prevention strategy (Beautrais et al., 2007). More recently, Zalsman et al. (2016) reported that the evidence for restricting access to means has strengthened since these studies, particularly in regard to controlling analgesics and jumping from hotspots.

Knowledge of the most frequently used suicide methods is therefore essential when formulating suicide prevention strategies (Mann et al., 2005; World Health Organization, 2014). Ingestion of pesticides, hanging and firearms are the most common methods of suicide internationally (World Health Organization, 2014); however, overall rankings of methods used vary between countries due to cultural factors. For example, approximately half of all suicides involve the use of firearms in America because firearms are readily
accessible (Miller, Barber, White, & Azrael, 2013). In New Zealand hanging, strangulation and suffocation are the most common methods of suicide for both female and males across the age ranges, accounting for 62.8% of all suicides in 2012 (Ministry of Health, 2015b). Poisoning by solids and liquids has been the second leading method of suicide since 2009 and was used in 10.6% of suicide deaths in 2012 (Ministry of Health, 2015b).

The treatment of psychiatric disorders is also considered to have anti-suicidal effects (Zalsman et al., 2016). Specific areas of treatment that have been identified include psychological treatments for mental disorder (Beautrais et al., 2007; Mann et al., 2005; Zalsman et al., 2016), pharmacotherapy (Mann et al., 2005; Zalsman et al., 2016) and community based mental health treatment (Beautrais et al., 2007). Zalsman et al. (2016) systematic review of suicide prevention methods established that effective pharmacological and psychological treatments for depression, treatment for psychotic disorders with clozapine, and the use of lithium for mood disorders are important in the prevention of suicide. A similar study conducted by Mann et al. (2005) concluded that psychotherapies alone or in combination with anti-depressants can be effective in the prevention of suicide attempts and suicidal ideation. Caution in the use of anti-depressant use in youth has been identified because of a potential association between anti-depressant initiation and the emergence of suicidal ideation in this group. However, the use of this medication is not discouraged because of the increased risk of suicidal behaviour (Mann et al., 2005; Zalsman et al., 2016).

Mishara and Chagnon (2011) take a somewhat different approach to this aspect of suicide prevention. These authors suggest that just because an increased incidence of suicide is observed in mental health populations, that it does not necessarily mean that treatment of mental disorder is the best approach to suicide prevention in this population group. Rather they focus on the wider explanations of suicide, including the bio-genetic, sociological and psychological context, and how this influences suicide prevention. Although they acknowledge the treatment of mental disorder does have an effect on the prevention of suicide, others factors such as improving the lives of those that experience mental disorder through the reduction in the negative effects of the disorder are also warranted. These authors suggestions for suicide prevention include reducing stigma, educating care-givers and the general public, improving social support and crisis intervention, and teaching effective coping skills (Mishara & Chagnon, 2011).
A high rate of contact with primary care services prior to suicide has been established. Luoma et al. (2002) review of 40 studies for which there was available rates on contact with health care services prior to suicide showed that three out of four suicide victims had contact with primary care providers within a year of suicide and 45% within one month of suicide. This is comparatively higher than rates of SMHS contact that are between 25% and 40% (Luoma et al., 2002; Ministry of Health, 2015a; Windfuhr & Kapur, 2011b). It has been shown that GPs do not routinely screen for suicidal ideation in depressed patients (Feldman et al., 2007); however, there remains insufficient evidence that screening in this context contributes to suicide prevention (Zalsman et al., 2016).

Physician education, such as training programmes for GPs, has also been shown to help prevent suicide (Beautrais et al., 2007; Mann et al., 2005). Mann et al. (2005) comment that physician education increases the incidence of people being diagnosed and treated for depression, which can result in the reduction of suicide rates. Beautrais et al. (2007) also conclude that the education of physicians has been proven to assist in suicide prevention efforts and that another area of potential focus may be community, organisational, and institutional gatekeeper education. This includes training agencies such as schools, prisons, and welfare centres to identify and refer people to SMHS who are at risk of suicide (Beautrais et al., 2007). However, Zalsman et al. (2016) comments that there are no randomised control trials that show gatekeeper training alone affects suicide rates because this intervention is often implemented alongside other initiatives.

A smaller number of studies have identified suicide prevention strategies that may have harmful effects. For example, no-harm contracts were identified by Beautrais et al. (2007) as being potentially harmful. Stanley and Brown (2012) comment that anecdotal evidence suggests that no-harm contracts help reduce clinicians’ anxiety about the risk of suicide, but there is no evidence to support the use of these contracts as an effective suicide prevention strategy. Beautrais et al. (2007) makes the similar remark that no-harm contracts may give clinicians a false sense of security and also potentially engender anger in consumers. Concerns have also been raised that the use of repressed or recovered memory therapy may increase the incidence of suicidal behaviour; however, there is very limited research available that examines this in detail (Beautrais et al., 2007).
Evidence based strategies for suicide prevention support the Ministry of Health’s (2008) planned action of improving mental health service delivery as an effective suicide prevention strategy (Mann et al., 2005; O’Connor, Platt, & Gordon, 2011; Zalsman et al., 2016). Focusing on mental health consumers as a targeted population using a tailored approach and the need to incorporate the provision of mental health services in national prevention policy has been highlighted as being important.

Part Two: Coroner Recommendations

It is agreed amongst health professionals and inquirers that complaint and inquiry services are essential and have an important role in health care because of the importance of learning from adverse events to improve the overall quality of care in health services (Freckelton & Ranson, 2006; Maclean, 2012). The full investigation of the circumstances of a person’s death can also provide clarity for their family and assure the community that the death has been investigated thoroughly (Mok, 2014). Despite these clear advantages, coroner inquiries and recommendations have received some scrutiny in recent years. This includes concerns that coroners’ full preventative functions are not being maximised and that their recommendations may not always be well supported by the evidence (Mok, 2014; J. Moore, 2014b). As a consequence, recent research has started to examine the topic. The remainder of this chapter will provide an overview of the literature available.

Currently there is debate in various countries about the lack of obligation of recipients to act or respond to coroner recommendations. This is particularly the case for Australia, The United Kingdom and New Zealand (Borrows, 2013). One of the main critiques of the lack of regulation regarding response to recommendations across various international coronial systems is the inability to evaluate the implementation and usefulness of the recommendations (Freckelton, 2007; Ranson, 2005).

Research that explores the implementation of coronial recommendations has been conducted in New Zealand and Australia. A New Zealand study investigated 79 coronial cases that had recommendations directed to a variety of organisations and established that the recommendations had been implemented in 57% of cases (Mok, 2014). This study also indicated that despite claims that coronial recommendations are often disregarded, in most
instances the recommendation were at least given some consideration. Recommendations that required only minimal changes were considered more likely to be implemented. In several of the cases investigated, recommendations had not been implemented because they had been lost in bureaucratic processes (Mok, 2014). A similar large scale study conducted in Australia, that also investigated the implementation of coroner recommendations across different settings, found that the rate of implementation varied greatly between states from 27 to 70 percent (Watterson, Brown, & McKenzie, 2008). This study also found a number of occurrences where coroner recommendations had been mishandled or lost. The authors concluded this was related to the lack of legal obligation to respond to the recommendations. The only state that had no instances of mishandled or lost recommendations was the Northern Territory, the only jurisdiction that required mandatory response at the time. Another Australian study investigated the number of recommendations that coroners were making (Ranson, 2005). This study showed that during the period 2000 and 2005 in Victoria Australia, only 1.4% of cases investigated by a coroner resulted in recommendations being made (Ranson, 2005).

A recent study in New Zealand was conducted that investigated the coronial system and recommendations (J. Moore, 2014b). This qualitative study reviewed all recommendations made by coroners in New Zealand between mid-2007 to mid-2012 and interviewed 127 participants including coroners, organisations, and other interested parties regarding the system. This study findings supported the need for enhanced communication and collaboration between coroners and interested parties. The study also highlighted a number of gaps in the current coronial law review including the limited proposals that target coroners’ prophylactic functions, the lack of investigation of mandatory response to recommendations, and the need to provide coronial services with adequate resourcing that will improve the quality of recommendations (Moore, 2014b).

A subset of this study focused on coroners’ recommendations about healthcare-related deaths (J. Moore, 2014a). This study outlined that the healthcare recommendations in New Zealand addressed the following factors:

- The introduction, review or changing of policy, protocols and procedures;
- The maintenance of clinical records;
- Training and education;
• Telephone triaging systems;
• The supervision of junior doctors;
• Sharing of information between healthcare workers;
• Raising awareness of unusual or rare presentations.

Participant interviews indicated that increased communication between coroners and healthcare organisations was required when recommendations are made about clinical care. The need for recommendations to also be evidence based was highlighted in this study. All the participants agreed that coronial services would benefit from more resourcing to better inform recommendations (J. Moore, 2014a).

A small qualitative study in England was conducted that investigated what organisational learning is generated from coroners’ recommendations (Claridge, Cook, & Hale, 2008). This study involved case studies and interviews with individuals that had responsibility for organisational learning in the National Health System. This study found that there was very little evidence of learning that was generated from the recommendations. In addition to this, the authors noted that there was a lack of structure and function in the way health services were responding to the recommendations (Claridge et al., 2008).

A small number of studies were identified that examined coroner recommendations in relation to mental health and suicide. The first study was conducted in Ireland and investigated coroners’ knowledge and attitudes towards suicide using a survey (Farrow, Arensman, Corcoran, Williamson, & Perry, 2009). The 97 coroners interviewed in this study emphasised the importance of suicide prevention strategies and supported more open communication about the topic. However, a high percentage of the coroners interviewed underestimated the importance of mental illness as a contributory factor to suicide, which was highlighted as a potential concern given this view is in contrast with the current evidence that mental illness is a significant risk factor (Farrow et al., 2009).

Two Australian studies were identified that examined coroner recommendations in relation to mental health. The first was a small study that compared the recommendations of six suicide and homicide coronial inquiries with the recommendations that had been made by the national confidential inquiry in the UK (Goldney, 2000). The national confidential
inquiry recommendations were a result of the investigation of 3000 suicides and homicides. This study concluded that the recommendations made by coroners in the six cases were very comparable to the recommendations made by the large inquiry system in the UK. This author comments that the recommendations should not be perceived as overly demanding by mental health services, because they simply represent what adequate mental health care should entail (Goldney, 2000).

Another Australian study specifically reviewed coroner recommendations regarding cases of suicide for people experiencing mental disorder (Freckelton, 2005). This study was conducted from a legal perspective and summarised recommendations that had been made by coroners at the conclusion of inquests into the deaths of persons with psychiatric diagnosis between the years 2000 and 2005. The recommendations related to a number of areas of clinical practice including risk assessment, information sharing, administration, absconding, prison systems, resourcing issues and education. This author highlighted that considerable effort, time and resourcing is exercised to identify these systematic factors that are potentially contributing to suicide, but questioned the extent to which the information had been utilised (Freckelton, 2005).

**Chapter Summary**

It has been established that suicide is a significant health and social issue in New Zealand, with internationally comparatively high rates of suicide. Those that suffer from mental disorder are considered particularly vulnerable to suicide and high rates of mental health service contact prior to suicide have been identified. Improving the care provided to people who are vulnerable to suicide is considered an evidence based suicide prevention initiative and coroners’ recommendations directed to SMHS also have the objective of suicide prevention through the improvement of these services. There is a small but emerging body of literature that examines the impact of coronial recommendations. Concerns have been raised whether the preventative functions of the inquiries are being maximised, and whether the recommendations are of consistent quality. There is a paucity of research that examines the impact of coronial findings that relate to cases of suicide and mental health and to date, no study has specifically reviewed coronial recommendations directed to SMHS regarding suicide in New Zealand and explored the impact that they have.
Chapter 3: Methodology

This chapter describes the qualitative dominant mixed model design and methods that were used to conduct the research. The research project was comprised of two phases. The first phase involved the retrieval and content analysis of available coroners’ recommendations to Specialist Mental Health Services (SMHS) in New Zealand that relate to cases of suicide. This phase of the study identified the major categories of coronial recommendations being made. The second phase focused on gaining an understanding of how the recommendations are handled by SMHS and to explore the first phase themes from the perspective of SMHS and family and whānau workers. This was investigated with individual interviews of SMHS leaders that are responsible for the implementation of the recommendations across District Health Boards (DHBs) in New Zealand, as well as a local family and whānau worker focus group.

A description of the qualitative dominant mixed model design will be firstly described. This will be followed by an account of the theoretical foundations, ethical considerations and the study aims. The methods pertaining to the two phases including sampling, data collection, and the use of qualitative content analysis and descriptive quantitative analysis will then be provided.

A Qualitative Dominant Mixed Model Design

Mixed methods research is a synthesis of both quantitative and qualitative research. It is defined as a category of research where quantitative and qualitative research techniques, methods, approaches, concepts or language are merged by the researcher into a single study (Johnson & Onwuegbuzie, 2004). Mixed method research legitimises the use of multiple methods by offering the logical and pragmatic view that more than one method can be used to answer a research question (Johnson, Onwuegbuzie, & Turner, 2007). It is becoming increasingly more recognised as the third paradigm of research (Harwell, 2011; Johnson & Onwuegbuzie, 2004) and recent evidence also supports its use in mental health science research (Palinkas, Horwitz, Chamberlain, Hurlburt, & Landsverk, 2011).
Mixed method research is a relatively contemporary approach in that its methodological identity has developed only in the past two decades (Harwell, 2011). However, its origins have been traced further back as far as early 20th century when the combination of the two methods was seen in the social sciences (Johnson et al., 2007). The late 1950’s saw the use of multiple approaches with the conception of using more than one method to reinforce the validity of the other results, which was later coined as triangulation (Johnson et al., 2007). The formalisation of a mixed methods paradigm was still not seen until the 1980’s and 1990’s. At this time qualitative methods were fast developing, which emphasised a polarisation between qualitative and quantitative research. Almost in reaction to this, the mixed method movement emerged (Johnson et al., 2007). Mixed method research has since evolved and is considered to have assumed a position as a matured methodological approach in its own right (Tashakkori, 2009).

Johnson and Onwuegbuzie (2004) consider two major types of mixed methods research; mixed model (mixing methods across the different stages of the research), and mixed method (the inclusion of a qualitative phase and quantitative phase). The design of this study fits Johnson and Onwuegbuzie’s (2004) description of a mixed model design because the second phase of the inquiry included a “within stage” mixing of qualitative and quantitative methods. More specifically, interviews were conducted that included both rating scales (quantitative data) and open ended questions (qualitative data). Johnson and Onwuegbuzie (2004) in fact cite the use of questionnaires that include rating scales and open ended questions as an example of a mixed model design.

Clarification of the method can be further made based on the priority given to the qualitative or quantitative aspects of the design (Creswell, Klassen, Plano Clark, & Smith, 2011), or in other words where the research sits on the qualitative-quantitative continuum (Johnson et al., 2007). On one end of the continuum research is qualitative dominant, the other end is quantitative dominant, and the middle is an equal mix of both paradigms (Johnson et al., 2007). This study is qualitative dominant in its design in that the research aims and methods are largely qualitative in their focus. However, the addition of rating scales in the second phase of the data collection produced quantitative data resulting in a mixed model design. This author provides the following definition of qualitative dominant mixed methods research:
“Qualitative dominant mixed methods research is the type of mixed methods research in which one relies on a qualitative view of the research process... while concurrently recognising that the addition of quantitative data and approaches are likely to benefit most research projects” (Johnson et al., 2007).

A qualitative focus was chosen as it is most consistent with the overall aims of the study. The coroners’ recommendations are written text. This data is fundamentally qualitative in nature and therefore requires investigation by qualitative methods and analysis. The second phase of inquiry sought to explore the first phase in more depth and to understand the mental health service response to the coroners’ recommendations. This in-depth type of exploration is also essentially qualitative in its focus because qualitative research aims to gather in-depth information to understand the human experience (Gerrish & Lacey, 2006). However, some benefit was also prophesied in adding a quantitative aspect to the collection of data in the second phase of the inquiry. Firstly, the rating scales allowed for the interview to have a higher level of structure to ensure essential information that was relevant to the study was collected. Secondly, the rating scales provided an outline that assisted in the collection and interpretation of the qualitative data by making it more uniform with the outcomes of the first phase results.

A Descriptive Approach

The study uses a descriptive approach in both the qualitative and quantitative aspects of the study. Descriptive studies involve a well-considered combination of sampling, data collection and analysis techniques with a lower level of interpretation. The result of this is a more simple description of the phenomena of interest in language that is close to the raw data (Sandelowski, 2000). It is considered a useful approach when straight descriptions of a phenomenon are sought (Sandelowski, 2000). Critics of this approach describe it as less sophisticated as other more theoretical approaches, yet it is because of its more simple form that descriptive studies are argued to be useful and necessary (Sandelowski, 2000; Thomas, 2003). Other qualitative approaches such as phenomenology, grounded theory or ethnography require the researcher to put an interpretive spin on what they are investigating through the specific lens of the approach (Sandelowski, 2000). This higher level of interpretation can be useful when there is previous knowledge on the topic and the
underlying meaning of information is desired (Thomas, 2003). However, these approaches also have the potential for important manifest information to go unnoticed due to the imposition of preconceived theory (Thomas, 2003).

The advantage of descriptive methods to produce straight unadorned answers to research questions (Sandelowski, 2000) is why it was chosen for this study. Given this study is the first of its kind to explore the topic, a broad design was considered most appropriate to ensure information was not lost with a higher level of interpretation. One of the aims of the study is to produce a summative description of coronial recommendations directed to SMHS regarding suicide. This is achievable within a descriptive design because there is no requirement to produce anything other than the descriptive information that is most relevant to the audience (Sandelowski, 2000).

**Theoretical Foundations**

Although a descriptive design is less theoretical, it remains important to consider what underlying theory is present. For this study this includes interpretivism and the position of the researcher.

**Interpretivism**

Interpretivism is a theory that is fundamental to qualitative research methods. It refers to the understanding that human beings constantly interpret and make sense of their surroundings and the meanings of others (Gerrish & Lacey, 2006). Within a research context it describes the assumption that an inquirer interprets the underlying meanings of human and social action or other relevant focuses of an inquiry. In this framework it is accepted that it is possible to understand the meanings of others in an objective way even when it is not explicitly described (Denzin & Lincoln, 2000). However, value-free data cannot be wholly obtained because the researcher has preconceptions, makes judgements during the research process, and interacts with the research and its participants. As described earlier when using descriptive methods the level of interpretation is low-inference, in that it does not describe the findings in terms of a conceptual or philosophical framework (Sandelowski, 2000). However, it does involve a degree of interpretation as this cannot be avoided based on the underlying assumptions of interpretivism. Description still
involves information being filtered through the researcher’s perceptions. Even summative
descriptions of text produced by content analysis still involve the researcher making
decisions about what to describe and how to describe it (Sandelowski, 2000).

**The Position of the Researcher**

The provision of information regarding the researcher’s stance is particularly important in
a descriptive design given the absence of a predetermined philosophical framework (Caelli,
Ray, & Mill, 2003). Through the sharing of information regarding the researcher’s
perspective one is able to demonstrate an awareness of possible bias on data collection and
analysis (Munhall, 2007), and it also allows the reader to better evaluate the research
(Caelli et al., 2003). The theoretical position of the researcher can be addressed through
describing what the researcher’s disciplinary affiliation and background is, what bought the
researcher to the topic, and describing what assumptions they make about the topic of
interest (Caelli et al., 2003).

My disciplinary affiliation is nursing and although I am comprehensively trained I have
only worked in mental health settings. Previous areas of employment include rehabilitative
and acute mental health inpatient nursing, community mental health case management,
clinical research, and nursing education. I came to the topic of interest as a result of my
master’s thesis findings. This small qualitative study explored mental health nurses’
perspectives of clinical responsibility and accountability. The nurse participants reported
concern at the prospect of being involved in a coronial inquiry and having their practice
scrutinised, which had a subsequent defensive impact on their practice. Surprisingly, when
exploring this theme I found there was very limited empirical research available about the
impact of coroner inquiries on mental health services in New Zealand or internationally.
This identified the topic of interest but it was essential that the focus of the investigation
was narrowed given there was limited previous research on the topic. Around this time a
targeted review of The Coroners Act (2006) was announced and the function of making
recommendations was receiving attention as area for potential reform. For this reason
coroners’ recommendations were identified as the specific area of focus for the research
project.
My clinical experience as a mental health nurse has led me to hold some assumptions about the topic of interest. One of the fundamental principles of mental health nursing is the importance of the therapeutic relationship and this principle has particular relevance in the management of suicide risk. The therapeutic relationship provides a context in which consumers and their families can seek out help from a mental health service. It also enables clinicians to make more informed assessments, have better insights into what is occurring for people, and pick up underlying signs that a person is experiencing difficulties. The best management of any risk in the mental health setting is good treatment, and the therapeutic relationship that mental health clinicians have with consumers, their families and other involved parties is the most fundamental aspect in achieving this.

**Study Aims**

The aim of this study is to review recommendations made by coroners to SMHS that relate to suicide and to explore the SMHS service and family and whānau worker response. The following research question and sub-questions were used to guide the study:

What are the areas of specialist mental health service delivery in need of improvement as identified by coroners as a means of suicide prevention in New Zealand and what is the SMHS and family and whānau worker perspective of this?

- What are the general themes of coroner recommendations to SMHS in New Zealand that relate to cases of suicide?
- What is the SMHS response regarding the clinical fit of coroners’ recommendations regarding suicide?
- What is the SMHS system level response to coroners’ recommendations regarding suicide?
- Are coronial recommendations that target working with family consistent with the family and whānau worker perspective?
Ethical Considerations

The study received ethical approval from the University of Otago Human Ethics Committee (see appendix 1). Part of this process included consultation with a Māori research advisor. The first phase of the study involved accessing data from the Australian and New Zealand National Coronial Information System (NCIS). An annual online access fee usually applies for third party users but because the study was being conducted for an academic qualification the access fee was waived. Authorised users of the NCIS are required to enter into an access agreement that governs the use of NCIS data (see appendix 2). The terms of this agreement included compliance with the NCIS privacy, security and indemnity protocols. Given the sensitive nature of information stored in the NCIS database special security measures were taken when information was removed from the system. This included the immediate de-identification of the deceased and other involved parties including family members and health and agency staff. This information was then stored in an encrypted file on the researcher’s laptop computer. This meant that the file was not accessible to anyone other than the researcher who held the password. At no stage was the file printed to make a hard copy and the database was only accessed via University of Otago computers.

The second phase of the study involved interviewing participants. Information sheets were provided to all potential participants via email (see appendix 3). The information sheets included information about the purpose of the study, the researcher, what participation would involve, confidentiality, study approval and contact details for a health and disability advocate. The information sheet was discussed prior to interviews and signed informed consent was obtained (see appendix 4). The transcriber also signed a confidentiality agreement (see appendix 5). Participants’ names and identifying details were removed from records prior to analysis and pseudonyms are used in this report. Special consideration was given to the use of narratives and parts of narrative were removed to ensure participant confidentiality. The participants’ roles are not specifically described in this report to further ensure confidentiality. Given the semi-structured nature of the interview a proportion of the questions were not planned in advance. This was explained verbally to the participants prior to the interviews with an explanation that they did not have to answer questions that they felt hesitant or uncomfortable with. This point was also outlined on the consent form.
The second phase of the study also involved a focus group of mental health family and whānau workers. These participants’ places of work are not included in the content of this report to ensure anonymity of the participants. Information sheets and consent forms (see appendix 3 & 4) were circulated via email to the participants prior to the scheduled interview and time was provided for discussion of this before the focus group was conducted. Signed consent was obtained at this time. At the start of the focus group it was explained to participants that if they felt uncomfortable or distressed that they could remove themselves from the group or request the interview was stopped. No issues of this kind were encountered. Two participants in the group were of Māori descent and were asked if any special considerations were needed regarding their culture. As a result the focus group opened and ended with a karakia (Māori prayer). One of the Māori participants also requested they review the transcript following the group interview to ensure information pertaining to Māori was accurate. Because of this request all participants were given the same opportunity to review the transcript. No changes to the transcript were made during this process.

**Design**

As previously discussed the study is a qualitative dominant mixed model design that uses a descriptive approach. Appropriate methods that fit with a descriptive design include the use of purposeful sampling given the aim to obtain cases that are information rich, and data collection methods that include both the examination of documents and semi-structured individual or group interviews. Additionally, content analysis is considered the most appropriate form of analysis because it allows the findings to be produced in a form that is close to the raw data (Sandelowski, 2000). The following sections will provide a description of how these methods were used in this study.

**Phase One Methods**

This phase addresses the first research sub-question of the study: What are the general themes of coroners’ recommendations to SMHS in New Zealand that relate to cases of suicide? The first phase of the research study involved the collection and content analysis of coroners’ recommendations directed to SMHS pertaining to cases of suicide.
The Australian and New Zealand National Coronial Information System
Database

The Australian and New Zealand National Coronial Information System [NCIS] database is an internet based data storage and retrieval system for coronial information. The purpose of the system is to allow coroners, their staff, the public sector, and researchers to access coronial data to inform death and injury prevention activities. The NCIS history dates back to the early 1990’s when the Royal Commission into Aboriginal Deaths in Custody recommended that a national record system was developed. It was not until July 2000 that the NCIS was officially launched for Australian cases having been at the time the only system of its nature in the world. The system was expanded to include New Zealand data in 2012. Currently the system is managed by the Victorian Department of Justice and receives funding from Australian Federal and State government agencies, the New Zealand Ministry of Justice and a user pay system for third party users.

The database contains New Zealand coronial cases since July 2007, which is when The Coroners Act (The Coroners Act, 2006) came into effect. The final search was conducted in March 2015 and available cases spanned between 2007 and 2014. The researcher had access to closed cases where proceedings have come to a conclusion and the coroner has made their final findings. Due to an approximate two year delay in cases being investigated and closed, only partial data was available for 2013 and 2014. The database search engine was used to identify the total number of available closed New Zealand cases with a finding of intentional self-harm. This search was then further refined by including only the cases that had recommendations made, which resulted in 164 available cases. The coroners’ reports in each of these 164 cases were reviewed for relevance to the study. The cases that were identified as cases of interest were those that meet the following inclusion criteria:

1. A coroner finding of intentional suicide. The database could only be searched based on the term intentional self-harm. This included one case that was determined by the coroner as unintentional suicide. This case was not included in the study.

2. The inclusion of recommendations directed to SMHS. The definition of SMHS in this instance refers to private and public services that provide specialised mental health care at a secondary or tertiary level. It did not include recommendations directed to government health officials or government departments such as the Ministry of Health.
The information that was available for each case included demographic information pertaining to the deceased, the cause of death, the classification of death, and attached documents including the coroners finding report, and police, autopsy and toxicology reports. The coroners finding reports were the main source of information as they contained detail regarding the circumstances of the death and the recommendations. The content of these reports varied from case to case. All reports included the coroner’s finding regarding the cause and circumstances of death. The majority of reports also included contextual information usually provided by families, witnesses or other relevant agencies such as police, DHBs or other health staff. Recommendations were usually outlined at the conclusion of the report and included a preamble to the recommendations that read:

“I make, under section 57(3) of the Coroners Act 2006, the attached specified recommendations or comments that, in my opinion, may, if drawn to the public attention, reduce the chances of the occurrence of other deaths in circumstances similar to those in which the death occurred.”

Some case reports did not specifically state that they were making formal recommendations but did include a section titled “coroners comments”. These sections tended to be at the end of the report and the content was similar to those that were more specifically identified as recommendations. Given these cases were categorised in the database as cases that included recommendations they were included. Six cases had been categorised in the database as having recommendations but did not have recommendations or comments in the report and were therefore excluded. Two cases did not have coroners’ reports attached in the database by the time data collection was completed and as a result these cases could not be reviewed for relevance to the study.

The cases that were identified as cases of interest were saved and stored on the NCIS database under the researcher’s username. The recommendations were copied verbatim, placed in an alternative document, de-identified before saving and assigned a research code. The reports contained between one and six recommendations and ranged from one sentence in length to one paragraph. Some contextual information and quantitative data pertaining to the cases was also collected. This included demographic information of the deceased, MHA status, diagnoses, the type of mental health service involvement, the DHB
that was the recipient of the recommendations, the method of suicide used and whether an
inquest or chamber finding was conducted. Inquests involve a public hearing being
conducted, whereas chamber findings are conducted by coroners in their chambers based
on documentation provided to them and consultation with interested parties.

**Phase One Data Analysis**

Descriptive analysis was used to analyse the background quantitative data and qualitative
content analysis was used to analyse the recommendations.

*Descriptive Quantitative Analysis*

The majority of quantitative data pertaining to the coronial cases that was collected is
categorical nominal data with the exception of the age of the deceased. Categorical
nominal data can be categorised into distinct groups and has no natural ordering (Gerrish &
Lacey, 2006). This data was entered into an Excel spreadsheet and analysed using
descriptive methods. Descriptive analysis of categorical data involves counting frequencies
of occurrences and expressing them as percentages (Gerrish & Lacey, 2006). Age of the
deceased was treated as categorical ordinal data, which is different in that it does have
natural ordering. This data was also entered into Excel and counted using frequencies;
however, the ordinal nature allowed for it to be summarised in age ranges.

*Qualitative Content Analysis of Coronial Recommendations*

Content analysis was used to analyse the coroners’ recommendations. Content analysis is a
method of analysing varying types of information including written, verbal and visual (Elo
& Kyngäs, 2008). It is a method of analysing text through the systematic categorisation
process of coding and identifying patterns (Hsieh & Shannon, 2005). It allows researchers
to understand a particular phenomenon of interest in a subjective but scientific way (Zhang
& Wildemuth, 2009). The purpose is to attain a summarised broad description of the
phenomena. This is most frequently presented in categories that include information or text
that shares the same meaning (Hsieh & Shannon, 2005). The first objective of this study
was to generate a generalised description of coroner recommendations made to SMHS in
New Zealand to inform further avenues of enquiry. This initial aim did not warrant an
overly interpretive means of data analysis, which is why content analysis was chosen over more interpretive methods.

The specific type of content analysis chosen for a particular study is dependent on the nature of the phenomena that it aims to describe (Johnson et al., 2007). When there is limited information regarding the topic of interest the inductive approach is recommended as it does not require any preconceived coding parameters (Hsieh & Shannon, 2005; Johnson et al., 2007). This approach allows the categories and the names of the categories to emerge from the data (Johnson et al., 2007). Given no previous studies that were specific to the topic were available to guide a deductive approach, inductive analysis was chosen.

For the purposes of this study the process of inductive content analysis described by Elo and Kyngäs (2008) was used. This process has three phases that include a preparation phase, an organising phase, and a reporting phase. The first step of the preparation phase involves selecting a unit of analysis. This can be a sentence, a phrase or a whole document (Hsieh & Shannon, 2005). The selected unit of analysis was the text from the findings reports that outlined the recommendations.

The second phase is the organisation phase. This process includes open coding, creating categories and abstraction (Hsieh & Shannon, 2005). This begins with reading the text repeatedly so that the researcher can immerse themselves in the content of the text (Johnson et al., 2007). The process of repeatedly reading the text began when the cases were first reviewed for inclusion. When a case was identified as meeting the inclusion criteria the whole coroners finding report was read. Once the text (recommendations and contextual information) was extracted and placed in an alternative document the researcher read this document a number of times to gain a sense of the recommendations as an entire group. Once this was complete the process of open coding begun. Open coding describes the process of writing notes and headings in the text whilst it is being read through. These headings describe the content of the text. As many headings as necessary can be written down to ensure they are representative of all areas of the text (Hsieh & Shannon, 2005). For each recommendation a heading that described that recommendation was written in the side column of the document.
The second part of the organising phase involves the generation of initial sub-categories and the reduction of the number of categories through collapsing those that are similar together (Hsieh & Shannon, 2005). This is done by grouping the headings into broader categories by deciding what data ‘belongs’ to a particular category. When conducting inductive content analysis the researcher decides how to organise and group the data through a level of interpretation of the text (Hsieh & Shannon, 2005). This process was undertaken by deciding what recommendations were similar or dissimilar and seeing if they fitted together. This resulted in the generation of the initial sub-categories.

The final step of this phase is described by Elo and Kyngäs (2008) as abstraction. Abstraction is the means of developing a general description of the research topic through producing final categories. Similar initial categories are grouped together to form generic categories and these categories are grouped together to form additional larger categories. This process continues as far as necessary to obtain the broad description of the phenomena into fewer main categories (Hsieh & Shannon, 2005). A tree diagram was used to assist in the analysis as suggested by Johnson et al. (2007) (see Figure 3.1). The final process of abstraction resulted in the 21 generic categories being condensed down to six major categories.

**Phase Two Methods**

The second phase of the study sought to address the remaining research questions:

- What is the SMHS response regarding the clinical fit of coroners’ recommendations regarding suicide?
- What is the SMHS level response to coroners’ recommendations regarding suicide?
- Are coronial recommendations that target working with family consistent with the family and whānau worker perspective?

In order to address these aims the perspective of the SMHS that were receiving the recommendations was required. This was addressed with individual interviews of SMHS leaders responsible for their implementation. A family and whānau worker focus group was also conducted to gain their perspective regarding recommendations that relate to family inclusive treatment. The remaining two sections of this chapter describe the methods used to carry out this phase of the study.
Figure 3.1: Example of organisation phase of the content analysis process
SMHS Participant Individual Interviews

This section describes the sampling and data collection methods used for the individual SMHS leader interviews. This includes a description of purposeful and snowball sampling, and the data collection interview schedule.

SMHS Participant Sampling

Within qualitative research the researcher often seeks to identify a group of participants that will provide a rich source of data rather than identifying total populations of people (Gerrish & Lacey, 2006). In order to establish the most appropriate people to interview, the researcher approached individuals (nursing, psychiatry, quality and legal) from the local area to discuss what individual roles in SMHS had responsibilities regarding coronial inquiries and the subsequent handling of the recommendations. This determined two leadership roles across DHBs that had involvement and knowledge of coronial processes and the related recommendations. These people were also responsible for the implementation of coronial recommendations within the SMHS they worked. All people fulfilling the identified leadership roles across the 20 DHBs in New Zealand were invited to participate. This sample is a purposeful sample, which describes the process of pre-identifying and purposively inviting the most informed participants (Gerrish & Lacey, 2006). Information regarding the study was then distributed at national meetings to the identified people. Follow-up group and individual emails were also sent inviting participation. Chain referral sampling, which describes seeking out further participants through the existing participants networks (Liamputtong, 2009), was also used. This occurred on two occasions when participants identified others within their DHBs that had a high degree of involvement in the coronial process. A total of sixteen participants were recruited across twelve DHBs.

SMHS Perspective of Coronial Recommendations Interview Schedule

An interview schedule using a combination of semi-structured qualitative enquiry and Likert-Type questions was developed specifically for the study. This interview schedule is titled the SMHS Perspective of Coronial Recommendations Interview Schedule (SPCRIS) (see appendix 6). The purpose of the SPCRIS was to capture the SMHS perspective of coronial recommendations regarding suicide and to gain an understanding of the processes.
that surround coronial inquiries that relate to SMHS. The use of a mixed methods interview schedule ensured a balance between having clear direction but with the flexibility of exploring participants’ responses. This meant that the research questions could be directly addressed but with the capacity for further investigation of interesting responses through qualitative enquiry.

Likert-Type questions are derived from Likert’s (1932, as cited in Boone & Boone, 2012) original attitudinal measurement scale. The original Likert scale used a series of questions with five response rate alternatives that included strongly approve (1), approve (2), undecided (3), disapprove (4) and strongly disapprove (5). Since this time Likert scales have been used commonly in research but have been adapted to suit different research needs (Boone & Boone, 2012). Likert-Type questions describe the use of questions that are similar to the original Likert response alternatives (Boone & Boone, 2012).

The SPCRIS starts with the following open ended questions to generate initial discussion:

- Can you tell me about your experience with coronial inquiries?
- Can you tell me about how coroner recommendations are handled within your DHB?

The remainder of the SPCRIS contains a series of 14 Likert-Type questions that have five response rating options. Each of the Likert-Type questions are followed by qualitative enquiry to qualify the responses given and to gain a detailed understanding of the participants answers. Participants were able to respond unsure or non-applicable if they did not have knowledge of the type of recommendation they were being questioned about.

The first eight Likert-Type questions aimed to gain an understanding of the SMHS system level response to coronial inquiries and recommendations. This included the need to collect information regarding the processes surrounding the inquiries, the SMHS perspective regarding the quality of the recommendations being made and what the SMHS response was to the recommendations in terms of implementation and distribution. The eight questions more specifically targeted the following: 1) the extent coroners consult with the DHB prior to making recommendations, 2) the evidence base of recommendations received, 3) the SMHS perspective of whether coroners have the right knowledge to make recommendations to SMHS, 4) how often recommendations are implemented by SMHS, 5)
the adequacy of resourcing to implement the recommendations, 6) how often recommendations are feedback to staff in SMHS, 7) the SMHS perspective regarding mandatory written response to coroners following recommendations, and 8) if it is perceived by SMHS that the recommendations contributed to the prevention of suicide.

The remaining six questions were specific to the major categories of coronial recommendations to SMHS regarding suicide found in the first phase of the study. The purpose of these questions was to determine the SMHS perspective of the different types of recommendations being made and explore whether the recommendations are consistent with current models of clinical care. The questions asked participants in their experience how appropriate recommendations are regarding: communication, restrictive management, staff education, working with family, risk assessment and service delivery.

The SPCRIS was initially piloted on two people working in leadership and educational roles in SMHS. It has been identified that an interview protocol should be pre-tested with persons that are demographically similar to the planned sample (Burke & Miller, 2001). These people were chosen because they were not in the sample population but had some understanding and knowledge of the topic. The purpose of the pilot was to clarify the most logical order of questions, identify working issues, and determine the amount of time the interviews will take to conduct (Burke & Miller, 2001). The pilot resulted in one question being removed from the interview schedule due to wording issues.

The majority of the interviews were conducted and audio-recorded over the phone using the SPCRIS. The interviews on average took around an hour. Telephone interviews are increasingly being used to conduct semi-structured interviews (Gerrish & Lacey, 2006). In this instance they were used as they were a cost effective and more convenient mode of enquiry. Given the sample was spread through-out the country it was not practical to travel to conduct the interviews, therefore telephone interviews were utilised so that the sample could be extended nationally. The main disadvantage to phone interviews can be the reduced ability to detect sub-text and the emotional implications related to the topic (Gerrish & Lacey, 2006). However, phone interviews can be less threatening and provide a more convenient option for busy participants (Gerrish & Lacey, 2006), which were both significant advantages for this study.
Family and Whānau Worker Focus Group

A description of the methods used to gain the family and whānau worker perspective will now be described.

Family and Whānau Worker Focus Group Sampling

A convenience sample of family and whānau workers from local family advisory and support services were invited to participate in a focus group interview. A convenience sample is a common form of sampling within qualitative research methods and is often used for pragmatic reasons in the sense that it is the only accessible option available to the researcher (Gerrish & Lacey, 2006). Given participants were required to physically attend the focus group, local services were the only available option. Three different services were approached to provide variation and anonymity for the participants. The family and whānau workers included Family Advisors, Māori Mental Health Workers, and non-governmental organisation (NGO) Family Support Field Workers.

These participants were chosen for sampling for a variety of reasons. The main strength of using this cohort of people was that they had both the perspective of being family members, as well as being employees of mental health services. They were able to share their personal experiences of interacting with mental health services as families of mental health consumers, as well as their perspective of the issues with family inclusive treatment from their employment. A number of the family and whānau workers also had experience of being advisors during inquiry processes, which provided further insights. Lastly, their employment also meant they had been in contact with a number of families of mental health service consumers, which gave them a broad overview of the type of feedback received.

It is acknowledged that interviewing families bereaved by suicide was another possible avenue of inquiry that would have been useful. However, given the sensitive nature of this line of inquiry it posed some ethical challenges that would require special attention. Firstly, it was felt that the interview process had the potential to cause families bereaved of suicide high levels of distress and that follow-up care would therefore need to be available if required. It may have also been necessary that an alternative interviewer was required given the researcher was a SMHS employee at the time of the inquiry. Both of these points required resource beyond what was available to the study.
The participants were recruited via their managers. The managers of each team were approached and information was provided for dissemination to their teams. The researcher also visited the Māori mental health team as way of introduction and to share information about the research. A total of eighteen individuals across the teams were invited to take part and nine accepted the invitation.

**Family and Whānau Worker Focus Group Data Collection**

A focus group is an open-ended group discussion that explores a specific topic for the purposes of data collection (Gerrish & Lacey, 2006). The purpose of this focus group was to explore the family and whānau workers’ perspective of the issues identified by coroners regarding SMHS work with families. A less structured approach to the topic guide was chosen with three pre-planned open-ended questions (see appendix 7).

- Can you tell me about how families feel about the level of involvement they have in their family members SMHS treatment?
- Can you tell me about the level of information that is provided to families by SMHS staff regarding the care of their family members?
- Can you tell me about SMHS staff obtaining information from families?

These questions were based on the sub-categories of the major working with family category of coroner recommendations from the first phase of the study. Prior to the focus group introductions were made and informed consent was gained and background information regarding the study was provided. Participants were given time to read a written hand-out of examples of coronial recommendations that are specific to working with families (see appendix 8). The focus group was then audio recorded for transcription. During a focus group interview the role of the researcher is that of moderator (Stewart, Shamdasani, & Rook, 2007). It is important that the researcher does not take on the role of participant by joining the discussion (Bohnsack, 2004). The researcher who conducted the interviews for the focus groups had to be aware of this due to having worked in the field and holding certain perspectives of the discussion that was occurring. Bohnsack (2004) suggests that this distance is achieved by adhering to follow-up questions that aim to expand participants’ discussion and generate detailed experiences. For example, could you tell me why you think that occurs? An additional role of the researcher is to ensure the
active participation of all participants in the group (Stewart et al., 2007). The allocation of

time for each participant to take turns in the discussion generally occurred quite naturally.
At times the researcher used questions to help redirect the discussion to other members of
the group. For example by asking, is this anyone else’s experience? The interview came to
a natural end and was concluded after two hours.

**Phase Two Data Analysis**

The data from the individual interviews of SMHS leaders and the family and whānau
worker focus group were analysed using descriptive methods. The final sections of this
chapter describe how this was carried out.

*Descriptive Quantitative Analysis of Likert-Type Data*

The data from the Likert-type questions from the individual interviews was entered into an
Excel spreadsheet. The data that is produced from Likert-type questions is ordinal in nature
because the levels of measurement demonstrate a greater than relationship (Boone & Boone,
2012), or a rank order (Jamieson, 2004). It is important to note that the intervals between the
denominations in this instance cannot be assumed to be equal (Carifio & Perla, 2007;
Jamieson, 2004). Therefore, one cannot presume that ‘agree’ is twice as much as ‘somewhat
agree’ and so on through the possible comparisons (Carifio & Perla, 2007). Because of this,
it is recommended that questions are analysed individually using descriptive methods, such
as counting frequencies (Jamieson, 2004). This approach was adopted for this study. The
data from the Likert-type questions were individually analysed using the descriptive method
of counting frequencies of responses. For example, counting the number of participants that
responded strongly agree, agree, neutral, disagree and strongly disagree. These results are
then described by the frequency of response for each category.

*Qualitative Content Analysis of Phase Two Data*

The audio-recordings from the individual interviews and family and whānau workers focus
group were transcribed verbatim and de-identified. The process of inductive content analysis
described in the phase one methods was then followed to analyse both sets of data. This
included the preparation and organising phase as described by Elo and Kyngäs (2008).
The preparation phase involved organising the data from the individual interviews into sets of data for each question of the SPCRIS. This involved dividing and combining the responses of each of the questions. For example, the qualitative data that was specific to question one from the SPCRIS regarding consultation was cut and pasted from each interview into one document and then this process was repeated for each question. This resulted in fourteen sets of qualitative data to be analysed separately. Although the text from the original individual interviews was split, it remained labelled with the participant research code.

Each set of the above data was analysed separately. This began with the organisation phase. As earlier described, the organisation phase involves open coding, creating initial categories and abstraction (Hsieh & Shannon, 2005). Open coding involved the text being given headings in the margins that described the text. A number of headings were identified to ensure that all the areas of text had been covered. These headings were then ready for the process of abstraction, which involves collapsing those that are similar together to generate initial sub-categories. Similar initial sub-categories were then grouped together to form generic categories. This process was repeated on the fourteen sets of data, which produced the qualitative categories for each question. An additional category, impact on staff, developed from data through-out participants’ interviews. This category was not a result of a pre-determined SPCRIS question but naturally emerged across the interviews. Therefore, an additional category was created and is reported on without Likert-Type response ratings.

The same processes of inductive content analysis was repeated for the family and whānau worker focus group transcript. This document was analysed as a whole. The preparation phase involved reading the transcript multiple times to become familiar with the data. This was followed by the process of open coding and creating the initial sub-categories. A total of ten initial sub-categories were formed. The final process of abstraction condensed these initial categories down to three major categories.
Chapter 4: Coroners’ Recommendations to Specialist Mental Health Services Regarding Suicide

This chapter presents the results of the first phase of the study, which involved the collection and content analysis of coronial recommendations made to SMHS in New Zealand regarding suicide. Coroners investigated the care provided by SMHS as part of the circumstances of death. In a number of the included cases the coroners perceived faults in the care that was provided to the deceased, which then dictated the focus of the recommendations. The analysis produced six major categories that provide a description of what is being recommended by coroners as areas of potential focus for improvement or change in the delivery of SMHS.

In the first category, **Restrictive Management**, the coroners’ recommendations focus on interventions that restrict peoples’ freedom in order to maintain their safety. This is followed by the **Risk Assessment and Management** category, which reports on recommendations that target how risk assessment and management is conducted in clinical practice and addressed in policy. The third category is the largest and is labelled **Communication**. This category reports on recommendations that target the sharing of information between health professionals and across services. In the fourth category, **Working with Family**, coroners perceived shortcomings on the behalf of the SMHS regarding the way they had worked with the families of the deceased and subsequently made recommendations that highlighted the services responsibilities concerning this. The **Staff Education** category reports on recommendations that promote learning from the adverse event for the service involved, as well as recommendations for more specific training for staff. The final and smallest category, **Service Delivery**, reports on recommendations that address some aspects of how the service is organised and delivered.

Background data is first presented for the cases where coronial recommendations to SMHS were made. This is followed by a report of the major categories described above.
Background Findings

This section provides background information regarding the cohort of cases that were included in the study. A description of the number of cases included, inquests held and the number of recommendation per DHB are described, followed by demographic information pertaining to the deceased.

Cases Included

At the time of the final search of the NCIS database a total of 3078 closed cases were available that had a finding of intentional self-harm (see Figure 4.1). Of these cases, 164 had resulted in recommendations and 70 of these had been determined as suicide and were directed towards SMHS. This equates to 43% of the intentional self-harm cases with recommendations being directed to SMHS during the period sampled. Due to multiple recommendations in some cases a total of 136 recommendations were included in the study.

Figure 4.1: Number of cases and recommendations included in study

Cases by Year

Cases included in the study spanned from 2007 to 2014 (see Table 4.1). The 2007 data is only a partial year because the collection of data started to occur when (The Coroners Act, 2006) came into effect in July. In this year, a small number of cases included (n=8) resulted in a relatively high total number of recommendations being made (n=21). The highest
number of recommendations occurred in 2008, with 19 cases that resulted in 48 recommendations. This is twice the number of recommendations made in other years. In the subsequent years 2009 and 2010, similar numbers are seen with 15 and 16 cases included and 22 and 23 recommendations respectively. A significant drop in recommendations can be seen in the following two years, with only 6 cases and 11 recommendations in 2011 and 4 cases and 5 recommendations in 2012. Cases from 2013 and 2014 were also included; however, only partial data was available for these years because of the approximate two year delay in cases being investigated and closed by coroners.

**Table 4.1: Number of cases per year**

<table>
<thead>
<tr>
<th>Year</th>
<th>Total number of intentional self-harm closed cases</th>
<th>Number of intentional self-harm cases resulting in recommendations</th>
<th>Number of cases of suicide with recommendations directed to SMHS</th>
<th>Total number of recommendations made to SMHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>242</td>
<td>15</td>
<td>8</td>
<td>21</td>
</tr>
<tr>
<td>2008</td>
<td>491</td>
<td>41</td>
<td>19</td>
<td>48</td>
</tr>
<tr>
<td>2009</td>
<td>487</td>
<td>37</td>
<td>15</td>
<td>22</td>
</tr>
<tr>
<td>2010</td>
<td>510</td>
<td>28</td>
<td>16</td>
<td>23</td>
</tr>
<tr>
<td>2011</td>
<td>505</td>
<td>24</td>
<td>6</td>
<td>11</td>
</tr>
<tr>
<td>2012</td>
<td>491</td>
<td>13</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2013</td>
<td>284</td>
<td>5</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>2014</td>
<td>68</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>164</td>
<td>70</td>
<td>136</td>
</tr>
</tbody>
</table>

**Inquests Held**

Inquests are held in a place that is open to the public, which can include media and family members (The Coroners Act, 2006). Alternatively, coroners can conduct inquiries from
their chambers and not hold an official inquest. However, a coroner must hold an inquest if the death occurred in official custody. Official custody includes persons detained by The Mental Health [Compulsory Assessment and Treatment] Act (1992)(MHA), The Intellectual Disability [Compulsory Care and Rehabilitation] Act (2003), The Alcoholism and Drug Addiction Act (1966) or those in prison receiving SMHS care. The relevance of official custody is the potential vulnerabilities one has when detained due to the restriction of rights, which is particularly pertinent for psychiatric consumers (Freckelton & Ranson, 2006). Of the 70 included cases, 56% (n=40) had an inquest (public hearing in court) conducted, and 43% (n=30) were conducted by chamber findings.

**District Health Boards**

Within New Zealand there are 20 DHBs that provide specialist mental health care, of which 16 had received recommendations from a coroner regarding suicide during the period reviewed with multiple recommendations in most cases (Figure 4.2 and 4.3). The following information is provided to demonstrate the distribution of analysed recommendations across the DHBs, but the numbers between DHBs cannot be compared as they do not take into account factors such as the size or demographics of the DHB’s population.

Capital and Coast DHB had the highest number of cases included in the cohort (n=14) and the highest number of recommendations (n=23). Southern DHB had a similar number of cases (n=12) but 10 of these cases repeated the same recommendation. A total of sixteen recommendations were directed to the Southern DHB. Canterbury and Auckland DHBs had seven cases each, which resulted in sixteen recommendations for Canterbury and thirteen recommendations for Auckland. Counties Manukau DHB had a smaller number of cases (n=5), but a relatively high number of recommendations (n=16). Similarly, Tairawhiti DHB had a small number of cases (n=3), but a high total of recommendations (n=11). Hutt Valley DHB had a moderate amount of cases (n=5) and recommendations (n=6), as did the Waitemata DHB with four cases and seven recommendations. Hawkes Bay and MidCentral DHBs had two included cases, which resulted in five recommendations for the Hawkes Bay and four recommendations for MidCentral. Both, Bay of Plenty and Whanganui DHBs also had two cases but a smaller number of recommendations (n=3) each. The private provider had one case that resulted in six recommendations and the Waikato DHB had one case that resulted in five recommendations. Nelson/Marlborough and
Wairarapa also had one case, but fewer recommendations (n=2 and n=1). Lakes, Taranaki, West Coast and Northland were the four DHBs that did not have any available cases with recommendations to include in the study.

**Figure 4.2**: Number of included cases per DHB

**Figure 4.3**: Number of Recommendations per DHB. *note 3 recommendations shared between two DHBs
Demographics

Demographic information of the deceased was collected including gender, age, ethnicity, diagnoses and MHA (1992) status.

Gender

A higher percentage of the deceased were male, which accounted for 64% of the cohort (n=45). The remaining 36% were female (n=25).

Age

The age of the deceased ranged from 14 to 66 years (see Table 4.3). Only one of the deceased was under the age of 15, and a further 17 were in the youth age range of 15-24. The largest proportion of the cohort were aged between 25 and 44 (n=38) and fewer (n=13) were aged between 45 and 64. One of the deceased was aged over 64.

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Number of deceased in age range</th>
<th>% of total cohort rounded to the nearest whole number</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;15</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>15-24</td>
<td>17</td>
<td>24%</td>
</tr>
<tr>
<td>25-44</td>
<td>38</td>
<td>54%</td>
</tr>
<tr>
<td>45-64</td>
<td>13</td>
<td>19%</td>
</tr>
<tr>
<td>&gt;64</td>
<td>1</td>
<td>1%</td>
</tr>
</tbody>
</table>

Ethnicity

Ethnicity data of the deceased was also collected (see Figure 4.4). The largest percentage of deceased were New Zealand European (n=52). This was followed by Māori (n=10), and
then smaller numbers of people who were European Not Further Defined (n=3), Pacific Islander (n=3) and Asian (n=2).

**Figure 4.4: Ethnicity of deceased**

**Diagnoses**

The diagnoses of the deceased were usually recorded within the body of the coroner’s findings report. These were not always clearly described in accordance with current diagnostic terminology; however, they were able to be grouped into the described categories (see Table 4.3).

Mood disorders were the most prevalent in the cohort with multiple references to this diagnostic group (n=45). This indicates that over half (64%) of the deceased had a mood disorder diagnosis. The next highest referenced group was psychotic disorders (n=16), which was reported in almost a quarter (23%) of the cases. Substance abuse disorders (n=12), personality disorders (n= 11) and anxiety disorders (n=10) all occurred at similar rates. Fewer cases of neurodevelopmental disorders (n=6) and eating disorders (n=4) were seen. Four case reports did not clearly articulate or make reference to whether or not the deceased had a mental disorder diagnosis.
Table 4.3: Diagnoses of the deceased. *note multiple diagnoses in some cases*

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Number of deceased reported with diagnosis*</th>
<th>% of total cohort rounded to the nearest whole number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mood Disorder</td>
<td>45</td>
<td>64%</td>
</tr>
<tr>
<td>Psychotic Disorder</td>
<td>16</td>
<td>23%</td>
</tr>
<tr>
<td>Substance Abuse Disorder</td>
<td>12</td>
<td>17%</td>
</tr>
<tr>
<td>Personality Disorder</td>
<td>11</td>
<td>16%</td>
</tr>
<tr>
<td>Anxiety Disorder</td>
<td>10</td>
<td>14%</td>
</tr>
<tr>
<td>Neurodevelopmental Disorder</td>
<td>5</td>
<td>7%</td>
</tr>
<tr>
<td>Eating Disorder</td>
<td>4</td>
<td>6%</td>
</tr>
<tr>
<td>Not Stated</td>
<td>4</td>
<td>6%</td>
</tr>
</tbody>
</table>

**Mental Health Act Status**

The MHA status of the deceased relates to whether the person was a formal patient under the MHA (1992) at the time of death. When a person is placed under the MHA (1992) they are required by law to undergo compulsory assessment and treatment. The alternative is an informal status, which describes a person receiving assessment and treatment by a mental health service on a voluntary basis. This has particular relevance because formal patients receiving treatment in an inpatient or community setting are considered by law to be in official custody.

The MHA (1992) status of the deceased was sourced from the coroner’s findings report. At the time of death 12 people (17%) were reported to be under the MHA (1992) and considered formal patients, although which section of the MHA (1992) these people were under was not reliably specified in the reports. The majority of the deceased were informal patients at the time of death (n=46, 66%), however in two of these cases people were
proposed patients awaiting section 10 assessment. In 12 of the cases (17%) the MHA (1992) status of the deceased was not specified.

**Mental Health Service Status**

This section describes the type of SMHS the deceased was receiving at the time of death or had previously received (see Figure 4.5). This information was usually described in the main body of the coroner’s finding report. The most common form of treatment the deceased were receiving at the time of death was outpatient treatment. This was the case for 32 of the 70 cases included. Of the 32 people that were receiving outpatient treatment 10 had been discharged from an inpatient setting in the last 28 days. Crisis service contact and/or treatment was the next most frequent type of service input. This input included one off face to face assessments, temporary crisis follow-up, telephone assessment and triage, and family contact. Just over a quarter (n=19) of the cases had crisis service input. The third more substantial group was those who had been inpatients at the time of death, which occurred in 14 of the cases. A small number of the cohort had also been discharged from all services (n=3) or referred to services awaiting assessment (n=2).

![Figure 4.5: Mental health service status of deceased](image)

*Figure 4.5: Mental health service status of deceased*
**Method of Suicide**

Within this cohort hanging and strangulation was by far the most common method of suicide with 54% of cases occurring in this way (n=38) (see Figure 4.6). Other methods of suicide occurred considerably less frequently. These included death from poisoning gases and vapours (n=6), poisoning from solids and liquids (n=6), submersion (drowning) (n=6), and firearms (n=6). The less common methods of suicide in this cohort were jumping from a height (n=4), being hit by a moving vehicle (n=2), incised wound to the neck (n=2) and asphyxiation (n=2).

![Method of suicide used by deceased](chart.png)

**Figure 4.6: Method of suicide used by deceased**

**Categories of Recommendations**

The following sections provide a description of the six major categories of coroners’ recommendations. In this section text from coronial reports is used to demonstrate the categories described. Asterisks are used when the name of a person, a service or an organisation has been removed for confidentiality purposes. In some instances pseudonyms have been used, which are also identified by asterisks.
Restrictive Management

Restrictive management describes treatment that imposes restrictions on someone’s activity and/or freedom. Current models of mental health service delivery aim for the less restrictive approach as it provides a more therapeutic context to treatment. The perceived benefits include enhanced engagement and the promotion of consumer autonomy and self-determination. However, when safety for a person or others is of concern restrictive interventions can be utilised. This is particularly relevant for those subject to the MHA (1992) who’s right to refuse treatment can be overridden. This major category reports on recommendations that comment on or advocate for restrictive measures in certain circumstances.

This category contains 25 recommendations, which is 18% of the total. The category is grouped into four sub-categories titled nursing observations, compliance, access to means and ward security. A description of these sub-categories follows.

Nursing Observations

Nursing observations are used in inpatient settings for risk minimisation and involve a nurse sighting and engaging a person at prescribed intervals. The level of observations is set at the time of admission based on a comprehensive risk assessment. The person’s safety is the principal concern but the therapeutic impact of the observations including the privacy and autonomy of the person is also taken into account. Setting the level of observations is usually the responsibility of the medical team. The lowest level of observation would generally be hourly checks, and the highest level would involve a nurse being within sight and arm’s reach of a person at all times. The level of risk and observation is reviewed at regular periods during the person’s admission and adjusted accordingly. In the included cases the coroners often perceived that the levels of observation were set too low for the level of risk or that the appropriate procedures were not carried out sufficiently. A total of nine recommendations are included in this category.

The most common type of recommendation in this category was the suggested review of observation policy. This included the advised incorporation of national documents and guidelines. The following two recommendations illustrate this. The first recommendation
endorses the use of a national document that was being written to provide guidance for DHBs. The second example suggests the review of policy so that it provides more descriptive guidance for clinicians making decisions about observation levels.

“That the national document regarding the observations and nursing engagement referred to in paragraph 94 of this finding be expedited and considered for adoption by the Health Boards in New Zealand.

That the Board give early consideration to a review of the document titled Increased Observations contained in its Mental Health Services Policy and Procedures Manual, with a view to providing better guidance to clinicians through the use of clearer language in the indications for increased observation at the varying levels set out therein and to striking a better balance in the Guiding Principles between the principle of patient autonomy and the need for decisive intervention in high risk situations. The document should emphasise the principle that patient safety must be the paramount consideration at all times.”

This recommendation focuses on the balance between safety and consumer autonomy with the remark that safety should have more weighting. The following example makes similar comments. In this case, the person was placed on routine observations on admission, which is the lowest level of observation. The coroner agrees with the family perspective that higher observations levels should be imposed on people until there is a clear demonstration of a person’s safety.

“There is inevitably going to be a gap between the implementation of the least restrictive approach to caring for patients with mental health conditions and providing an environment where they are guaranteed to be safe. Unfortunately, *Jane fell into this gap. *Jane's family and friends consider that the gap should be bridged by clinicians erring on the side of more restrictive observation levels being imposed initially, until a patient has demonstrated they are safe in that environment and sufficient time has expired to reassure the clinicians that the observation level can be relaxed. I have some sympathy with that approach. The tragic outcome of *Jane's
last admission demonstrates that it is extremely difficult to predict suicide. This is also supported by the literature referred to during this Inquest. Therefore the clinicians’ paramount concern in the first instance should have been *Jane's safety, particularly in view of her recent history of multiple, serious, suicide attempts. I am not advocating a return to the asylum model of mental health care; I am simply suggesting that the pendulum needs to swing more towards maintaining the safety of the patient in the initial stages of treatment.”

Other recommendations made similar proposals with the emphasis being placed on minimising the risk. The final example also has this focus but it makes a different proposition. It suggests a trial of wireless wrist straps to monitor people’s breathing whilst inpatients. In this case, the person had died during the night, yet regular checks by the nurses had not identified this was the case until the morning. Limited contextual information was provided in the report about how this proposal came about, but it did explain that if a person stopped breathing whilst wearing the device the nurses would be alerted by way of alarm. It was recommended:

“*That a trial operation of new technology of utilising the use of wireless wrist straps be undertaken to monitor patients at risk but expressly subject to appropriate research protocols.*”

Within this category coroners targeted inpatient nursing observations. Suggestions to review relevant policy and incorporate national guidelines were made. More guidance for clinicians making decisions regarding levels of observation was recommended and safety was identified as having the most importance when making these decisions. The recommendations tended to promote more restrictive levels of observations for inpatients at risk of suicide.

**Compliance**

Compliance describes a person’s willingness to follow a prescribed course of treatment. In mental health care compliance has a unique set of circumstances. This is because of the potential risks that are related to a person’s illness not being well managed and the related
use of enforced treatment by law. On the flip side are the perspectives of consumers, including the reasons for non-compliance such as the side effect profiles of many psychopharmaceuticals or the disempowering nature of enforced treatment. Within the included cases the coroners perceived more could have been done by the services involved to ensure compliance with the agreed treatment plan. A total of seven recommendations were included in this category.

The main form of treatment that is addressed within these recommendations is medication. Non-compliance with medication was discovered during the course of the inquiries and in some instances from post-mortem toxicology investigations. The coroners commented in these cases that the treating mental health service needed to be more vigilant and proactive in ensuring that people are compliant with medication in the community setting. This point is illustrated in the next example.

“One of the duties I have to consider, is whether it is appropriate for me to make comments to try and prevent deaths in similar circumstances. The comment I make with a view to preventing deaths occurring in similar circumstances to those in which the death of *Jacqui occurred is that when a patient is under compulsory care under the mental health services and there is a history of non-compliance with medication, that extra vigilance is required by mental health services to ensure compliance. It is a matter of being on watch.”

The next recommendation takes a further step in suggesting a lower threshold for police assistance to enforce medication compliance. The administration of long acting injectable medication is possibly one of the more common forms of enforced compliance in mental health care. If a person refuses medication in the community whilst under the Mental Health Act (1992) police can be called for assistance. Usually in practice this would involve transportation to a hospital facility to have the injection potentially under restraint. Decisions to enforce treatment in this way are very complex, which is evidenced in the following case example. The deceased had a psychotic illness that required medication for control of symptoms and due to a history of non-compliance they were under a Community Treatment Order and prescribed long acting anti-psychotic medication. However, the deceased had been avoidant of SMHS, therefore at the time of death the deceased had not received the
medication for 28 days. The family had been opposed to the deceased receiving the medication because of perceived side effects, which compounded the issue. In this case the coroner questioned if a more assertive approach could have been taken to locate the deceased and administer the medication. The subsequent recommendation was made.

“To the Chief Executive of *DHB: That *DHB Mental Health Service considers whether it should adopt a lower threshold for considering whether to seek Police assistance to enforce a community treatment order in relation to overdue medication.”

In addition to addressing medication compliance, three of the recommendations had a wider focus on compliance with treatment. The final example targets compliance with the agreed discharge plan. After discharge from SMHS a person often requires ongoing treatment and supports from primary services or other community agencies. This would be planned prior to the discharge and stipulated in the management plan. In the case described the deceased had not attended his GP for follow-up as agreed on discharge from the community crisis team. The recommendation suggests that the service should check post discharge that the person has complied with the agreed plan.

“That the DHB should consider a process whereby when a patient is discharged from treatment on the basis or understanding that the patient will comply with an agreed course of action, whether as a condition of the discharge or not, there will be, at a minimum, some active follow-up by the DHB within a reasonable time to determine, so far as that it is possible, if there has been compliance and, if so, the outcome. If there has not been compliance, there should be a proactive attempt, at the very least, to engage the patient further and [subject to the patient's consent] his family.”

This category reported on recommendations that focused on ensuring people are compliant with medication and treatment plans. It was suggested that SMHS services needed to be more assertive in ensuring compliance and in some cases more forceful.
Access to Means

This category reports on recommendations that target restricting access to lethal means for persons at risk of suicide. There are numerous methods of suicide, therefore restricting access to means can take many forms. Some are widespread in approach, for instance, barriers to rooftops, and others are individual, such as restricting the quantities of dispensed medication. Controlling access to means usually occurs on a temporary basis whilst the risk of suicide is considered to be elevated. However, within hospital settings, because of the high risk population, a more universal approach is taken to ensure readily accessible means are not available to all persons. This category contains five recommendations, which were mainly set in the hospital environment. In these cases the coroners revealed available means of suicide that warranted further investigation.

The hazards that were identified in these cases included medication dispensing, unlocked bathrooms, unmaintained shrubbery in the court yard and plastic bin liners. The following is an example of a recommendation that addresses the later of these.

“That an investigation be undertaken to seek out alternatives to plastic bag rubbish bin liners in places where mental health patients may be at risk.”

One of the included recommendations also targeted the wording of environmental check policy. Environmental checks are routinely undertaken in inpatient settings to identify and remove any hazards. If appropriate this would include personal items such as appliances with cords. The policy had stipulated that “electrical cords must be secured or removed;” however, the coroner considered the word “secured” to be ambiguous and in need of further clarification.

“*DHB has made a number of changes to its procedures in response to its investigation into Mrs *X death. However, in my view, the Environmental Check Policy is still unclear. This is discussed in paragraphs [33] to [36] of this finding. I recommend that *DHB review its policy in light of the comments I have made in those paragraphs to ensure that it is clear what steps must be taken to identify and remove hazards from the Unit.”
This relatively small sub-category included recommendations that specifically target access to lethal means that could be used for suicide, mainly in the inpatient setting.

**Ward Security**

This category includes four recommendations that focus on the hospital ward environments, more specifically, how they ensure people cannot leave without authority. There are a variety of ward environments in mental health hospitals in New Zealand. Many are open wards, which do not have locked doors. Some hospitals also have secure units, which are locked and have secure outdoor areas. Typically these more controlled environments are for more acutely unwell people, those who are deemed higher risk or are part of forensic services. In the included cases people had accessed the ward courtyard or left the hospital to suicide. Concerns were raised by the coroners at the ease with which people could carry out these actions. The recommendations therefore focused on increasing the security of the units to avoid such reoccurrences.

The following two recommendations provide examples that illustrate this category. The first example suggests the front entrance of the hospital be made more secure and the second suggests a higher level of nursing control regarding access to outdoors areas.

“I recommend also to the DHB that it look again into ways to secure the entrance of the building to reduce the chances of patients leaving unauthorised and unquestioned.

*That access to the courtyard in Ward *X be under the control of nursing staff.*”

This relatively small category included recommendations that would result in the environment of the hospital being made more custodial.

**Risk Assessment**

This major category includes recommendations that are specific to the risk assessment of suicide. Risk assessment is an estimate of the likelihood of an adverse event occurring in
certain circumstances at a specific point in time (Ministry of Health, 2003). An assessment is based on information collected including current presentation and mental state, recent circumstances, and historical background (Ministry of Health, 2003). The assessment informs the formulation of risk, which is a process of organising and describing the risk factors. Current models of practice frequently include the use of a low, medium, or high rating, but it is also essential that this is quantified with the risk data. A risk management plan is then designed based on the formulation. This plan records the interventions that aim to minimise the likelihood of the risk occurring (Ministry of Health, 2003). The following category reports on recommendations that target how risk assessment is conducted in clinical practice. This category includes sixteen recommendations, which is 12% of the total. The sub-categories that are reported on include risk assessment and management procedures, psychiatry input and telephone risk assessment.

**Policy and Procedures**

The recommendations in this category focus on the organisational approach to risk assessment by targeting the policy and procedures. In the included cases the risk assessments and management plans of the deceased were often scrutinised and with hindsight it was believed the assessment and subsequent plan were flawed. Consequently, the coroners made recommendations that targeted relevant policy and procedures in an attempt to regulate the process in clinical practice. This sub-category contains nine recommendations and is the largest in this category.

The first example makes a simple recommendation that the DHB risk management plan incorporates the Ministry of Health Guidelines for risk assessment and management.

> “Consider the Ministry of Health Guidelines referred to in the evidence and integrate these Guidelines more fully into the *[hospital name removed] Risk Management Strategy."

The next example focuses on the documentation of risk. Questions were raised at the inquiry about whether a risk evaluation had comprehensively been completed at the time of admission as concerns were raised at the low assessment of risk. It was reported by the assessing clinician that this was incorporated into the initial assessment as per practice in
the unit at the time and that they stood by the assessment made. The coroner proposed the following so that the evidence and rationale for the assessment is clearly recorded.

“That the *DHB formally adopts and implements a separate form for the initial assessment of risk a patient poses to him or herself or to others on admission to a mental health facility.’’

In the next example the coroner endorses an expert opinion. This covers a number of points mentioned in the other recommendations including how a risk assessment should be conducted and the need to review relevant forms. However, the report also comments on the need for policy regarding staff training and updates regarding risk assessment and management.

“Ms *X comments that while *DHB appears to have appropriate policies and procedures in place to ensure there is a consistent approach provided to service-users and provides guidance to staff in their roles and responsibilities, there is no policy or guideline relating to when and how often risk assessment training should occur. Ms *X recommends:

- Assessment should be triangulated by combining the history from the patient, the mental state observations by the clinician with collateral history from another informant.
- Patients with psychotic symptoms (though not proven in *Johns case) even in the absence of any other risk factors for suicide should be reviewed.
- Contemporary contextual risk training with a focus on formulation and sound documentation is offered to the community mental health clinicians on a regular basis as a means of maintaining and improving staff confidence.
- The risk identification form is reviewed.

I consider those recommendations are appropriate.”

Finally, two of the included recommendations questioned how much weighting should be given to the information received from the consumer during assessment based on the fact
they could be intentionally misleading the assessor. In the example provided a family member who was present at the assessment felt the deceased had misinformed the assessors to avoid further action on their part. The coroner comments that a person’s answers to questions cannot be trusted and made the recommendation that a questioning protocol be developed that reduces the need for judgement about a person’s responses regarding risk to self.

“A patient’s answers to questions should on no account be taken at face value but should always be challenged. If this has not already occurred a questioning protocol should be developed which is specifically designed to contain within it its own checks and balances so that it becomes difficult for a patient and/or the patient's support person to provide responses simply designed to convey that all is well when it is not.”

The recommendations included in this category pursued the organisational approach to risk assessment and management by focusing on policy and procedure. Aspects of how risk assessments should be conducted were highlighted and suggestions regarding protocols and policy were made.

**Psychiatrist Review**

The recommendations in this section cover the perspective that review by a psychiatrist is indicated when there is a perceived risk of suicide. This category is relatively small as it contains four recommendations. Within current models of mental health care, risk assessments are considered routine practice and are carried out by various disciplines. This includes social workers, registered nurses, psychologists and occupational therapists. Newly registered doctors, psychiatric registrars and consultant psychiatrists also regularly undertake this task. When a person is assessed as an increased risk of suicide it is normal practice to consult others in the multi-disciplinary team (MDT) that are working with the person including the assigned psychiatrist. The purpose is to share the information, corroborate the assessment and jointly discuss the management plan which may include an additional assessment by a psychiatrist. However, the MDT is not always readily available. For example, in afterhours crisis work a clinician would conduct an assessment and decide if the input of a psychiatrist was required at that time. In some of the included cases it was
questioned whether it was appropriate for other disciplines to carry out initial assessments and make these judgements when there are increased risk factors. In addition to this, the frequency of review by a psychiatrist for the purpose of risk assessment was also discussed as a potential issue. These two points are illustrated in the examples below.

The first example stipulates that it should be a psychiatrist that assesses a person when there has been a recent suicide attempt. In this case the person had been seen by an occupational therapist at a crisis service following referral from the GP. The person was assessed as not meeting criteria under the MHA (1992) at the time of assessment; however, follow-up arrangements for community treatment were made as well as the plan for interim monitoring in the community by the crisis team. Sadly, the person died the following day. The coroner questioned the appropriateness of the person not being seen by a psychiatrist when they presented and made the suggestion that the risk form should guide other disciplines about when to engage a psychiatrist.

“I consider that where review is warranted as the patient has attempted suicide or is at risk of suicide that review should be by a Psychiatrist. I also consider the review of the risk identification form be such that it effectively guides the assessor as to when it is appropriate for the patient to be reviewed by a psychiatrist.”

The second example suggests that more regular review by a psychiatrist in an inpatient setting may have allowed for the suicide risk being identified. In this case, the rationale for reduced psychiatry contact was poor engagement, therefore the coroner makes additional suggestions about how assessment could still take place.

“Although I do not consider that the specific failure by Dr *X to conduct a focussed interview with *James on a more frequent basis was a circumstance of his death, hindsight allows us to see that one or more additional assessments may have resulted in any greater suicide risk being identified. I accept the difficulty in that *James saw interviews with Dr *X as distressing. Strategies could be employed to allow a psychiatrist to observe and interact with a patient less formally or
This category focused on psychiatrists conducting risk assessments with the aim of increasing the detection of suicide risk.

**Telephone Risk Assessment**

In this final category the recommendations question the quality and appropriateness of telephone risk assessments. A total of three recommendations are in this grouping. Telephone contact with SMHS is frequently the first point of contact for people in crisis. These triaging calls are most commonly taken by a crisis team or a community mental health team. An initial assessment of the situation would occur over the phone and the clinician would then decide if further action was required. The recommendations in this section question if these phone assessments are suitably robust for persons with suicidal ideation.

This category is illustrated with the following excerpt. In this scenario family made contact with the crisis team due to the deceased voicing suicidal ideation. A clinician made telephone contact to assess the situation. The risk was deemed low at the time therefore no immediate action was taken. The coroner queried whether an assessment over the phone is sufficient in these circumstances.

“It recommend that *Mental Health and Addiction Service as part of the review of the triage process review the appropriateness of telephone assessments (rather than face to face assessments) where they have referred to them a person who has indicated that he/she intends to commit suicide.”

This example is similar to the others included in the category. All three recommendation question the ability to accurately assess a situation over the phone. One recommendation makes the addition of suggesting the relevant policy is reviewed.
Communication

This category reports on recommendations that target communication between providers both internally and across organisations. Current models of mental health service delivery require collaboration with multiple providers. It is essential that the various professionals and agencies work together to ensure the strongest response to consumers’ needs is delivered. Inadequate communication between providers can lead to the quality and safety of treatment being significantly compromised. In the identified cases the coroners uncovered a lack of communication between health professionals and services, as well as errors in the exchange of information including documentation practices.

This category includes 35 recommendations, which is 26% of the total recommendations included in the study. It encompasses three sub-categories, including inter-agency communication, internal communication and documentation. An account of these categories follows.

Inter-agency Communication

Inter-agency communication describes the sharing of information across organisational boundaries. It is not unusual for a person to be involved with numerous services whilst receiving specialist care for mental illness. These services might include other health providers, such as primary care settings or NGOs and non-health services, for instance social or correctional services. The collaboration and sharing of information across these settings was the target of the coronial recommendations in this category. This section is the largest in this category as it contains fifteen recommendations.

The first example focuses on communication between health professionals who are working with a consumer at the same time. In this case the person was receiving treatment from a private therapist and psychiatrist whilst under the DHB SMHS. The coroner commented that there was not a clear communication line between the various providers. This point lead to the following recommendation being made, which outlines the importance of communication in these instances.
“This Court believes it is paramount that mental health providers have an open communication between any practitioners who are dealing with a patient at the same time or during the referral process from one to another and it is equally important that those professionals provide updating reports to the patient’s general practitioner.”

The special mention of updating a consumer’s General Practitioner (GP) was emphasised in the above recommendation and three other recommendations categorised in this grouping. These references relate to the role of the GP in the delivery of mental health care: GPs are frequent referrers to SMHS, co-prescribers during treatment and often resume care on discharge.

The next two examples also address communication between health services. The first tackles communication between two different DHBs. This was a result of a fairly uncommon circumstance of a young person transitioning between the two providers due to shared custody arrangements.

To the Chief Executives of *DHB and *DHB: That the DHBs review whether further collaborative processes are required to better manage the community mental health care of children and young persons whose living arrangements include both DHB areas.

The next example is more specific to the sharing of risk information with a NGO that was providing supported accommodation to the deceased. In the days leading up to this person’s death they had been monitored more closely by the community mental health team because of the identified suicide risk. However, the lack of process surrounding the communication of risk information between the SMHS and NGO provider was identified.

“There is a need for formalised processes and protocols between the DHB and facilities such as *[mental health NGO name removed] for the communication of safety concerns, risk and planning and management of risk.”
The final two examples target the interface between SMHS and non-health organisations. Police and correctional services were most commonly referred to with five recommendations targeting the sharing of information with these organisations. Poor communication between the services was identified by the coroners, which in some instances led to errors in procedures and inadequate follow-up. The following excerpt is a recommendation that demonstrates these circumstances. The deceased had been receiving treatment from a community mental health service at the time of imprisonment. It was the community team’s understanding that referral by the prison to forensic mental health services would occur in these circumstances; however, it did not occur in this case. The recommendation proposes a review is undertaken to establish clear paths of communication in these instances.

“I comment that prompt advice of imprisonment to psychiatric service providers and alcohol and drug service providers of persons recently utilising such services is important in both alerting the providers to a change in circumstances of the person, and alerting the providers to communicate any relevant information that may assist the prison service in the care of the person. How that information is conveyed (whether electronically or otherwise) and what consents are required and how provided is a matter for review. It will be my recommendation to the Department of Corrections, Police, and *DHB that a review be completed of procedures to ensure timely (including electronic) communication of relevant information impacting on the health and safety of persons detained in *[areas name removed] Prisons.”

The final example in this sub-category targets communication between mental health providers and social services. The deceased had previously been under the Child Youth and Family (CYF) umbrella. Ongoing care and protection issues were identified by the mental health service, however, multiple re-referrals to CYF had been declined. This was on the basis that the deceased’s mental health issues were the primary concern and that the person’s age was nearing their exclusion criteria. The coroner commented that SMHS require good interagency co-operation with CYF to ensure the strongest response possible for clients with these complex needs. The subsequent recommendation was made
proposing a review be conducted by the Ministry of Social Development in consultation with the DHB about the collaborative processes between SMHS and CYF.

“To the Chief Executive of the Ministry of Social Development and the Chief Executives of *DHB: That the Ministry of Social Development (in consultation with *DHB) reviews whether the arrangements between CYF and the *DHBs are sufficiently robust to enable a properly collaborative response between CYF and the DHB's mental health services in order to meet the complex needs of young people (up to the age of 17 years) who have both mental health needs and care and protection issues.”

This sub-category highlights the importance of inter-agency communication between SMHS and other providers. The coroners identified that poor communication across organisational boundaries can have negative consequences on the support provided to mental health consumers. Private health providers, GPs, NGOs, police, corrections and social services were all identified as agencies requiring effective communication with SMHS.

Internal Communication

Internal communication describes the sharing of information within SMHS. This includes communication across disciplines within a multidisciplinary team, as well as across internal services, for example, between a community mental health team and an inpatient team in the same SMHS. A SMHS can contain multiple individual services and speciality areas, which produces a complex interface. Therefore, the sharing of information within the bounds of the service is an important aspect of providing safe care. In these categorised cases, the coroners identified inadequate communication and collaboration across these contexts. A total of nine recommendations are included in this category.

The first example addresses how information is conveyed between health professionals within the multi-disciplinary team. Concerns were raised in this case regarding the quality of information provided by a social worker to senior practitioners. The coroner consequently proposed the DHB review the relevant processes.
“It is the Court's view that the *DHB Mental Health Services review their process as to how a social worker communicates their notes to a senior practitioner so that a review of a patient's mental health is fully appraised.”

The next excerpt provides an example of a recommendation that targets the collaboration between two different services within the same DHB. The deceased was not referred to Community Alcohol and Drug Services (CADS) because it was thought self-referral would be more appropriate as it would establish motivation. However, the coroner comments in the report that communication between CADS and the mental health clinician would have been beneficial. The recommendation suggests that the DHB reflect on the disconnection between CADS and the other mental health teams.

“It is beyond the scope of this Inquiry to reflect on changes that might be made to the models of care which exist for CADS' services in relation to DHB care. However, I am in agreement with Dr *X that too often there appears to be a disjunction between alcohol and drugs services and other mental health care. *DHB may wish to reflect on the issues raised. A copy of this finding will also be sent to the Ministry of Health Mental Health Directorate to consider this issue.”

The final example has a different focus. This case highlights the potential for error when sending information in written form between services. In this case information regarding a crisis presentation out of hours was sent via fax; however, it was not received by the intended recipient, resulting in inadequate follow-up. The coroner subsequently made the recommendation to the DHB to formulate a system that ensures the sender of a fax checks that it has been received.

“In relation to referrals/handovers sent by facsimile, it is my recommendation that the *DHB's Mental Health Service give consideration to implementing a system which ensures that the sender of a facsimile requiring any follow-up action in relation to clinical care, checks that such facsimile has been received by the intended recipient.
In this category, issues were identified regarding the handover of information between clinicians and services within SMHS, therefore the coroners suggested the DHB review its practices regarding communication in these circumstances. Comments were also made in some of the cases regarding the disconnectedness between the various specialty services, therefore it was proposed by the coroners that the links between services be strengthened.

**Documentation Practices**

In the health care context documentation provides an official record of what has occurred for a person during contact with a healthcare provider. It is considered an integral part of providing safe and quality treatment. It has multiple purposes including the sharing of health information; a record to inform treatments; a record of information for consumers; for research, quality and educational purposes; and as a legal document that can be used as evidence in legal proceedings or by other regulatory bodies (Austin, 2011). In the included cases the coroners’ findings draw attention to sub-optimal documentation and accordingly make recommendations that aim to address the issues identified. This category contains eleven recommendations.

The majority of recommendations focused on the accurate recording and maintenance of information. These recommendations tended to be specific to the areas of treatment that had not been well documented in the cases investigated. For example, in the following case the coroner considered the follow-up post discharge from an inpatient facility was inadequate and poorly coordinated. The lack of a recorded management plan and risk information was considered one of the causative factors, therefore the recommendation below was made outlining the need for this as a basic requirement.

“That upon the discharge of a patient from [*unit name removed], especially patients who remain the subject of a community treatment order, the terms and conditions of such discharge, the nature and extent of any risks to which the patient remains subject, the early warning signs
and all necessary interventions (including monitoring) shall be
documented in the Multi-Disciplinary Team Plan."

It is also a requirement for clinicians to record relevant information from telephone conversations with consumers or other relevant parties. The following recommendation addresses this point. It suggests the DHB implement a documentation process for telephone referrals and calls.

*The District Health Board adopt the telephone triage documentation process for telephone referrals and calls during working hours as recommended in the *(another coroner’s finding) report.*

In addition to recommendations that focused on the maintenance of documentation, the availability of the records was also targeted. In the next case example, a person was seen at an alternative service to the one they normally attend. It was highlighted in the inquiry that the assessing staff did not have access to the electronic records, which may have impacted the level of monitoring that was provided to the person whilst they were waiting for assessment. Therefore the coroner recommended that electronic records are made available to all staff.

*I recommend that *DHB ensures that electronic medical records currently used by *DHB Mental Health Services be available to assessing staff.*

The final example provided in this category concentrates on recording out of hours attendances. It emphasises the availability of a computerised system that alerts assigned clinicians to out of hours contact and suggests that this system is enforced as a safeguard for ensuring appropriate follow-up post crisis.

*The computerised 'red flagging' of patients who may have been seen after hours is a sensible back-up system to ensure that follow-up actions are undertaken. In this respect I recommend that the Service give consideration to formalising that system; for example, by ensuring that acute, crisis services consistently 'red flag' in all appropriate cases, and*
that clinicians be encouraged to log into the caseload screen (where the red flags would appear) on a consistent, daily basis.”

Within this sub-category documentation was emphasised as an essential aspect in the delivery of SMHS. Sub-optimal documentation was linked with inadequate communication and follow-up. The main area of focus in these recommendations was the need for clinicians to accurately maintain records.

**Working with Family**

This category describes recommendations that target SMHS working with family. Family can extend to a person’s wider family, partners, friends, advocates, or other associates. It is defined by whom a person identifies as their family (Royal Australian and New Zealand College of Psychiatrists, 2000). Family members’ voices were frequently heard when reading the coronial reports as in many of the cases they participated in the inquiry processes. The sharing of their perspectives was made in different forms including verbally at inquest, by written correspondence or via legal representation. In many of the identified cases families felt dissatisfied with the care provided by the mental health service to their loved one including their level of involvement. Similarly, the coroners also described perceived shortcomings of the SMHS regarding how they worked with and involved the family during the assessment and treatment of the deceased. As a result coroners made recommendations that concentrated on this aspect of care.

A total of 21 recommendations were categorised under this theme, which is 15% of the total number of recommendations. The category is divided into three smaller sub-categories, which include communication with family, family inclusion, and obtaining information from family. When describing these results, the term family has been used to describe all forms of family as this is the term most frequently used in the coronial reports.

**Communication with Family**

This category contains recommendations that emphasise the need to provide adequate information to families about the treatment of consumers. It is the largest of the three sub-
categories in this theme as it contains eleven recommendations. In the identified cases the lack of information left families feeling uncertain how to best support their loved ones. It also created confusion over the expectations of what families would provide in the way of monitoring. As a result the coroners made recommendations that targeted the need to provide clear information about the treatment being provided and in some instances instruction about what action might be required. The first example illustrates the nature of a number of recommendations classified in this category. It is a clear statement that better communication with families is needed.

“It is clear that the common thread in this case highlighted again the need for much better communication between the Mental Health Service, the client and the family of the client as to what should be a co-ordinated and well documented and planned approach that is particularly required within the area of mental health services.”

The wording of this recommendation implies that the issues regarding communication with families were commonly identified. In the next recommendation the coroner proposes that families receive clinician details in a simple written form with the addition of a written declaration that clinicians want the families to make contact. In this case, the coroner perceived that there was a reluctance by families to make contact with SMHS and therefore commented that it was the responsibility of mental health clinicians to engage with the family rather than to expect that they will make contact when there are concerns.

“I recommend the *DHB develop a simple and brief notice to families for all mental health patients advising, in particular, the name(s) of the significant clinicians and case workers, their contact numbers, particularly their after-hours numbers, and that should also include a clear assurance that the DHB actually wants the family to engage the clinicians if there are concerns. I say again that, to be effective, it needs to be concise and easy to understand.”

In the next example the coroner recommends that the DHB should review the case again to determine whether adequate instruction and information about medication was given to the mother of the deceased. This point was also highlighted in two other cases. This
recommendation refers to the information being delivered in a culturally appropriate way. This was the only recommendation included in the study that raises culture as a factor.

“I recommend that the DHB Mental Health Services review Mr *X’s case again and consider: ii. Whether adequate information and instruction about ensuring Mr *X was not only provided with, but took his medication, were given clearly to Mrs *Y in a culturally appropriate manner.”

The final area of focus in this category is the communication of risk information to families. These recommendations outlined the importance of communicating to families about the potential risk of suicide as well as giving clear advice about what monitoring is required by family. The following example suggests the use of written forms of information with the advice that a written copy of the risk management plan is given to families.

“THAT the risk management plans developed by CAT Team members following serious acts of self-harm or attempted suicide by patients be reduced to writing and a copy thereof made available to those family members/friends into whose care the patient is to be placed, with clear and explicit advice as to the nature and extent of ongoing risk and the need for monitoring.”

This category highlighted concerns regarding the lack of communication occurring with families and as such the recommendations stipulated that this required the SMHSs attention. Details regarding service contacts, medication, and risk management were more specifically targeted in some of the recommendations. The use of written forms of communicating information was also proposed.

**Family Inclusion**

This sub-category encompasses recommendations that are broad in their application as they cover the overall concept of involving families in consumers’ treatment. Involving families in treatment goes beyond providing them with information. It means ensuring they are consulted, listen to and engaged throughout the course of treatment with the
consumer’s consent. There are five recommendations in this grouping. The first two examples illustrate the more general nature of these recommendations. They suggest the need to review and improve current practices regarding family involvement.

“I recommend that the Adult Community Psychiatric Service *DHB review and if considered necessary, strengthen its practices in regards to family involvement in these circumstances (particularly following transition from *Youth Services).

I recommend to the *DHB to once more reiterate to staff in the inpatient service Associate Professor’s *X reminder of 2009 about family involvement.”

The second example above emphasised to the service that this case was not the first of its kind. The coroner identified that the same issue, poor collaboration with families, had been found in other investigations, and despite a recent reminder to the service about the need to actively involve families the same mistakes had been repeated. The next recommendation expands on the above examples in that it quantifies the importance of involving family in treatment. It highlights that family involvement, although not always appropriate, has therapeutic value. It was perceived by the coroner in this specific case that it would have been hugely beneficial if it had occurred.

“Communicate more frequently and more effectively with the family of its patients, both from the perspective of the family (and their need to be updated and involved) but, more importantly, from a therapeutic perspective. There will be times where family contact or involvement would be inappropriate for a patient, but I observe that, in the case of *James, the involvement and support of family would have been immensely valuable as a part of the therapeutic in his care.”

In this category, involving families in consumers’ care was highlighted by the coroners as an area of mental health service delivery in need of reflection. These recommendations act almost as reminders to SMHSs that they have a responsibility to involve families in the treatment of consumers for the betterment of the service they provide.
Obtaining Information from Family

This final category contains five recommendations that target the collection of information from families regarding consumers’ presentation and treatment. Obtaining information from families is particularly important in gaining an accurate picture for assessment and evaluation. In some instances it is also important to corroborate the information received from the consumer. A range of information is usually required, for example a description of the person’s recent behaviour and level of functioning, historical information and individual circumstances. The families’ interpretation of a person’s presentation and their perspective regarding the response to treatment is also considered important, given they usually know the person better than the treating clinicians and have considerably more contact with the person. In these cases a perceived lack of effort to obtain information from families resulted in important information that could have better informed the risk assessment being overlooked. In addition to this, the families reported a lack of opportunity to disclose information. Three examples are provided that demonstrate this category.

In the first case the family believed the deceased had intentionally misled the clinicians in their risk assessment to avoid further contact with the service. The coroner subsequently recommended that families should be involved in these assessments and that they should be spoken to separately so that their views can be obtained without the restriction of talking in front of their loved one.

“I recommend that the *DHB Mental Health Service reassess its assessment procedures in respect of potential suicide victims. In particular if there are family support people present at an assessment or if such people can be contacted at the time of the assessment by telephone- if not present- these people should be spoken to independently and separately from the patient and their candid views as to the patient's condition should be sought.”

The other two recommendations provided are similar in that they pinpoint the importance of collecting information from family during assessment procedures; however, they also make special mention of privacy. The privacy of consumers’ information is an essential
consideration for clinicians when they are interacting with families. Clinicians are bound to abide by privacy law, therefore permission from consumers is usually pursued when obtaining information from significant others. The next recommendation refers to information being collected within the limits of privacy law.

“Further, as set out in paragraph [13] of this finding, the Court recommends that the Mental Health Services consult with a patient's caregiver to obtain a further overview provided it is done within the prescribed limits of the privacy law.”

The next example expands further on privacy. The example is specific to the collection of information for the purpose of risk assessment. There is a provision within privacy law that allows a clinician to override a non-disclosure request if there are concerns about a person’s level of safety. A decision to override a consumer’s permission regarding disclosure is usually made by a clinician based on the individual circumstances of the situation. The next recommendation suggests that clinicians should have a low threshold for overriding a request for non-disclosure when there is perceived risk of suicide.

“I recommend that when assessing a patient who presents with suicidal indications that relevant health information be collected, including if appropriate from family, whānau and other relevant persons to provide the information necessary to make an informed risk assessment (and if there is risk of self-harm, there be a low threshold in applying the exemption available to override the wishes of the person being assessed objecting to the gathering of that health information).”

The need to obtain information from families that informs treatment was emphasised in this category alongside the special mention of doing so within the limits of privacy law. These recommendations also included the suggestion that special provision is made regarding how the information is obtained from families to ensure that it is conducive to open disclosure.
Staff Education

This major category contains recommendations that target the facilitation of learning and education for the staff of SMHS. A large proportion of the recommendations in this section advocate for lessons to be learnt from the adverse event and promote the use of the coronial findings for educational purposes. A smaller number of the recommendations also suggest education for staff on specific topics.

This category contains a total of 24 recommendations, which is 18% of the total recommendations in the study. It comprises three sub-categories, which include learning from the adverse outcome, autism education, and medication education. These sub-categories will now be described.

Learning From the Adverse Outcome

This larger category describes recommendations that aim for the involved mental health service to learn and acquire new knowledge as a result of the coronial finding. This category contains twenty recommendations, which is the majority of the recommendations for this theme. A number of these recommendations are non-specific in that they simply recommend the use of the findings for learning purposes. In other cases the coroners highlight certain aspects of care that were poor and circumstances of the case that can be learnt from.

The first example was a repeated recommendation to send the findings to the DHB to be used for staff teaching. This recommendation was repeated by the same coroner to the same DHB in ten different cases.

“I recommend that a copy of this Finding be forwarded to *DHB for its information and for training and education purposes.”

The next recommendation targets more specific learnings for services from the suicide. This recommendation proposes the circumstances of the deceased admission is used for educational purposes in the future. It contains specific comment about whether the inpatient facility to which the person was admitted was appropriate.
"Consider the circumstances of the admission of *Susan as a learning tool for its future actions. As has been stated by the family and referred to by Consultant Psychiatrist, *Dr X, it may be that *Susan did not actually "fit" at *(unit name removed) and may have been more safe in another facility.”

The follow-up of incident review findings and recommendations was also targeted. Concern was raised in some cases that the review findings had not been implemented by the time the coroner’s investigation took place. Accordingly, coroners made recommendations that suggested prompt action on the findings to ensure what was learnt from the case was not lost. One of these recommendations also suggested regular audits to ensure implementation has occurred. This example is provided below.

“Pursuant to section 57(3) of the Coroners Act 2006, I recommend that the *District Health Board Mental Health Service periodically audit the Community Acute Service to ensure the recommendations made in the Incident Review Report are implemented.”

This large category contained a number of simple recommendations that suggested the DHB learn from the poor outcome of the case investigated. The use of the reports and findings was recommended for education and training. Others suggested the DHB reflect on the circumstances of the case and consider how it might influence future practice in similar events. A small number of these recommendations also highlighted the importance of implementing and reviewing the findings of the SMHS internal investigation findings.

**Autism Education**

This relatively small category reports on recommendations that suggest education for staff regarding Autism Spectrum Disorders. Autistic Spectrum Disorders are a group of life long conditions that affect a person’s social and communication skills as well as the way the person thinks and behaves (Lord, Cook, Leventhal, & Amaral, 2000). Because autism is a neurodevelopmental disorder it is not classified as a mental illness. However, people with these disorders experience higher rates of comorbid mental health diagnoses such as
depression, anxiety and psychosis thus resulting in frequent contact with SMHS (Matson & Nebel-Schwalm, 2007).

In this category there are three recommendations that were a result of two cases. In these cases it was highlighted that mental health staff who had worked with the deceased lacked appropriate knowledge about the disorder. The coroners subsequently made recommendations proposing the need for staff education which is evidenced in the following excerpt.

“I recommend that the DHB: Ensures that mental health staff working with clients with Asperger Syndrome or any other autism spectrum disorder have current and ongoing education on the disorder.”

Medication Education

This small category contains one recommendation that proposes further information regarding an anti-depressant medication being acquired. Psychopharmacological interventions are frequently employed in current mental health treatments for a range of disorders and are predominantly the responsibility of a psychiatrist. In this case, the coroner questioned whether the anti-depressant Venlafaxine accumulates in the blood and therefore would result in an exacerbation of the effects of an overdose. The prescriber was unsure of the answer to this query, therefore the coroner suggested further inquiry was required and that this information could then be distributed to other prescribers for educational purposes. The recommendation is provided below.

“I recommend to the DHB that they make inquiries from the providers of venlafaxine and if appropriate of a pharmacist, to inquire whether in fact there can be the accumulation of venlafaxine in the blood as that is an important factor for dispensing or prescribing doctors to know. It would be helpful for other people around the country.”
Service Delivery

The World Health Organisation (World Health Organisation, 2007) describes service delivery as being concerned with how inputs and services are organised and managed, to provide safe and effective health interventions, with equal access and across settings. Attention to various components of a service delivery model is required to ensure this objective is achieved (World Health Organisation, 2007). This category addresses three aspects of mental health service provision including delays to care, the provision of community services and the roles and responsibilities of staff. This category is the smallest, containing 15 recommendations, which is 11% of the total recommendations included in the study.

Delays to Care

Pathways to care describes the process of a person and their family accessing a mental health service from the time of referral. Within current structures of public mental health care there are multiple layers of services including both general services (e.g. general adult services) and speciality areas (e.g. mental health perinatal services). The first contact usually involves the GP, self or family referral. In most instances an assessment is conducted to clarify if a person meets the criteria for treatment and to determine what individual service would best fit their needs. The coroners’ recommendations in this category highlight apparent deficiencies in this process including delays following referral and the ease at which people can navigate the system. A total of nine recommendations were categorised in this section.

The need to decrease the wait time for assessment following referral was the most common type of recommendation in this category. These recommendations tended to be broad in focus in that they highlighted delays were of concern but were not specific about how to address the issue. The first example demonstrates this general focus by suggesting the DHB takes steps to ensure people referred to the service are seen promptly when referred by a health professional. The second recommendation also highlights the issue of delays in treatment following referral but makes the suggestion that a review is undertaken to establish and rectify the cause of delays.
“That the Board take steps to ensure that every young person referred to its Child and Adolescent Mental Health Services is seen in psychiatric consultation promptly in every case in which that young person is referred by a registered medical practitioner or other health professional and/or is being prescribed medication by such a person for a mental health condition.

That a review be undertaken to support the report of Dr X*, in that the multiple layers of service delivery as it applies to mental health patients be undertaken to eliminate possible delays with patient care and to provide a simple pathway for the patient and their families to deal with.”

Policy regarding access to services was also targeted and is illustrated in the next example. In this case the person had presented to the hospital and requested a shower the day of his death, but this request was declined. The coroner’s recommendation endorses the action of the DHB implementing an “any door” policy for assessment following the adverse event.

“The second matter is that notes and positive action should have been undertaken when Mr X* presented for his "shower". The Hospital Board acknowledges this fault and has taken steps to ensure the "any door is the right door" policy is fully implemented.”

The following recommendation also targets access but has a focus on crisis services. In the following case a person attended emergency services the day prior to their death with suicidal thinking. They had been upset by the length of wait for the assessment and the difficulty they had in locating the service. The coroner attends to this in the recommendation by suggesting the DHB should make it more straightforward for people trying to access the service.

“I recommend that the *DHB take into account what could be considered to be issues of some suboptimal care offered to *John. Specifically *DHB should make it easier for afterhours visitors to find EPS and contacts, ensuring patients are attended to as soon as
practicable in a secure and private setting and ensuring appropriate follow up of all persons who have attended the Service.”

In this category the coroners considered there to be faults in the pathways to care processes. The main issues highlighted and addressed in these recommendations were delays in treatment and difficulty accessing services. The recommendations suggested delays needed to be reduced, contact information needed to be readily accessible and the pathways simple and easy to navigate.

Community Services

This category reports on recommendations that propose the review or development of mental health community services and resources. Community health services are delivered away from the hospital setting and include both outpatient specialist services run by the DHB, and other governmental or non-governmental support, respite and residential services. This category is smaller than the previous categories as it contains a total four recommendations.

Three of the recommendations in this category targeted the development of community services for consumers including respite and residential facilities. Respite provides intermittent short-term breaks for a consumer, and residential treatment provides longer term supported accommodation to assist a person in their recovery. Within the included cases the coroners had questioned the adequacy and availability of these services. The following is an example of a resulting recommendation that targets the provision of respite facilities. In this case, the wife of the deceased had great difficulty in accessing respite for the consumer prior to his death.

“That the *DHB review its provision for Respite Care Facilities to ensure that there is an adequate availability of such facility on a needs basis.”

The other categorised recommendation endorses and advocates for the expansion of a new community initiative that is run by the DHB. This scheme involves specialist mental health nurses providing assessments for persons detained in the police watch house. This scheme had not been running at the time of the person’s death and the coroner commented that this could have, in the short term at least, changed the outcome for the person.
“I strongly recommend that the Watch House Psychiatric Nurse scheme is continued and expanded to other busy Police stations in New Zealand.”

In the cases included in this relatively small category the coroners questioned the adequacy of respite and residential services and suggested review of these services. Alongside this, one recommendation also endorsed a community initiative.

**Roles and Responsibilities**

This small section includes two recommendations that address the roles and responsibilities of mental health clinicians. An outline of clinician’s roles and responsibilities is usually provided in local policy documents to provide clarity, guidance and a level of expectation. These guidelines ensure that services are delivered in a consistent way. The included recommendations focus on clarifying the responsibilities of clinicians. The following recommendation illustrates this small category. This recommendation was a result of confusion over the allocation of a key worker. The key worker was assigned by default because of a lack of referral to an alternative team for follow-up. The appropriate allocation of a key worker was seen to contribute to the service being delivered in a manner inconsistent with normal expectations.

> “The root cause analysis review team concluded that there should be an immediate addressing of the responsibilities that align to individual roles within the Mental Health and Addiction Service to ensure that the service is co-ordinated, effective and co-operative. I endorse that recommendation.”

The above recommendation and the other included in this category were endorsements of the DHB’s internal investigation findings. Both focus on the need to clarify clinical responsibilities.

**Chapter Summary**

A total of 134 coronial recommendations directed to SMHS from 70 cases of suicide were included in the study. Six major categories of recommendations were identified including
communication, restrictive management, staff education, risk assessment, service delivery and working with family (see Figure 4.7). These categories provide a description of what coroners perceive to be the areas in need of focus for the improvement of SMHS as a means of suicide prevention.

<table>
<thead>
<tr>
<th>Communication (n=35)</th>
<th>Restrictive Management (n=25)</th>
<th>Staff Education (n=24)</th>
<th>Working with Family (n=21)</th>
<th>Risk Assessment (n=16)</th>
<th>Service Delivery (n=15)</th>
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<tbody>
<tr>
<td>• Inter-agency (n=15)</td>
<td>• Nursing Observation (n=9)</td>
<td>• Learning from Adverse Outcomes (n=20)</td>
<td>• Communication (n=11)</td>
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<td></td>
<td>• Ward Security (n=4)</td>
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<td>• Medication (n=1)</td>
<td>• Telephone Assessment (n=3)</td>
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**Figure 4.7: Overview of the major categories and sub-categories of coroners’ recommendations to SMHS regarding suicide**

In the communication and working with family categories the recommendations acted as reminders to the services about their responsibilities in these domains. The restrictive management and risk assessment and management categories had similarities in that the promoted safety as being paramount. This perhaps was best evidenced by coronial comments regarding the need to promote safety over consumer autonomy in the nursing observation category. The service delivery category highlighted concerns regarding delays to treatment, as well as a smaller number of recommendations that suggested the development of community services of persons living with mental illness and review of policy regarding staff responsibilities. The staff education category focused mainly on using the findings for learning purposes, which is one of the main objectives of coronial inquiries. The following chapter will explore these categories from the perspective of SMHS leaders that are responsible for their implementation.
Chapter 5: Specialist Mental Health Service
Response to Coronal Recommendations: The Clinical Fit

This chapter focuses on the SMHS response to the six major categories of coronial recommendations that were identified in chapter four. This is addressed by reporting the results of the final six questions of the SPCRIS (see appendix 6) interviews of New Zealand’s SMHS leaders that are involved in the inquiries and responsible for the implementation of coronial recommendations. Participants were asked in their experience how appropriate recommendations were regarding each of the six categories of coroner recommendations. The findings include the participants’ perspectives of how the different themes fit with current models of clinical practice.

In the first category, recommendations that promote restrictive management are considered to be often at odds with current evidence and theory with the exception of those that targeted access to means. It is perceived by many of the participants that coroners tend to promote safety over consumer autonomy without a thorough understanding of the importance of consumer self-determination. The next category, risk assessment, was also considered less useful. Participants commented on mental health clinicians’ limited ability to accurately predict risk. Concerns are raised by some of the participants that these recommendations engender a culture of tick boxing and defensive practice rather than more meaningful interactions with consumers. Some considered recommendations regarding risk assessment useful as commentary. The third category discusses participants’ responses regarding recommendations that target communication. In this category participants considered these recommendations were helpful reminders but the difficulty was in knowing how to implement them. Participants also discuss what they perceived to be the barriers to adequate communication in clinical practice. In the next category, participants acknowledge SMHS shortcomings in working with family, but also felt that the complexity of working with families is not always well understood by coroners. Participants also describe coronial inquires as a forum for families to express their perspective, which was perceived to be the main justification for the inquiries. Participants
considered recommendations regarding **staff education** as generally appropriate; however, some concerns were raised about how the individual lens of one case did not take into account the need to prioritise different training of staff. Lastly, recommendations that addressed aspects of **service delivery** were generally considered to be consistent with internal findings, but some deemed it to be the business of the service rather than that of coroners.

The Likert-Type responses are reported on for each category described above in conjunction with the qualitative categories that emerged from each question. Participants were able to respond not applicable if they did not have experience of receiving a recommendation under the category described. Some participants that did not provide a rating still contributed to the qualitative discussion.

**Restrictive Management**

This category describes the SMHS leaders’ responses to coronial recommendations that refer to restrictive interventions. As described in chapter four, restrictive management refers to treatment interventions that enforce restrictions on a person’s freedom for the maintenance of safety. Current models of SMHS delivery in New Zealand aim for the less restrictive approach as it is generally accepted that this is a more therapeutic context for treatment; however, this needs to be weighed against the need to maintain safety of consumers and others. A total of eleven participants provided ratings for this category (see Figure 5.1). Just under half of those considered these recommendations to be very appropriate (n=1) or appropriate (n=4). A high rate of neutral responses were given (n=5) and one participant responded not very appropriate.

Participants’ qualitative responses provide some insights to the ratings given. Many of the participants perceived that the theme contained recommendations that were a mix of good and bad, which is described in the first sub-category. In the second sub-category, participants discuss the position of the coroner regarding the balance between safety and the less restrictive approach.
Figure 5.1: SMHS leader participants’ frequency of response regarding the perceived level of appropriateness of coronial recommendations that promote restrictive management

Mixed Bag

This sub-category describes the common participant response that recommendations in this category are a mix of good and bad. Recommendations that target access to means were considered to be very useful by most of the participants, which was highlighted throughout participants’ interviews. However, some were less convinced that the other sub-categories, which included ward security, nursing observations and compliance, had a positive influence. This included concerns that overly restrictive measures could be detrimental to the engagement of consumers. The first participant narrative demonstrates the neutral position of the participants by describing it as a mixed bag.

“Fencing carparks and places because people say there's lots of other tall buildings why fence it. But we know that there's patterns, people go to certain places, so when a coroner says fence something that's great. But on the other thing, coroners' recommendations that you know people should not be able to freely exit and should be under all those things which can be [detrimental] to engagement, which is our first tool in suicide prevention, that's not helpful. So it's a mixed bag.” (5)
Recommendations that target access to means were readily endorsed by many other participants because it was well recognised as being an evidence based suicide prevention intervention. This is portrayed in the following two participants’ responses.

“So speaking from the evidence base, I think access to means is something that we can get some good buy in in terms of compulsion... I think it's absolutely perfectly okay to remove a firearm from people who are suicidal or dangerous to others. I'm all for coroners putting their thumb on that side of the scale as often as they can.” (11)

“Restriction of access means is where they could actually be really quite influential. I mentioned just sort of putting barriers on the Grafton Bridge. I'm always quite surprised they don't come out more strongly on the whole weapons thing for example...” (4)

The following participant comments that recommendations that target environmental hazards in inpatient units are also useful learnings across DHBs when redesigning inpatient facilities.

“Those findings in other places have been useful for us. We’re currently designing the new unit and we’re taking those findings and recommendations into account.” (13)

When discussing the recommendations perceived as less helpful, participants most frequently referred to experiences of receiving recommendations that targeted nursing observations. As described in chapter four, nursing observations are used for risk minimisation in inpatient settings and have traditionally involved a nurse observing a person at prescribed intervals and making a record of the observation. A repeated point made by participants was that the focus needed to be shifted from observing people to engaging people in a more meaningful way, which is why these recommendations were perceived as less helpful. This point is illustrated in the following participant narratives.

“Certainly the work we've been doing and you know all the literature we've looked at, it's surrounding engagement as opposed to the
observation and how that's done and the relationship. But sometimes it can but it depends on the context. Sometimes people find it really intrusive, sometimes people get really angry because they're being observed. Sometimes it's absolutely necessary to keep people safe but it's a clinical judgement.” (2)

“Increasing the amount of observation doesn't have any impact on the persons' suicidality. Observations don't stop someone from killing themselves and never will. It's about the engagement and the working through the histories related to why the person is wanting to do that.” (3)

The above participant goes on to state that nursing observations are only useful for blame when adverse events occur.

“They're useful for pointing the finger to say you didn't do your job properly. Like you didn't tick the box at ¼ past 3. And that person killed themselves at 20 past 3.” (3)

Some participants also perceived observation recommendations as potentially damaging to the direction that is being pursued in clinical practice. This point is made by the following participant.

“Because observation becomes privileged over engagement. And engagement is what's going to make the difference. So that's where you get into a mechanistic tick sheets and containment. It's not reinforcing the practices that will make a difference like good therapeutic engagement. In fact it works against it.” (5)

This sub-category describes participants’ overall view of recommendations contained in this category. This clarified that access to means was perceived as a useful focus for recommendations, but on the other hand, restrictive interventions that promoted containment over engagement such as nursing observations were considered less desirable.
The Biased Position of the Coroner

In this sub-category participants perceive coroners to promote safety more heavily over the less restrictive approach. This was considered out of balance by many of the participants. Participants discuss a perceived coronial bias towards societal views and expectations regarding safety as well as a bias towards the family perspective. Some participants believed coroners’ stance to come from a laypersons’ perspective because it demonstrates a lack of understanding of the sophisticated approach required to manage the balance in practice. The first two narratives demonstrate this opinion.

“I am aware that that's a tricky area perhaps for someone who doesn't know anything about it to get their head around and sometimes coroners might not quite have the right balance there” (1)

“I think sometimes, in some ways the coroners often reflect more of the society type view of mental illness which is not surprising given they don't necessarily have any expertise in it. So they will often be far more paternalistic in their view of what should happen for people with mental illness than we are at the services... I've often thought, one of the people they might do best getting advice from is a really good consumer.” (15)

The above excerpt highlights that coroners’ protective views do not take into account the consumer perspective. An observed bias towards society and family was considered the main rationale for coroners erring on the side of restrictive management. This point is reiterated by the following participant.

“I think that coroners have more of a sense of family wishes than they do of independent autonomy. They're putting their fingers down on the side of community and family wishes in terms of lock them up, keep them locked up until such time as they can actually be safe... I think they are putting their thumbs squarely on the non-autonomous side more often than they should.” (11)

The next participant expands on this point by commenting that the coroners’ position may stem from a number of political agendas and influences. The narrative highlights that
coroners have to weigh up these different pressures during inquiries rather than focusing purely on what is considered most appropriate clinically.

“Coroners are in a position where they need to know they can consider what's appropriate that includes recommendations for a particular hospital they also need to make recommendations considering how that will look politically and what that will look for the family involved in a patient's care. They have many other pressures on them and so it's a position where they need to meet a variety of needs which might not only be clinical.” (12)

The coroners’ risk averse position was also considered by a number of participants to contradict current evidence because “it goes in the face of where we're going” (6) in the delivery of SMHS. The following participants’ narratives further demonstrate this point.

“I think the coroners, once we're in that kind of coroner’s process they tend to more err on the side of but if you'd just done more containment this person would have survived. And I don't think the evidence always supports that.” (15)

“The more you restrict people within, if you try to apply a recovery framework the more you restrict people the less ability they have to manage their own distress and also their autonomy. It does conflict with the philosophy of recovery.” (3)

The final narrative provides a participant’s experience of receiving a recommendation that endorsed the use of restrictive measures. The participant discusses the complexity of the case and by doing so highlights why the recommendation was misguided.

“We had one a few years ago where someone very impulsively jumped off something and died. The coroner's recommendation was this person should have been locked up essentially... and the fact is the coroner shouldn't have given that recommendation. The fact is the person shouldn't have been admitted to hospital in the first place, it exacerbated
the situation and that was actually an independent clinician... who came and did part of the 95 review. So we mismanaged the cohort of personality, borderline personality disorder patients and actually have a policy of very rarely admitting them these days... I think they’re [coroners] right out of their depth when it comes to that sort of stuff.” (6)

This sub-category portrays the participants’ perspective that coroners hold a biased position towards the community and the family of the deceased. As a consequence it was considered that the balance between safety and the less restrictive approach was overly protective in some cases.

**Risk Assessment**

This category describes the SMHS response to coronial recommendations that target risk assessment in mental health care. Risk assessment is used to formulate a predicted level of risk related to a person’s clinical context and risk management describes the interventions that are provided to mitigate that risk. A total of thirteen participants provided ratings regarding this theme (see Figure 5.2). The most common response was neutral with six participants responding in this way. Four participants provided positive responses to risk assessment and management recommendations with the ratings very appropriate (n=2) and appropriate (n=2). A similar frequency of response was given for the not very appropriate (n=1) and not at all appropriate (n=2) categories.

In the qualitative responses many of the participants voiced concerns about these recommendations. In the first sub-category the participants questioned how helpful focusing on risk assessment was for suicide prevention efforts given the limited ability of clinicians to accurately assess risk. The second sub-category outlines additional concerns that these recommendations encourage defensive practices. A small third sub-category outlines participants’ responses that indicate these recommendations are useful commentary.
Suicide Prediction

In this sub-category, many of the participants considered recommendations that target risk assessment and management as less useful because of the poor ability of mental health clinicians to predict risk. Participants frequently referred to the evidence to support this perspective. This is illustrated by the following participants’ comments that describe a general misconception that mental health clinicians can predict suicide.

“I think the evidence is very clear that we are very, very poor at individual risk analysis... The biggest fallacy, that we can really make significant impact to individual risk of suicide without the much broader based public health changes.” (12)

“Our knowledge and ability to predict suicide is very poor and I think there is a disconnect between expectations and fact.” (14)

Some of the participants also described experiences of coroners commenting on the risk assessment of the deceased and highlighting that the level of assessed risk had been
inaccurate. Such comments were often defended as having the advantage of hindsight as well as demonstrating a lack of understanding about the difficulties inherent in risk assessment. These points are evidenced in the next participants’ responses.

“Well he knows what the outcome was so it's probably easy for him to see that. Whereas it's not quite so easy to see otherwise you'd make a different decision.” (2)

“I think in the past coroners have said your risk assessment said this person was a high risk or low risk but then that changed. Yes, of course it changed because risk assessment is only a snap shot at that given time. So sometimes the coroners' recommendations have not taken into the account the dynamic nature of clinical risk.” (3)

“Certainly when they make comments about staff being better at risk assessment, you can't disagree. On the other hand sometimes you often know that staff are very busy, people are reluctant to talk and disclose information, you've got a limited time, and so all of that together means a less than adequate risk assessment when you actually put it under a lot of scrutiny.” (15)

When discussing the most appropriate context for risk assessment in clinical practice, the majority of participants agreed with the coronial perspective that face to face assessment would enable a more accurate assessment of risk. Participants considered that the most appropriate clinicians to conduct risk assessments were those who had the most involvement in consumers’ treatment regardless of discipline. These perspectives were provided in response to the recommendations that target telephone risk assessment and psychiatrist conducting assessments. The following narratives provide examples that evidence these factors.

“I agree with that risk assessment shouldn't be undertaken over the phone. If you're going to make a proper assessment of someone you need to do it face to face. So totally agree with that.” (3)
“The most important thing in it, you know you can't elicit the right information if you don't have the right relationship and you're not talking to the right people. So whoever knows the person best as far as clinicians go is generally the best person to do that risk assessment, risk management.” (5)

This sub-category summarises a number of the participants’ responses that recommendations that target risk assessment are less useful because of the lack of capability to accurately predict the occurrence of individual suicide. Some of the participants were also somewhat defensive about coronial scrutiny of risk assessments.

**Tick Boxing**

In this sub-category, participants report concerns that risk assessment and management recommendation promote a culture of tick boxing. A tick boxing culture refers to an overemphasis on bureaucratic process rather than more productive action. Concerns were raised by the participants that this type of culture diverts attention away from actually helping consumers in a more meaningful way. The first piece of narrative expresses this argument.

“I think the whole issue about risk assessment is something that has been relatively unhelpful particularly around suicide prevention efforts and I think coroners' findings around that have exacerbated the problem rather than being helpful... By making services then needing to respond to the recommendation of better risk assessments or more thorough risk assessments or even just more risk assessments is something that we should be doing that will prevent suicide deaths. And I think what that's lead to, is really a culture of tick boxing risk assessments rather than thoughtful interviews and analysis of people’s situations.” (13)

The next participant also makes the point that focusing on risk assessment can lead to tick boxing but also provides a description of what they consider as more important in the interaction between clinician and consumer.
“I think that again it gets back to the idea that we're ticking boxes is meaningful in some way. I think the only value in that is the human connection that is made and the understanding or the opportunity I should say that that encounter gives the person on the other end of the phone to voice to another human being that could give a damn about where they're stuck and hopefully have a positive encounter.” (11)

The importance of not looking at risk in isolation was also discussed by some participants. The following participant comments that risk should be targeted by adequate treatment rather than focusing on completion of risk assessment.

“I'm strongly opposed to ever talking about risk assessment on its own. And I'm also strongly opposed about talking about risk too much in mental health because the best risk management is good treatment... we've done a disservice by separating the risk of treatment.” (5)

In this sub-category participants expressed concerns that coronial scrutiny on risk assessment promotes a culture of tick boxing, which deviates the attention away from what might be more useful for consumers. An approach that targets the overall management of a person’s treatment was offered as a more appropriate way of working.

**Useful Commentary**

This sub-category summarises a small number of participants’ responses that risk assessment recommendations are useful as commentary. These participants generally deemed it appropriate that coroners comment on risk assessment within the limitations of the case being investigated so that potential errors could be identified and taken into consideration. This is illustrated by the following two narratives.

“Again it may not be sufficiently qualified or have the knowledge to make accurate recommendations or informed recommendations but like the other previous questions any commentary about the process which is being followed or gaps in that process needs to be taken into account.” (14)
“They say it can report objectively that we've completed this and we've completed that but in the actual nature of how we do the risk assessment or what the risk assessment might contain or how it's carried out I don't think it's their place to recommend or make comment on. I think they can just objectively kind of comment on whether it was carried out or not.” (6)

These comments indicate a perceived limited ability of the coroner to extend their commentary beyond identifying gaps in the risk assessment and management process. Nevertheless, some value was perceived in the commentary by this small number of participants who deemed the recommendations appropriate.

**Communication**

This category describes participants’ responses regarding coronial recommendations that target internal communication, interagency communication, and documentation. A total of ten participants made a rating about how appropriate recommendations are regarding communication (see Figure 5.3). Almost all of these respondents rated them as very appropriate (n=4) or appropriate (n=5). The remaining participant responded neutral.

In the first sub-category, participants substantiated these responses by stating poor communication between services was usually legitimately identified and therefore they acted as good reminders to the services about the importance of adequately sharing information when required. In the second sub-category, some of the participants report that the response to these recommendations is substandard and a number of perceived barriers to inter-agency communication are discussed.
Figure 5.3: SMHS leader participants’ frequency of response regarding the perceived level of appropriateness of coronial recommendations that target communication

Helpful as Reminders

This sub-category describes the general view of the participants that recommendations that target communication act as useful reminders. Participants acknowledged that coroners correctly identify poor communication between SMHS and other involved services in inquiries. Many of the participants did not view this as new information, but still considered it helpful because it identified the continual need to improve communication both internally and across agencies. The following participants’ responses demonstrate this generally accepted view.

“Usually when things go wrong and it's a communication issue agencies haven't done what they should and the coroner tells us we should so it's a bit hard to argue with really.” (4)

“I think it probably reinforces how we should be working and reinforces best practice and we should be working with other agencies.” (2)
“I just think we all know how problematic that [communication] was and coroners' are just continue to be helpful. I don't think there's anything particularly insightful that they offer but it's helpful to have other people continue to tell us what they already know or we could do better.” (13)

The next participant comments that the broader scope of coronial inquiries allows for communication issues to be considered across settings. This participant considered the ability to identify communication failings as a strength of coroners.

“That's part of their role and the value that they add to the care we provide in the community. They have that perspective of multi-agency oversight in their inquest, so they often provide very good information about how Services work with one another, that we may not have any knowledge of or that we may not be particularly good at. That's something that they do really well.” (11)

This sub-category portrays the common opinion amongst the participants that recommendations that target communication accurately highlight an area in need of improvement, which was only considered as beneficial.

**Poor Implementation**

This sub-category describes participants’ reports of poor implementation of recommendations that target communication. Knowing how to address communication failures was considered to be more problematic than the identification of the issue. As a result, a number of the participants reported that the implementation of these recommendations was generally not well executed. Participants also discussed what they perceived to be the barriers to adequately sharing information across settings, which demonstrates the complexity of the matter. The following narratives firstly illustrate the point that communication breakdown is considered a difficult area to address in practice.

“It's like an observation and a recommendation but how do you do it and that's a part we all struggle with.” (13)
“It's a sort of recommendation that they do not too badly. The responses to it, however, are crap because they're multi agency. It highlights why they're making the recommendation that they should be implementing those ones, is a disaster... Because it's a multi-agency fix it tends not to happen... everyone’s got their own fight with them and it doesn't happen in my experience... They're good recommendations but they're not implemented.” (5)

The above participant identifies that the problem of poor collaboration of various services is also inherently why attending to issues of communication are difficult. The next participant describes a response to a recommendation that did successfully get various services to work together to produce a memorandum of understanding as a means of responding to the issue of poor collaboration.

“So look, I can think of a suicide, it's about five years old now, where this guy was seen by a community forensic team, and was seen by WINZ [Work and Income New Zealand], he was seen by our area mental health provider, our Māori mental health provider, our own CAT [Crisis Assessment and Treatment] team all in the space of half a day I think... Everyone got heavily criticised in that coroners' report but all the groups did get together and debrief and establish MOU’s [Memorandums of Understanding] about how they interact.” (6)

The above participant was the only one to describe a response to a recommendation that targeted communication beyond it increasing an awareness in the service. A lack of integration between health services was most often cited as the rationale for poor inter-agency communication, alongside the fragmentation of the general public sector. These points are demonstrated in the following participants’ examples.

“I think that is a structural feature of the public service and the health sector so it's not necessarily easy for mental health to fix but I still think we can work hard at trying to make it better.” (13)
“…of course not being co-located with any other sort of health agencies.” (9)

“If somebody had a community therapist or counsellor for instance, it is quite possible that we would not even know that we're essentially sharing care with another mental health professional in the community unless the client told us.” (11)

The above participant goes on to describe the day to day challenges that clinicians face that make it difficult to share information with known involved parties including time constraints and a lack of integrated technology.

“For example talking to GP's, they're busy getting through their day, we're busy getting though our day and to be able to get each other on the phone and have a discussion about the person who's in front of us is just very difficult... and there's no good system in place now technologically that we can go and look to see what's going on at the primary care level for instance or for them to be able to see what's going on at secondary care level. That's not the case worldwide.” (11)

In addition to the fragmentation of the various services that work with consumers, privacy was also identified as a barrier to open communication between the agencies. The next participant’s response is an example of this.

“The right for people to have privacy and also the need for the service to deliver a safe service and communicate at times of heightened risk. And there is a need for ongoing education, discussion about it and peer support for those decisions which are easy to think about in theory but in practice with the case in front of you can often involve lots of nuances which can make it difficult I think to determine whether there's not sufficient grounds or not to communicate between agencies when the patient may be reluctant for that.” (14)
In this sub-category it was identified that addressing communication as suggested by the coroners was considered to be a difficult task by SMHS. The fragmentation of the health sector and public services alongside privacy issues were considered as the main barriers to improving this aspect of consumer care.

**Working with Family**

This category reports on the SMHS leaders’ response to coronial recommendations that target working with family. A high rate of response was provided for this theme with a total of thirteen participants providing a rating (see Figure 5.4). The majority of these participants considered these recommendations to be very appropriate (n=6) or appropriate (n=5). The remaining neutral category and not very appropriate category had one participant response in each.

![Figure 5.4: SMHS leader participants’ frequency of response regarding the perceived level of appropriateness of coronial recommendations that target working with family](image)

The qualitative responses indicate that participants agreed with coroners that working with family is an area in need of improvement for SMHS, which is discussed in the first sub-
category. In the second sub-category, participants discuss what they perceived to be the barriers to SMHS enhancing this aspect of service delivery. In the final sub-category, participants express the view that one of the primary functions of coronial inquiries is to allow the family to share their perspective. Comments included in this final sub-category featured throughout participant interviews but are reported on in this category as it is fitting with the category's theme.

Acknowledging the Inadequacies

In this sub-category, there is an acknowledgment by the SMHS leaders that coroners often accurately identify failures about how SMHS have worked with the family of the deceased. It was also generally accepted that these issues went beyond the cases investigated by coroners in that it was an area of practice that required further improvement throughout services. A number of the participants did perceive that some progress had been made in recent years but also conceded that further work was required. The following examples demonstrate the acknowledgement of the SMHS leaders that inclusion of family in consumers’ treatment remains suboptimal.

“It's our biggest problem really getting staff to appropriately interact with families.” (4)

“If I had to do a very global rating, I'd say we do it badly... We certainly do it inconsistently. I think there's some good practitioners but as a whole we've got a long way to go.” (15)

“Coroners are often commenting on the lack of family involvement and care and I think that's a very helpful finding recommendation because I think that is one of the key areas for improvement by Mental Health Services”. (13)

“That's because the only ones I can recall are have highlighted major failures in the past... Failure to consult or involve family. Even not meeting our legal obligations under the Act... it's been a major theme,
The above narratives indicate that the participants perceived these recommendations to be helpful. The following participant expands on this by describing how they are useful. This includes comments that indicate the recommendations are congruent with the current theory and that they reinforce the services obligations regarding this aspect of treatment delivery.

“We don't really have a problem with that because our philosophy in Mental Health and Addiction is supposed to be inclusion, partnership, family, whānau, consumer, so really it fits well with our philosophy anyway. In most times that sometimes when things haven't worked out has been disconnection with family. The coroners' recommendations are very appropriate because they're saying maybe you should have engaged better with that person and their whānau. You should have thought why that consultation, you should have listened to the family when they were telling you this.” (3)

A number of the participants did comment that progress had been made and that clinicians were getting better at involving families. This is described by these participants:

“Look it's improving and there's some people that do it really, really well.” (9)

“Slowly, incrementally we're getting better” (5)

“I think it's going well but as with anything there's always room for improvement...” (16)

Other similar statements were also accompanied by the acknowledgment that further work was required. This is also evidenced in the following participant’s example that demonstrates some effort is being made to involve families but that practice remains less than ideal in some instances.
“...we're actually pretty good now at contacting families. People have got that message but a lot of the times people get talked at, they don't get engaged with so I'm thinking of a recent example, actually a complaint where someone has gone along to the appointment and their father’s taken them. 10 minutes at the end of the meeting, Dad gets brought in and told what's happening. Well that's much better than not involving Dad but Dad's actually got a lot to say and a lot of anxieties and a lot of things that no one asks him about, so they sort of ticked the family involvement box but actually they haven't.” (4)

In this sub-category SMHS leaders acknowledged the inadequacies that occur regarding the inclusion of families in consumers’ treatment and although some recent improvements were perceived by the participants there was agreement that further progress is required.

The Complexity of Working with Family

In this sub-category, participants describe some of the complexities of working with families and how this impacts on the services ability to address some of the issues identified by coroners. Participants described various factors that contributed to the suboptimal involvement of families. This included the challenging nature of working with families in distress, the conflicting wishes of consumers and families and the time constraints that occur in day to day practice. There was also a perception amongst some of the participants that the complexity of these matters is not always well understood by coroners. The first piece of narrative starts by demonstrating the belief amongst many of participants that working with families can be challenging for mental health clinicians.

“I always think that the concept of using the family as part of the treating team is kind of where it is most successful but like some consumers are challenging, some families are challenging and it just is really hard in day to day practicalities.” (10)

The next piece of narrative provides a context for the day to day challenges for staff by offering the example of working with family when consumers are in crisis. The participant
describes this as a time that opportunities to attend to families in distress are missed. High levels of stress for clinicians at these times is cited as a factor in the narrative.

“I think when you're working with families at that real acute end where there's high levels of stress and it's draining and exhausting because you've got someone that's really unwell and it's really disruptive to everyone’s life. I think that's often where opportunities are missed, thinking around outpatient interface with inpatient units and families have got high expressed emotions when it's kind of at the end of the road and just kind of having that compassion and understanding around that.” (9)

The need to target how individual clinicians are interacting with families was considered by some of the participants. The following two narratives suggest a change in staff culture and attitudes towards families is required.

“The skills to work with family are less of a problem than the willingness and the acceptance of it is a key part of treatment. Yeah we could get some more skills but its more attitude.” (5)

“Well and its partly training, it's experience, it's having people on the ground who actually believe it, understand it, know it and role model and support people to do it really. Culture, really the culture.” (4)

More specific factors that act as barriers to working with family were also discussed. The most common of these was the issue of privacy. Participants acknowledged how difficult non-disclosure status was for families of consumers; however, the need to adhere to the wishes of consumers regarding privacy was considered of utmost importance. Participants described a conflicted position between the requirement to abide by privacy rules and consumers wishes and the need to attend to the family. The following participant responses illustrate these points.

“I think the struggle we have since we're again socialised to put the person in front of us and their wishes in terms of privacy as paramount. Then trying to sort of put a foot in both worlds is challenging. And it
causes a lot of conflict within us which is never comfortable about do we breach privacy, I understand that your family wants to know things about what's going on for you, you say you want nothing to do with them, can I persuade you otherwise, if not then you've got an angry family on your butt.” (11)

“Well if the patient wants family involvement then we should be bending over backwards to do that. And equally if they want us to respect their privacy we should be doing that too. And if we respect their privacy and there is a bad outcome it's very common for a family to feel as if they haven't done enough for a patient, to feel aggrieved that they haven't been kept in the loop especially well. I think those are very explicable and understandable and I think coroners reasonably make recommendations that recognise the families distress but they may not be implementable if you see what I mean.” (12)

The above comments imply that coronial recommendations regarding family inclusion are not always able to be applied in practice when the need to adhere to the rules of privacy act as a barrier. A further factor that was considered by participants included the time required in a strained system to truly involve family. Participants’ comments indicated that there was pressure on clinical staff to be progressing the treatment of consumers and that involving family slowed down the process. This type of response is shown in the following two participants’ narratives.

“It's like just bringing in one more person into anything it just makes it so much more complex and given the pressure on our system it slows things down. And I think people shy away from it because it's hard.” (5)

“I think it's too hard in terms of you might have to make more than one phone call. If they're not immediately available to you, it's inconvenient to the way many doctors practise” (6)

It was perceived by some of the participants that some of the above described difficulties may not be well understood by coroners. This was evidenced in participant statements
such as this one: “The families aren’t always as straight forward as the coroner may think they are” (2). The following example expands more on this point by describing the tensions that are sometimes present between consumers and their families and how the coroner is not usually in the position to understand this in an inquiry.

“Unfortunately, post hoc a good bit of what coroners I think miss is the struggle that the clinical services have with clients who refuse outright to have contact with their clinical information to their families. Families aren't always supportive. Families in some points are harmful to clients and I think coroners' often miss that the person that they’re talking about actually had some issues with their family and they hear the family post hoc concerns but they don't get to hear about from us the sense that clients in many cases don’t want to have anything to do with their families and on some cases have pushed through views about family contact that were really at odds with the patient’s wishes. And that puts us in a difficult space. We try to engage with families as much as we can but I don't think that coroners' routinely struggle with those sorts of issues that we have to in the moment and have been but I think in many cases [coroners are] preferential to families rather than seeing things through the eyes of we [clinicians] who try to balance things in the moment do.” (11)

A similar view to the above narrative was shared between small numbers of the other participants. The final narrative demonstrates a different perspective. This participant describes an inquiry experience where a more balanced approach was taken by the coroner when considering the family’s perspective.

“One of the coronial inquests I was involved in had a very difficult family, needed quite active management during the whole process. They were not happy with the role that the District Health Board played or didn't play in the treatment of their deceased relative. It would have been easy for the coroner to suggest that some of what the family were talking about was [correct] ... whereas I think a balanced approach to the information that we gave was given.” (1)
A number of perceived barriers that impact on the way in which SMHS interact with family have been reported in this sub-category. Although it was generally acknowledged that services were underperforming when it comes to working with family, the participants reported that the complex nature of interactions with consumers and family in day to practice meant that the problems identified were not easily addressed.

**Families Having a Voice**

This sub-category describes the common perception amongst the participants that one of the functions of coronial inquiries is to attend to the families need to understand what had occurred to their loved one. This included families having a forum to express their perspective about what happened and what role the SMHS had in that. Participants also felt it was important that an external body investigated suicides so that the families could be reassured that the death had been unbiasedly examined. There was an overall acceptance amongst the participants that the benefit of attending to the families’ need to have a voice was justification in itself for the inquiry process. The need to provide families of the deceased with the opportunity to have a voice and share their perspective through the inquiry process is demonstrated in the first two responses.

“It's been bruising at times but that's been about a particular coroner who reasonably I think sees it as an opportunity for the family to have a voice and say what they need to say to move on, so that's okay too.” (5)

“Where else do they get the chance to say what they actually think...? They don't get much opportunity to do that, do they? I mean for like a family there's nothing worse than being shut down and having nowhere to put it. Where else can they put it?” (10)

The next examples articulate the view that it is important for families to have an external review of what has occurred. The participants also specified that this included reviewing the treatment provided by the SMHS to the deceased.

“So I think it is an important part of what they're for because even when they disagree with what we've done and that we always say to them, the
coroner is external and you can talk to them... they appreciate that the coroners' thing it's quite separate to us, so that's really good.” (5)

“Even when we've done a really good review and the families will have been quite satisfied with that. There's something about for families understanding that there is a sort of external body scrutinising us and I think that is important. Even from the families where we've got I think a pretty good relationship notwithstanding the terrible event. Often when we get the coroners court they ask more questions of us again that they haven't asked before. So I think that can be, in terms of the whole, of everyone involved that the coronial process is an important part of the whole system.” (15)

The above participants’ comments, as did others, indicate a level of justification for the inquiries because of the function it fulfils for the families. The balance between this function and the participants’ previous comments about the inquiries lack of contribution to suicide prevention was also discussed:

“In one hand I’m saying I don’t think the recommendations make a huge amount of difference but I do still think it's a good institution, it's a good process, it gives especially for families to be able to kind of unravel, have their day to really uncover what happened. The coroner's going to try to get to the truth... if someone in your families' died and you need to get accorded that respect really.” (4)

The above comments demonstrate the level of importance the participants placed on fulfilling the families of suicide victims need to have coronial inquiries. Some of the participants also considered the impact that this has on the inquiry process. This is demonstrated in the following narrative that comments on the influence of the deceased’s family and their grief.

“I think it's kind of emotional thing to it. Its right that they get to, you know the family should be part of the process. That's a little bit
institutionalised but the coroner is dealing with a grieving process and I think that does kind of influence it a wee bit...” (9)

The final narrative for this category considers what families want out of the inquiries. This participant believes families want to be heard and reassured that lessons have be learnt.

“As long as they, it's a universal theme, so long as they feel like we're learning the lessons and hearing them it's all that they want and it'll make it better for someone else... Fair enough too.” (5)

This sub-category reported the participants’ perspective that the need for family to be heard by an external agency was one of the main benefits of coronial inquiries. A small number of participants also commented on the influence of the family and their grief on the inquiry outcomes.

**Staff Education**

This category reports on the SMHS leaders’ reaction to coroners’ recommendations that propose staff education. This includes staff training on specific topics that were considered to be a knowledge deficiency in the cases investigated, as well as more general learning from the adverse outcome. Thirteen of the sixteen participants provided a Likert-Type response (see Figure 5.5). Just under half of these participants considered these recommendations to be appropriate (n=6), alongside one response of very appropriate (n=1). A smaller number of the participants considered staff education recommendations to be not very appropriate (n=2) and the remaining four were neutral.

The first sub-category describes the common response that recommendations that suggest staff education are by and large useful, particularly in terms of gaining knowledge from the mistakes made. However, in the second sub-category some concerns are raised that the recommendations do not take in to account other staff educational requirements.
**Figure 5.5:** SMHS leader participants’ frequency of response regarding the level of perceived appropriateness of coronial recommendations that target staff education

**Generally Useful**

This sub-category describes the common participant response that coronial recommendations that suggest staff education are “in general usually pretty useful” (3). Participants made comments that if knowledge insufficiencies are legitimately identified it is reasonable to expect the service to respond to them. Participants also acknowledged that it was important for services to learn from the mistakes made in the case investigated. The first two narratives illustrate the general position of the participants regarding recommendations that suggest staff education.

“Oh I think most the time it is appropriate... often it's about reinforcing information that people do need to practice.” (2)

“I think anytime that there is a genuine knowledge deficit identified or skill deficit identified that information should be taken seriously and considered just like we would any other commentary of our service.” (14)
The next participant identifies that staff are the SMHS main resource, therefore an essential aspect of delivering effective treatment. Given this, concentrating on staff development is considered to be appropriate by this participant.

“I think it's probably appropriate in that I think what Mental Health and Addiction Services do is provide people with skills and knowledge and expertise. I think our workforce is our greatest asset but also our greatest weakness. Ensuring that we have the right people and they are responding in the right way at the right time is important. So I think a focus on workforce is important.” (13)

The majority of the participants also supported the use of inquiry outcomes to educate staff. Some of the participants commented that learning from mistakes was a powerful medium for staff education. This is described by the following participants.

“Particularly when those findings are shared I think they're very powerful statements about what can make a difference.” (13)

“I remember as a Staff Nurse, we learn from mistakes and think oh gee we should maybe have done something slightly different here.” (8)

This sub-category outlines the common perspective amongst the SMHS leaders that recommendations that suggest staff training are generally appropriate, particularly the use of inquiry findings for learning purposes.

**Prioritising Educational Commitments**

In this sub-category concerns are raised by some participants that coronial recommendations that propose training “have a very narrow context” (5) and therefore may not “fit with the overall developmental needs of the staff of the service” (5). Because of this, the participants considered it essential that the suggested training is prioritised alongside other educational commitments. Participants described multiple layers of training and educational requirements in SMHS, which included compulsory core training and updates, ongoing professional development and identified staff knowledge deficits.
The following narrative illustrates this by describing the complex educational needs of SMHS staff.

“There's requirements from the professional bodies, there's requirements from the likes of frameworks such as recovery frameworks... that sort of stuff, there's requirements from the wider District Health Board generalist services, so if you stack up all of the education that's required in a year to be delivered to all staff in mental health and addiction it's an incredible amount. Some of it's mandated by legislation and some it is by a policy and practise but then you layer on top of that stuff from HDC or from the coroner... There’s a bit of difficulty managing the education that's been suggested by the coroner because you've got to layer it on top of all those other commitments.” (3)

The next participant voices concerns that coroners’ recommendations potentially could be prioritised over equally or more important subjects. The need to upskill mental health staffs’ physical health assessment and treatment knowledge through an initiative called Equally Well is used as a competing example. This initiative aims to reduce the physical health disparities between people who experience mental health and addictions problems and those that do not.

“We have a vast amount of training and education that's needed in fixing this thing and sometimes by them saying staff should receive this education, this often or something that can impinge on other parts of the programme and privilege some things you can get things out of whack, it can change the balance. ...more people might be dying because of something else... I guess the whole equally well thing... I mean okay, you've got a mental illness you die twenty years earlier than the general population. Suicide's part of that, it's not the biggest part of it. So but the coroners' stuff doesn't hit that other stuff.” (5)

As a consequence of the above comments made, some of the participants considered the educational needs of staff were not generally well determined by coroners. This final point is illustrated in the following two participants’ responses.
“My experience is that coroners' really don't have a good sense about how staff are educated and aren't really up to date on what we're doing, what we're planning, what things are going on at the moment. But I don't think they give good advice in that regard.” (11)

“The people who should be commenting on the training needs of staff are best determined from within the mental health service itself.” (14)

Within this sub-category participants challenged staff education proposals by stating the circumstances of one case did not take into account the services need to prioritise a wide range of staff educational needs.

Service Delivery

In this category participants were asked how appropriate coroners’ recommendations are that target service delivery. A total of eleven participants provided ratings (see Figure 5.6). Over half of these respondents considered these recommendations to be appropriate (n=7). A small number of participants rated them as not very appropriate (n=1), and not at all appropriate (n=1). The remaining two participants were neutral.

A number of the participants considered these recommendations appropriate because in their experience they were congruent with the SMHS internal findings which is described in the first sub-category. In the second sub-category, a smaller number of participants considered service delivery to be the business of the service because it requires an in-depth understanding of the system.
Congruent with Internal Findings

This sub-category summarises the common response that service delivery recommendations generally are appropriate because in the participants experience they were based on the SMHS internal findings and recommendations. The following narratives demonstrate this view.

“Look I think it's appropriate because building on other things for the most part they have looked at the review that has happened. For the most part that is sort of independent expert witness who is someone who knows the sector and understands service delivery and understands what best practise is within that context. I don't think I've ever experienced where it's completely left field.” (9)

“Never had a recommendation like that that wasn't something where we already acknowledged and identified.” (1)
“This is in my experience of getting our review reports endorsed by them means that they just endorse already our recommendations which are often about service delivery or changes.” (15)

The above rationale was provided by the majority of participants that rated service delivery recommendations as appropriate.

**The Business of the Service**

In this sub-category concerns are raised by some of the participants about recommendations that target aspects of service delivery. These participants perceived service delivery to be the “*business of the services*” (13) rather than that of the coroner. Participants did not consider coroners to be in a position to comment on service delivery because of a lack of understanding of the complexities of the system. The first piece of narrative demonstrates this view.

“*I think is where they stray out of the, this is the least useful part about when they comment on that. I think service delivery and issues with service delivery are probably the business of the services.*” (13)

The following examples demonstrate the main rationale given for this opinion. This involves the perception that coroners do not have a thorough enough grasp of how the system functions to enable them to make effective recommendations in this area.

“*They might not quite understand that kind of context of how you deliver a service.*” (6)

“It's a bit like the other one, the multi-agency one. Nice idea, shame about the result... There's a miss-match between the recommendations and the system I think. Usually they try really hard to understand the system and make it better and it's too complex.” (5)

“I think coroners are in a very difficult position because they're not doctors and they're not health, they're not the delivers or providers of
health and so my experience is that recommendations reflect those difficulties... So often I don't think, I think either they say things that we know very clearly or say things that are un-implementable.” (12)

The above two participant responses imply that there is a lack of comprehension by the coroners, which inevitably leads to some recommendations that are less useful or difficult to implement.

Chapter Summary

This chapter summarises SMHS leaders’ views regarding the different types of recommendations that are made to SMHS regarding suicide. It was readily acknowledged by the participants that communication and working with family are areas of focus for improvement for SMHS. In both of these categories the majority of participants considered these recommendations as useful, even though the issues highlighted were not new information for the SMHS leaders. Participant responses did indicate that the difficulty was in knowing how to address the issues identified. Chapter eight will further explore the working with family category from the perspective of family and whānau workers.

The staff education and service delivery categories also received a moderate amount of support. Recommendations that target staff education, particularly the use of inquiry outcomes to inform staff were viewed as useful. But, concerns were raised that recommendations regarding specific training did not take into account the services’ need to prioritise a wide range of staff educational needs. Service delivery recommendations were considered acceptable because they tended to be similar to the services internal findings. A small number of participants were cautious because of the belief that service delivery was better determined by the service.

The restrictive management category and risk assessment category incurred a higher rate of neutral responses and the qualitative answers indicated that the participants were less supportive of these recommendations. In the restrictive management theme, participants highlighted recommendations that address access to means as being useful because targeting access to means was reported as congruent with current suicide prevention
research. But the recommendations that promoted restrictive interventions that were damaging to consumer engagement were considered less desirable. A bias towards society and the family perspective was identified by the participants as a contributing factor for these recommendations and some expressed concern that coroners’ stance on safety was out of balance and counterproductive to the current direction of SMHS delivery. Focusing on risk assessment was perceived to be the least useful because of the reported clinical evidence that clinicians have a limited ability to accurately predict risk. Concerns were also raised that coronial scrutiny on this aspect of care may promote a culture of tick boxing practices that are not therapeutically useful for consumers.
Chapter 6: The Specialist Mental Health Service System Level Response

This chapter focuses on the Specialist Mental Health Service (SMHS) system level response to coronial inquiries and recommendations. This includes the SMHS leaders’ perspectives regarding coronial inquiry processes and the overall quality of recommendations received, as well as what action the services take in response to the recommendations. This is addressed by firstly reporting the results of the first eight questions of the SPCRIS interviews (see Appendix 6) of New Zealand’s SMHS leaders.

Firstly, the SMHS reports of the consultation that occurs prior to recommendations being made are described, followed by their perceptions of the evidence base of the recommendations and whether it was considered if the coroners have the right knowledge to make the recommendations to SMHS. Participants also describe the rate of implementation of the recommendations and how well resourced they are to enable them to implement them. The SMHS leaders’ views regarding mandatory response and whether they perceived the recommendations to contribute to suicide prevention are also recounted. The final category that is reported on the SMHS leaders reports of how the inquiries impact on the staff involved. This category emerged throughout the participant interviews and therefore is not reported on with Likert-Type frequency of response data.

Each category highlighted above is described using participant narrative. Pseudonyms have been used and are identified by asterisks. The participant interviews are numbered from (01) to (16).

Consultation

In this category participants were asked to rate how often coroners consulted with SMHS regarding recommendations. The most common responses were almost always (n=5) and often (n=4) (see Figure 6.1). Slightly fewer participants responded that coroners consult only sometimes (n=3). The frequency of response for the remaining categories decreased with two respondents answering rarely and one reporting consultation never occurred.
Participants experiences of consultation with coroners prior to recommendations being made is described in three categories. The first sub-category reports participants’ experience that there is usually the opportunity for feedback as part of the formal inquiry processes. The second sub-category describes participants’ experience that challenging the recommendations rarely changes the outcome. In the final sub-category some of the participants describe having a good relationship with coroners, which was perceived to be beneficial.

Opportunity for Feedback

This sub-category summarises participants’ descriptions of their experience of consultation with coroners during inquiries. Most participants reported consultation being limited to formal inquiry processes. This was most commonly described as having the opportunity to comment on the provisional findings. Some participants also identified that it was a requirement to consult if adverse comment was to be made and to receive notification of intended recommendations. The following narratives summarise these points.

Figure 6.1: Frequency of SMHS leader participants’ response regarding the perceived level of consultation with coroners regarding recommendations
“It's usually a really formal process in writing. They will communicate with us in writing about their findings and give us an opportunity to respond to that.” (13)

“So what we do is we get the preliminary reports through so we get an opportunity to feedback in to that and I think that's very often.” (3)

“In fact I understand that their process is that wherever there are recommendations and certainly wherever there are adverse comments to be made it is a requirement that they consult.” (1)

Some participants also reported experience of consultation occurring at inquest when the coroner asked a clinician in the witness stand their opinion on an intended recommendation. This is described by the following participant.

“My experience is that the coroner during a hearing might give an idea of what recommendation he's thinking of and give you an opportunity to make comment during an actual hearing about that.” (15)

Participants’ responses indicted that consultation is more often limited to the formal process of commenting on draft reports. Less formal discussion regarding planned recommendations was reported by a small number of participants.

**Challenging the Recommendations**

Within this sub-category the SMHS leadership staff describe their experiences of disputing recommendations when they were perceived as inappropriate. Participants reported that attempts to challenge recommendations tended to be unsuccessful. For some this led to a reluctance to provide feedback in future cases. The following narratives report experience of challenging recommendations without any subsequent changes being made by the coroner.
“This is one of those situations where you know where we've provided feedback to say that would not be appropriate, however, the coroner continued with that and the recommendation.” (3)

“We had pre-hearings and whatever we had planning funding there and we told them it was a really stupid idea in the most respectful terms of course but it still came out.” (4)

“There was one time when the coroners' recommendations were legally wrong... and we wrote back politely pointing out that he was legally incorrect but with that one for example he still continued, the final findings came out still with that recommendation in them.” (15)

The above participant goes on to state that these sorts of responses make the service reluctant to provide feedback in future cases. This is outlined in the following narrative.

“If we've received a preliminary finding and had the chance to comment then we may make comment. I suppose our experience has been that that's not led to any change in the recommendations so perhaps that reduces your energy for the next time around kind of wanting to make comment on it.” (15)

A small number of the participants reported having experience of recommendations being successfully challenged. The following example describes clinical evidence being provided at inquest that was at odds with a proposed recommendation, which resulted in the coroner abandoning the recommendation.

“It's interesting in the case where the Coroner said he backed down from the issue of having a fence around our service. That probably wasn't based on less restrictive environment and I think Dr X gave some evidence in that inquest and some background around that but you know it's sort of putting mental health services back quite a bit and he did the Coroner at the time mentioned he backed down from that recommendation around a perimeter fence.” (8)
Although a small number of participants described similar situations to the above narrative, overall participant experience was that opposing recommendations seldom influenced the outcomes of the inquiry.

**Having a Relationship**

Within this sub-category a smaller number of participants described having good relationships with coroners. When the service reported having a good relationship with the coroner a higher level of communication was implied. This was perceived to have an advantageous effect on the process and outcomes. The first piece of narrative demonstrates this by commenting that having a relationship with the coroner is beneficial to the general process.

> "I think having a good relationship with the coroner’s office, inquest officer and all that, is very useful. In terms of making sure the process flows smoothly." (2)

The sharing of information was more specifically identified as a key benefit to the service having an effective relationship with the coroner. The following participant describes the mutual sharing of information, which results in the internal review being informed by information provided by the coroner and equally coroners benefitting from information being received from SMHS.

> "I will quite often phone the coroners and ask them have you got the provisional post-mortem can you send that through... We've had cases where the coroner has had a load of questions from the family members and we've been conducting a root cause analysis review of the event and they've sent through the questions and we've incorporated them into our reports and we've sent them copies of the reports for the individual that they're completing inquest on." (16)

A number of participants also discussed the SMHS internal findings report being used as a means of sharing information. It was perceived that this report had a heavy influence on the outcomes of inquiries as reported in this participant’s response:
“They often wait for our sentinel event review... this particular one does, and they're heavily influenced by it actually.” (6)

The next participant shared a similar perspective, but quantified it by describing a conversation with a coroner that confirmed this.

“She [The coroner] has said to me that the better the report is, the Serious Incident Report is that we do, like the more evidence that has been appropriately investigated the less likelihood it is that they're going to come up with recommendations because they can see that it's actually, that no stone's been left unturned, kind of idea.” (10)

The final example depicts a considered approach to coroners. This participant describes the relationship with coroners being historically difficult. A change in the way the organisation interacted with the coroner was therefore pursued in order to repair the relationship. This involved fronting up to inquiries in a transparent way, which was perceived to be favourable in gaining the coroners’ trust.

“We're managing that relationship so it works for us, not against us, I suppose. When I first started we had a really difficult relationship with the coroners and they had pretty much no confidence in the Mental Health Service at *DHB because we often wouldn't respond to coroners' requests, there were often big delays, reports weren't provided when asked too, just lots of stuff not often going right. And so... that's why I fronted every coroner's court [it was] was to kind of say I will come here and talk to you, I will face up to my responsibilities. It was a good way of getting [the] confidence of a coroner that we were serious about doing stuff right.” (15)

In this sub-category participants described the value of having a relationship with coroners. The benefits included smoother processes during inquiries, the sharing of information and the coroner having more trust in the service.
Evidence Base of Recommendations

This category described the perceived evidence base of coronial recommendations received by the SMHS leaders. A large proportion of participants responded neutral (n=9) to the statement that coronial recommendations to SMHS are evidenced based (see Figure 6.2). Four participants indicated disagreement that recommendations received are evidence based with the ratings disagreed (n=2) and strongly disagreed (n=2). The remaining participants rating agreed (n=2) and strongly agreed (n=1).

Figure 6.2: SMHS leader participants’ level of agreement that coronial recommendations to SMHS are evidenced based

A number of the participants identified that coroners collect information from various sources including expert witness to prepare their findings. However, the use of clinical evidence to inform coronial recommendations was perceived to be very limited. These conflicting points may account for a higher number of neutral responses. These factors are described in the following sub-categories; the collection of facts, absence of clinical evidence and expert witness.
The Collection of Facts

Participants acknowledged the skill coroners have in collecting facts from various sources and then assimilating that information to formulate their findings. The evidence discussed in this instance included information pertaining to the sequence of events, reports and background information from involved professionals or services, pathologist results, family perspectives and in some cases expert witness. The following two narratives demonstrate this theme. The first describes the use of professional reports to inform findings, thus contributing to the evidence base of recommendations. The second highlights coroner’s skill in investigating suicide to identify the circumstances of the death.

“He or she will write and talk to us about who he's liaised with to form a professional opinion you know to assist him to make a professional opinion if that's appropriate. He calls for reports from the professionals that are involved with the event so in effect yes he is using that professional response to form the basis of his report... He does use the information that is given to him which is evidence based in a way.” (7)

“I think coroners do a very laudable job at trying to get the information as best they can and to try, you know again take the perspective of the community lay person, if you will, and execute their investigatory roles to kind of ferret out all the bits that might not otherwise be known.” (11)

Similar comments as the above narratives were made by a handful of other participants, which in summary recognise that although coroners are not experts in the field they have investigatory skills that enable them to uncover the facts.

Absence of Clinical Evidence

This section describes participants’ reports that coronial findings and recommendations lack clinical evidence. Clinical evidence is research based literature, which is considered essential for informing current models of mental health service delivery and treatments. The process of collecting information to inform the inquiry as described in the previous theme was considered by many as a reasonable approach. However, the majority of the
participants reported concerns about the lack of research based clinical evidence to further support inquiry findings. This lack of clinical evidence was perceived to lead to inappropriate recommendations in some cases. The first examples demonstrate the commonly held belief amongst the participants that coronial recommendations are not always informed by clinical evidence.

“I don't know that there's too much research based evidence in their findings.” (5)

“I guess what I'm interpreting evidence base is on a literature, public literature. They sometimes will be doing that but sometimes they also base their recommendations on the particular individual circumstances of a case. But their recommendations may seem relevant to that case but there might be different literature about that.” (13)

The following two participants substantiate the perceived lack of evidence by highlighting the absence of referenced literature in coronial reports.

“You know I can't find evidence anywhere or referenced anywhere.” (6)

“In virtually every coroners case I've been involved in and/or the report, medical evidence doesn't seem to make its way into the report so I've read some stuff which is completely bonkers and non-evidence based and utterly impractical in terms of coroners' recommendations.” (12)

Some of the participants also described a lack of knowledge on behalf of the coroner about the more intricate details of mental health service treatments and research base. The participants provided examples of when this lack of understanding resulted in recommendations being made that were at odds with current evidence. This is described in the following two excerpts.

“Some of the recommendations are not very well thought through. They indicate a lack of understanding of the territory... There are similar kinds of recommendations from coroners around mental health facilities that I've been aware of where they simply may not understand what the
nature of an inpatient environment is or what the relationship is between the Mental Health Act and people who are perhaps informal clients on an inpatient unit who may come and go from the unit.” (1)

“Sometimes the coroners' recommendations in my experience have been counter or have been at odds with what would be considered the evidence around the management of certain treatments, around people who are self-harming and suicidal.” (3)

This sub-category highlights that coronial recommendations addressed to SMHS are considered deficient in clinical research base. A lack of understanding on behalf of the coroner regarding the more complex aspects of mental health delivery was also remarked upon as a contributing factor when recommendations are made that contradict the evidence.

**Expert Witness**

A significant part of the discussion regarding the evidence base of recommendation focused on coroners using expert witnesses. The coroner may receive evidence from an expert at any stage in the inquiry if they consider it necessary or if they are invited to do so from the deceased next of kin or other involved parties (The Coroners Act, 2006). The expert is required to declare their qualifications and provide evidence impartially. They are also required to state the facts that they base their opinions on and specify what literature supports their stance (The Coroners Act, 2006). The use of expert witnesses was generally considered by the participants as being favourable in that experts contributed to the clinical evidence base of the findings. However, some participants discussed what they perceived as limitations to the use of expert opinion. The first two pieces of narrative summarises the general consensus amongst the participants that expert witnesses contributed to evidenced based outcomes.

“Coroners don't have any expert knowledge. They gain that expert knowledge through people who are experts. The extent to which the coroner makes findings which are properly based on the evidence will be
a function of the extent to which they get proper advice. They can get that by calling experts to give evidence before them if they need it.” (1)

“A lot of those are based on the experts which are usually clinicians from within the sector who do come from, the most part, from an evidence based research kind of orientated background... So based on that and when you read through the reports where you look at the perspective that those experts are asked to give I could conclude that that's often what the decisions are based on.” (9)

A small number of the participants commented that expert opinions were underutilised by coroners. This is firstly described by the following participant.

“They have access to any experts that they want. I think that there are good experts on the subject out there that they could use but they don't.” (10)

The next participant expands on this point by raising concerns that coroners consider suicide and mental health as less technical than other areas of health, which leads them to conducting many inquiries without expert advice.

“What has struck me really strongly with being in a large number of coroners' hearings is that for suicide is I think the coroners all kind of believe that they can understand something about mental health, mental illness and suicide in a way that they would never dare to presume that if we were complex cardio/cardiac surgery or neuro-surgeons because at that point they would seek usually expert advice about the case and about what's happened. The difficulty with suicide is that it kind of can be seen as something that anyone can understand rather than it perhaps requiring an expert opinion to understand. So I think therefore Mental Health Services are at the risk of coroners' opinions which are based really on their own personal view rather than a true understanding of the kind of complex nature of interplay that leads to a suicide outcome.” (15)
A smaller proportion of the participants commented on the level of reliability of expert witnesses because of the difference in opinions amongst experts in the field on certain topics. These comments tended to be weighed against the benefits of expert opinions in most instances. The following two participants’ responses illustrate a certain level of caution when interpreting expert opinion.

“I have certainly been aware of cases both peripherally here and in
*DHB where I was before where expert advice was suspect. But in large
in general, I think it's well advised.” (11)

“You know, I've seen psychiatrists have different opinions in court about
the same case... certainly I like reading what the experts say but I don't
necessarily agree with what they say.” (10)

In this sub-category the use of expert opinion was endorsed by the participants because it was perceived to contribute to the clinical evidence base of recommendations. However, a handful of participants felt that this resource was underutilised by coroners. It was also raised by some participants that the quality of expert opinion could vary.

**Coroners’ Knowledge**

In this category the majority of the participants responded neutral (n=10) to the statement that coroners have the right knowledge to make recommendations to SMHS (see Figure 6.3). Four of the participants disagreed with the statement with the responses disagree (n=2) and strongly disagree (n=2). A smaller proportion of the cohort agreed (n=2) that coroners have the right knowledge to make recommendations to SMHS regarding suicide.

The high rate of neutral answers is qualified by the participant’s qualitative responses in the main sub-category titled it depends on the coroner. Coroners’ lack of expertise to make recommendations to SMHS was also identified as a smaller sub-category.
Figure 6.3: SMHS leader participants’ level of agreement that coroners have the right knowledge to make recommendations to SMHS regarding suicide

It Depends on the Coroner

This sub-category reports on the participants’ responses that, “it’s very dependent upon the coroner” (16), whether they have the right knowledge to make recommendations to SMHS concerning suicide. The participants reported that in their experience the different coroners appeared to have varying levels of knowledge regarding SMHS delivery and suicide prevention. This was considered dependent on the level of experience they had as a coroner, “how much they’re prepared to go with the extent of bias” (4), and the extent they sought independent expert advice. It was also perceived that the outcome of the inquiry was also determined by which coroner was conducting it. The following narratives encapsulate this theme.

“I think mainly because there are so many variables. I think when you have, it depends on the experience of the coroner. It depends on someone who has done one or two clinic cases as to someone who might have been doing this for five or six years it’s quite different from my experience. It depends again on the selection of the independent experts that the coroner uses. It can depend on the nature of the suicide and
some of the response from families as well and I think that often comes down to some of the experience of the coroner.” (9)

“I think I would agree but again I would preface that by saying that I think there is quite a wide variation... I guess when you see such wide variation... you wonder what is the level of peer review amongst coroners about their recommendations.” (13)

Similar comments to the above narrative regarding the variation in coroners was interwoven throughout the participant interviews but featured most dominantly in this category.

**Lacking in Expertise**

A small proportion of participants commented that coroners lacked the necessary expertise to make recommendations that addressed clinical aspects of treatment delivery. Participants commented that coroners were limited in their ability to comment on treatments without expert advice because they lacked the appropriate qualifications. This sub-category is illustrated by the following participants’ responses.

“I suppose as an independent reviewer of the cause of death, yes, because he has his information from the pathologist to form that opinion. I don't think it's probably a coroner who comes from a legal background would be the ideal person to comment on the care, assessment and treatment leading up to the suicide.” (7)

“In terms of giving specific recommendations about treatment or diagnosis or such, I think it's a coin flip. It's about 50/50. Some coroners seem quite cautious about treading into areas where they really have no specific training... It’s been unusual for our coroner in the jurisdictions that I oversee to go into those issues. It's not been the case nationwide. There have been some coroners' that go just jumping right in like a bull in a china shop and speak on things that we really don't think they're well advised to speak on.” (11)
It was generally acknowledged by the participants in this sub-category that the coroners functioned well as external reviewers of the event but that they should be cautious when commenting on the care provided to the deceased given they lack the expertise.

**Implementation of Recommendations**

A total of eleven participants rated how often coronial recommendations were implemented in their DHB (see Figure 6.4). The majority of these participants reported that coronial recommendations were almost always (n=7) or often (n=3) implemented. One responded sometimes and the remaining five were unsure.

![Figure 6.4: Frequency of SMHS leader participants’ response regarding the perceived frequency of implementation of coronial recommendations by SMHS](image)

The first qualitative sub-category, Endorsing What is Already Known, describes participants’ reports that recommendations are often implemented because they are congruent with internal findings. Although a high rate of implementation was indicated the second sub-category suggests that implementation is not always thorough. In this sub-category it is identified that getting traction to effectively implement recommendations can
be difficult. The final sub-category discusses the political aspects of decision making surrounding inquiries and recommendations.

**Endorsing What is Already Known**

The participants’ main rationale for a high rate of implementation of coronial recommendations was that they simply endorsed what had already been identified or was known by the service. Therefore the service had previously taken into consideration how the issue would be addressed and in some cases taken steps to attend to the problem. This was perceived to be particularly the case when coronial recommendations were based on the internal findings. The following two narratives provide examples of this point.

“They are generally the ones that we have put through for an RCA [root cause analysis] report. So we always implement those.” (16)

“The coroners' just confirming... the extent of the internal or external review found. And sometimes by the time you get to the coroners' recommendations you've already implemented corrective action anyway.” (3)

Equally, the recommendations that were not based on the internal findings were described as identifying issues that the service was already aware of. This is described by the following participant who comments very little is learnt from coroners.

“I would say that most often the observations the coroners make are ones that we're well aware of and are already taking some effort to impact. So it's not as if we're learning anything new from coroners in most instances.” (11)

Another participant articulated a similar point by stating the recommendations often reinforced what was known to be good practice and concluded therefore that “it makes perfect sense to implement the recommendations.” (2)
Getting Traction

This sub-category describes the difficulties in getting enough traction to successfully implement coronial recommendations in SMHS. As already described, many of the participants perceived coronial recommendations to be frequently implemented within their DHBs. However, some participants reported that implementation does not occur as comprehensively as the coroner might expect. Participants described what they perceived as the barriers to gaining the momentum that was required to effectively implement coronial recommendations. The first piece of narrative demonstrates a participant response that suggests implementation of recommendations is not always thorough.

“Almost always we'll do something. Or we do everything in the way it was intended by the coroner most of the time I would have thought. I mean I would not be confident that we would do it as intended all the time...” (13)

Getting the momentum required to robustly implement recommendations was acknowledged as the main difficulty by participants. The next participant refers to this as an issue for coroners.

“I think their recommendations for some are reasonably valid; however, to get that traction is difficult for them in their position they can recommend all they like but actually having that traction to move it forward and be accountable for reporting back that yes we've listened and we've acted on the recommendation so I think that is a difficulty there is getting that traction from DHBs.” (8)

Some of the participants’ answers indicated that superficial implementation occurred when the service was unsure how to adequately solve the issues that had been identified. The following participant provides the example of sending memos as a means of tick boxing implementation even though it is known that this action is usually ineffective.

“The joke amongst *SMHS leaders is that you tick off a recommendation by I sent a memo to staff telling them they needed to do this, and that's actually of no use, sending a memo to staff reminding them they should
be asking about suicide in this situation because we know that there's very little evidence that sending a memo changes anyone's practice. But it means you can put a tick in the box saying you have done something with that recommendation.” (15)

Some of the participants reported what they perceived as the barriers to satisfactory implementation. One of the more common points was that the recommendations were not specific enough as described by this participant:

“I mean they have to be specific enough to be implemented. It's more... when they're sort of a bit more sort of hard to pin down as opposed to something quite specific.” (2)

The next person makes a similar point by providing the example of needing to change the culture of a service to successfully implement wide ranging recommendations. The culture of a service is often shaped by staff practices, attitudes and behaviours, which can be very difficult to target. This is described in the following narrative.

“Something might be around kind of culture and that's a really, you need a long bow for that, it takes a long time. You've got to do a whole lot of things under that so sometimes if they're really large recommendations that they can be really hard. How do you keep that momentum going?” (9)

In the last piece of narrative, trouble in disseminating and implementing recommendations nationally was highlighted. This participant described a recommendation that they considered useful for all DHBs; however, attempts to implement the findings more widely were unsuccessful.

“For example, there was one set of recommendations that came out of an inquiry here... which really should have got traction nationally because of course the issues here were no different to the issues anywhere else in the country. It does seem that getting sensible coronial recommendations
implemented in the way that you might hope that they would be across the country when that's clearly where they need to apply is fraught.” (1)

This sub-category implies that coronial recommendations may not be thoroughly implemented in all cases. Participants’ narratives indicated that getting the traction required for robust implementation was challenging because it was difficult to know how to tackle the issues identified or to disseminate the findings.

**Political Pressure**

In this section participants describe the position of the coroner in society and how this politically influences the implementation of recommendations. Many of these participants commented on the high status and political power of coroners. This consequently led to the perception that a certain level of respect for their opinion was required, which swayed the services towards implementing recommendations. This commonly portrayed point is evidenced in the following participants’ narratives.

“We also hold the position of respect so unless it is really silly and there's no reason not to do it, we will do it.” (4)

“Coroners are considered to have important things to say and to ignore them would be politically dangerous. So we tend to implement them almost exclusively.” (11)

The potential of being answerable for not implementing recommendations in future coronial inquiries was a further factor that was considered by the participants. This is described in the following exert.

“We'll be back in court and there may be a similar scenario and really we don't want to stand up and say well we just completely ignored your last recommendations your honour. So you are aware of needing to pay due respect to the coroner’s opinion and recommendations.” (15)
The following participant makes a similar point and candidly admits that the political protection of the organisation is also a factor.

“I know they don't have overt power but standing up in the coroner’s court the next time and saying, “oh no we didn't do that”, is and you know something happens. A bit of its arse protection. Organisational or arse protection. So if it's not a big deal, not going to cost too much, not going to get in the road of anything, you do it anyway.” (5)

This participant also described a recommendation that the service had some misgivings about but because of pressure, the change to practice proceeded.

“I realised that at the time that it wasn't the right thing to do but the push for it was so strong that we almost had to do it.” (5)

In the above scenario the participant admitted that in hindsight the practice change had some detrimental effects on the care provided to the consumers in the unit. This highlights the potential impact of implementing recommendations that are driven by political pressure without the sufficient backing of the evidence.

**Resourcing**

Participants were asked to rate the level of resourcing available to their DHB to enable the implementation of recommendations. Almost all of the participants rated the resourcing to be adequate with the responses very adequate (n=1) and adequate (n=11) (see Figure 6.5). A small proportion rated resourcing to be not adequate (n=2) and one participant remained neutral.

Many of participants considered coroners’ recommendations to be usually cost neutral. This is described in the first sub-category. A smaller proportion of participants commented that there was very limited extra resource to cover costly recommendations. An account of this is provided in the second sub-category.
Cost Neutral

This sub-category reports on participants’ responses that resourcing to implement recommendations was generally cost neutral given it was mostly managed within the existing structures of the SMHS. Participants reported that the main resource used to implement recommendations was staff time within quality and leadership roles, which was already an accepted part of the role responsibilities. This is illustrated in the following narrative.

“Any resourcing comes from the FTE's [full time equivalent] so it's about how you decide to divide up your FTE's that you get allocated to manage services and I suppose the bigger the service the more common use of scale you have... But I think the responsibility sits with the leadership team. But part of the responsibility as opposed to an additional resource.” (2)

The above description of the allocation of in service resources for coronial recommendations was the response provided by the majority of the participants.
Limited Additional Resources

A smaller number of participants commented on the limited additional resources available to make changes based on recommendations. It was perceived by some of these participants that if implementing the recommendation was going to incur additional costs that the changes required were unlikely to proceed. This type of response is outlined below.

“We're broke. If the coroner asks us to do something that's going to cost money it's just going to get kicked back and get in line behind doing basic things like employment staff to meet basic needs.” (12)

The following participant believes that the lack of additional resourcing is one of the main factors that contributes to inadequate implementation of recommendations.

“The whole purpose of these is really to try and prevent a similar situation happening again then if we don't implement the recommendations it's all a waste of time really. But we don't have enough resources to implement changes in a really good robust, integrated and long standing way.” (15)

Two participants did report extra funding being received because of coronial recommendations. This is demonstrated in the following participant’s report that a coroner’s recommendation was used as leverage to receive the additional funding required to make changes to an inpatient unit.

“We did get a recommendation about the inpatient suicide to make some significant changes to our inpatient unit which the coroner said didn't necessarily relate to the suicide but he chose to or she chose to take the opportunity to make the recommendation... We got several thousand dollars... based on the coroner's recommendations... It was actually quite helpful that recommendation in that we knew there was some work needed to be done. I guess we used it as leverage really.” (6)
Overall, participants’ statements indicated that the majority of recommendations could be implemented because they were cost neutral. However, if they required further monetary resource the service was restricted or less likely to implement them.

**Staff Feedback**

A high rate of feedback to SMHS staff regarding coronial recommendations was portrayed (see Figure 6.6). The majority of participants reported that coronial findings were fed back to staff almost always (n=8) or often (n=5). A smaller number of participants reported that the findings were feedback only sometimes (n=2) and one participant responded that it occurred rarely.

![Frequency of SMHS leader participant’s’ response regarding the perceived frequency of feedback of coroner findings to SMHS staff](image)

**Figure 6.6:** Frequency of SMHS leader participant’s’ response regarding the perceived frequency of feedback of coroner findings to SMHS staff

The participant’s qualitative responses provide further detail regarding the type of staff feedback that occurs. The first sub-category describes participants’ reports that feedback is often restricted to the staff involved in the inquiry. The second sub-category discusses the lack of wider distribution amongst SMHS staff including what the participants perceived as the barriers to this.
Feedback to Staff Involved

The majority of the participants reported that coronial findings and recommendations are circulated amongst the staff who had a high level of involvement in the deceased’s care. Consumers generally have an assigned group of clinicians that would be involved in their treatment. This may include a case manager, consultant psychiatrist, primary nurse and psychologist. Participant responses indicated that feedback was generally restricted to these people and their management, which is illustrated in the following narratives. The first participant reports on those that normally receive the information. The later narrative suggests that the feedback to the general SMHS staff population is restricted to those who have contributed to the inquiry.

“The staff who were involved in that person’s care. Our quality team, mental health quality team, so that includes all their managers, the management team.” (6)

“If they're involved in the coronial process doing statements and things then I'm confident that they get information back. But I'm not confident that if you had been that person’s nurse on a couple of days that you would.” (5)

The above narratives indicate that the findings are reliably circulated amongst management and the clinicians that were immediately involved in the deceased care. This was specified by most of the participants.

Limited Distribution

This sub-category discusses the lack of wider distribution of coronial findings to SMHS staff. Participants commonly believed that broader feedback would be beneficial for learning purposes and that it was something that staff wanted. However, the SMHS leaders were cautious given some identified barriers such as privacy. Some participants did report attempts or plans to formalise feedback of the findings to the wider population of staff. The first narrative demonstrates the common participant response that limited information from coronial findings is communicated to the general staff population.
“I certainly don't recall them being filtering down, even when I think back to a registered nurse level I just don't think the filter down was particularly, if there was anything it wasn't a lot. We'd notice some changes in processes I would say but it wasn't exactly clear as to what drove that, whether it was the coroners' findings or not.” (8)

A number of participants’ comments indicated that staff wanted to receive information pertaining to the outcomes of the inquiries. The following participant’s comments are an example of this.

“That's one of the things staff experience surveys or whatever they’re called, say that they don't hear back about incidents.” (10)

A similar conclusion can be made from the next response. This participant spoke about a report that was circulated widely as requested by a coroner. They were sceptical that this would have any impact, but found that the staff response was different to what had been expected.

“I just sent it out to everybody and then I thought no-one will read that because it's too long because maybe we need to précis it but a lot of people fed back to me how powerful it was reading that whole report.” (4)

Although it was perceived by the majority that wider feedback could be useful, the participants reported some barriers to this occurring. One of the points made by the participants was the difficulty in determining the most appropriate way of delivering the information as described in the next narratives.

“Something we'd been talking around also is around... how do you also spread say a suicide that might happen within an adult team, how do you spread some of those learnings across, say, older adult, child and youth?” (9)

“If you over memo and over send to people it just becomes meaningless.” (4)
Issues concerning privacy were also identified by many of the participants. This included respecting the privacy of the deceased and the staff involved as highlighted in these narratives:

“I think there's probably a sense in which the details that have been in the full report about how the person died are not things that which we would usually circulate. For reasons for respecting the privacy interests of the deceased.” (1)

“I think there's a lot of worry around how will that be for the staff that were involved in that in terms of can you de-identify staff enough that you can share those learnings.” (9)

The following participant also commented on the restrictions of publication as determined by (The Coroners Act, 2006), which was interpreted to mean that the report could not be distributed through-out the service.

“Being aware that often they're not for public or publication so being conscious of that.” (13)

In spite of some of the above concerns raised by participants, attempts to distribute the findings more widely were being made by some. This is illustrated in the subsequent narrative that describes a new planned process for the DHB.

“I can tell you in this DHB we've implemented a process for direct feedback for any work we do examining the outcomes so we should go from never to always for everything, coronial and non-coronial. When those reports are completed and signed off what will now happen is... the recommendations... get sifted, they then get sent to the team leaders to feed back to staff at team meetings. So every time there is a service there is a bad outcome we can learn from that.” (12)

This sub-category outlined that the distribution of the findings was limited to those involved and management. The wider dissemination for learning purposes was considered as potentially useful by the participants, but how this would be achieved ensuring the privacy of the deceased and those involved remained unclear for many.
Mandatory Response

Within this category participants were asked to consider if they agreed to mandatory written response to coroners following recommendations being made. As previously described there is no requirement for recipients to respond to coroners regarding recommendations under current coronial law. However, debate has recently arisen out of the reform about whether a response to coroners about recommendations should be made mandatory. Almost all of the participants agreed with written response to coroners being made mandatory (see Figure 6.7). Most of the participants responded that they strongly agreed (n=10) or agreed (n=4). A small proportion were neutral (n=2).

Participants reported two perceived benefits to having mandatory response to recommendations, which included ensuring feedback was given to the coroner and guaranteeing the accountability of SMHS. These two points are described in the following two sub-categories.

Figure 6.7: Level of SMHS leader participants’ agreement with mandatory written response to Coroners recommendations
A Feedback Loop

The primary rationale for agreement on mandatory response by participants was that it seemed logical to have a “feedback loop back to the coroner about the District Health Board implementation of the recommendations” (3). The main benefit of mandatory response as portrayed by the participants was quality improvement of the process. Many of the participants shared the view that mandatory feedback had the potential to enhance the recommendations being made by coroners. This point is illustrated by the following two participants’ responses.

“Because then they get a proper feedback and are more likely to make better recommendations.” (5)

“Because I think if you're not going to do something you need to say why you're not doing it. For example, we're not going to admit everybody that presents wanting to kill themselves because we would need a big institution with lots of beds.” (2)

Similar comments to the above were made by most of the participants. The majority of participants described limited amounts of feedback being provided under the current system. This is illustrated in the following participant’s comments.

“Our system hasn't been so good in that lately, we're been trying to do that but I’m not sure it will happen” (4).

Two participants reported that they already provide a response and commented that mandatory formal response “wouldn't make any difference to our processes” (3).

In this category participants supported formal response to coronial recommendations being made mandatory because it was perceived that feedback would potentially improve the recommendations.
Accountability

This sub-category describes participants’ comments that mandatory response would also ensure the service was accountable for conducting follow-up on recommendations. Participants referred to the importance of being accountable for implementing recommendations or communicating to coroners the rationale for not implementing recommendations. The first example demonstrates a participant response regarding the accountability of the service.

“I think it kind of holds you to account that you've got to respond that you have, one, that you agree with them and that you'll get on and do them and you have completed them. It's good to be held to account.” (9)

The next response considers the resource that goes into inquiries and therefore the importance of ensuring recipients of recommendations adequately follow through with the process. This view is similar to comments in the earlier category, Getting Traction, where participants reported difficulties in gaining momentum to adequately implement recommendations.

“Currently I think there is around that coronial findings and recommendations is just like any others can languish for all sorts of reasons and not be followed up. If we're going to invest the time and money and resources into the expensive time consuming processes that surround these inquiries and findings we have to assume that what comes out of them has merit and not just a now the recipient of the recommendations to file it and do nothing about it.” (1)

This category identifies service accountability as a rationale for the support of mandatory response to coronial recommendations. This was provided by a smaller number of participants than the previous category.
Suicide Prevention

In this category participants were asked to rate the level of agreement that coroners’ recommendations to SMHS contribute to the prevention of suicide. Responses were distributed across the rating scale (see Figure 6.8). Five participants responded that they agreed that coroners’ recommendations contribute to suicide prevention. The same number of participants responded neutral to the statement (n=5) and an equivalent number of participants disagreed that coronial recommendations prevent suicide with the responses disagree (n=3) and strongly disagree (n=2).

A number of the participants expressed uncertainty that coronial recommendations to SMHS contributed to suicide prevention. The rationale for this is described in the first sub-category nothing new. Creating the opportunity for discussion was cited as one of the benefits of the inquiries and was considered by a smaller number of the participants to be a possible factor for suicide prevention. This is described in the second sub-category. The final sub-category summarises participants’ comments that coronial inquiries have the potential to contribute more to suicide prevention if improvements to the system are made.

Figure 6.8: Level of SMHS leader participants’ agreement that coronal recommendations contribute to suicide prevention
Nothing New

In this sub-category the lack of new knowledge being generated by the inquiries was provided as the most common rationale for those that expressed doubt that coronial recommendations to SMHS contribute to suicide prevention. Participants reported that in many cases the issues identified in coroners’ recommendations had already been recognised by the service or another inquiry. Therefore, action to address or to attempt to address them was already underway or completed. Subsequently, the recommendations were perceived by these participants to have very limited impact on suicide prevention efforts in SMHS. The following two excerpts provide examples of this type of response.

“It's reinforcing good practice and why are we reiterating what we all know type thing.” (2)

“Well they're usually things like you haven't engaged enough with the family, we know that, it's something we're constantly working on... so they're just stuff that we're kind of working on in quality improvement way completely regardless of the coroner and them making recommendations is not going to make any difference.” (4)

A lack of research to indicate that it was contributing something new to suicide prevention efforts was also cited by some of the participants. This is outlined in the next two narratives.

“I can't find anything apart from some statistics that comes out of the coroners' office that I think influences any of our actions.” (6)

“If you read the medical evidence of suicide prevention I don't think you'll find coronial process or a coroner’s report either for individuals or groups ever being cited as intervention that reduces suicide.” (12)

In this sub-category, a number of participants shared the view that coronial recommendations to SMHS are limited in their contribution to suicide prevention because of a perceived lack of new information being generated from the findings.
Opportunity for Discussion

A number of the participants recognised that coronial recommendations create the opportunity for discussion, which was believed by some to have suicide prevention potential. The first piece of narrative provides an example of this by commenting that coroners’ findings increase awareness in SMHS about the issues identified.

“In terms of keeping us aware that the problem exists and looking in terms of some of the stuff that continues to be associated with suicide, they're useful.” (11)

A smaller number of participants also discussed the influence coroners can have on societal views through their public voice in the media. This received mixed responses from the participants in that some considered it to contribute to suicide prevention, whilst others had concerns regarding how this had been conducted in the past. These conflicting responses are illustrated in the following narratives.

“In the fact that it informs the public and it gets people talking, it's not behind closed doors and kept secret and the suicide stats are released, so yes I do think it plays a part in suicide prevention in regards to keeping everybody informed and education of people. Encouraging people to get help rather than trying to do it by themselves.” (7)

“I think the whole media thing, my own personal opinions been a little bit hit and miss. How they've managed that.” (6)

“He [coroner] just took it on as a project and some of the stuff that he was putting out there [in the media] was just wrong” (4)

The above comments demonstrate that some participants perceived benefits to coroners discussing suicide in the media, but concerns were also raised about this being done without the clear backing of the evidence in the past. However, participants considered the generation of discussion within SMHS as positive as “they continue to draw attention to the issue” (13).
Potential

This sub-category reports on participants’ comments that coronial inquiries and recommendations have the potential to advance suicide prevention efforts if improvements to the system are made. Some of these participants identified what they perceived as areas that required change for the coronial system to positively influence the SMHS response to suicide. The first piece of narrative provides an overall statement that suggests the system needs development to fulfil its potential.

“The thing is that there is the opportunity for them to be influential in what they're doing but they're not because there's room for improvement because of the fact that the information isn't necessarily helpful.” (10)

The use of evidence base was the most commonly identified factor in need of improvement. This included using research and expert opinion more often to better inform the recommendations, as well as collecting information across coronial cases to provide a more substantial evidence base. These points are outlined in the following narratives.

“It would seem beneficial to have people there that actually were, had made themselves experts in the field.” (10)

“I guess that speaks to the possibility that coroners should develop their own database and think more about collecting similar cases and I think we would all probably find their recommendations more compelling if they were based on a bigger kind of evidence base.” (1)

It was also more specifically identified by some of the participants that focusing on restricting access to lethal means, which has a good evidence base, would assist in preventing suicides. This is described by the following participants.

“Limiting access to means is probably the one that I think has been the most successful.” (14)

“Let’s say coroners repeatedly see a persons died from paracetamol overdose, why don't we limit the amount of paracetamol you can buy at
A perceived limited impact on suicide prevention by some participants led them to question more seriously what needed to change. The following participant questions what coronial inquiries contribute to health care given the duplication of findings of other inquiries and suggests further discussion is required.

“I think it would be worthwhile personally to take a step back and say what do we want of our Coroners now, how does that differ, how does that add value to the quality that we try to bring to health care, how does that add value to educating the community and informing the community different than HDC for instance or different than public advocacy. I think it's a discussion well worth having.” (11)

In this sub-category participants considered coronial inquiries and recommendations to have the potential to contribute more meaningfully to suicide prevention. However, it was perceived by many that improvements to the current system are required to fulfil this potential. The following comment helps summarise this sub-category. “I think it's like anything, it's a service that has great promise that essentially sets out to do good things and it will be great to see that eventuate.” (12)

**Impact on Staff**

In this final category participants describe the impact that coronial inquiries have on the staff that are involved. Many of the participants reported that being involved in a coronial inquiry caused significant amounts of stress and anxiety for clinicians and as a consequence a high level of support for the staff was required. The severity of the strain caused by the inquiries is illustrated in the following participant’s descriptions.

“It’s just like a great big black cloud for them going to a coroner’s court.” (10)
“I think staff are still quite frightened by the process. The moment you talk around lawyers, individuals begin to get quite defensive and are concerned around is it about something they have done wrong and will they be highlighted in that.” (9)

“There's very little in our work lives as clinicians and very little in our work lives as administrators and managers in the mental health service that's any more frightening than having to front up for a coroner’s inquest.” (11)

Some participants also reported that clinicians had very adverse experiences at coronial inquests. This included reports that clinicians felt severely criticised by coroners and that SMHS were more heavily scrutinised than other agencies or organisations. These points are outlined in the following narratives.

“Oh look there's been some really negative staff experiences. I've just been dealing with that recently. They've been crucified in the coroner’s court or found it very difficult” (6)

“The coroners tend to make a lot of negative comments and a lot of demands on the Specialist Mental Health Service and in my experience they don't put primary care under the same scrutiny at all.” (15)

The wider impact that this scrutiny has on the way clinicians deliver services was also considered by some. This included the perpetuation of defensive practices amongst SMHS staff. Defensive practice refers to making treatment decisions that are not necessarily in the best interest of consumers, but practiced to avoid the potential for future blame. The next participant comments that coronial inquiries promote such practices.

“There's nothing more frightening than having to front up and always in the back of clinicians minds when they're in the front line is, how would this look in front of a coroner’s inquest? That drives a good bit of defensive medicine and my own personal view is drives a lot of practice that's really not particularly helpful.” (11)
As a result of the stress and anxiety that was associated with coronial inquiries, a number of the SMHS leaders reported supporting staff during inquiries. This included the need for informal support as well as formalised training packages to prepare staff in some DHBs. This is described by the following two participant responses.

“I think I guess we've learnt over time how to try and best do that with individuals and keep them informed about the process and what to expect and what that might be like.” (9)

“So I think it's a bit of a shock for people but what we've tried to do is prepare people that through the training package and also through providing that individual support... We go through... 2006 Coroner Act facts and what the role of an inquest is. When they occur, all that sort of thing.” (2)

This category describes participants’ reports of inquiry related stress and anxiety for staff, which was attributed to previous negative staff experiences of coronial inquiries. The perpetuation of defensive practices was highlighted as a potential negative consequence of this.

**Chapter Summary**

This chapter summarised the SMHS response to coroners’ findings by providing a description of the SMHS clinical leaders’ perspectives of coronial processes and a description of the responses from SMHS to the recommendations. Consultation was reported to occur in most cases and having a relationship with the coroner was considered to be beneficial. However, participants’ experiences of challenging recommendations was generally reported to be unsuccessful. Recommendations were perceived to be less suitable when they did not fit with the evidence. The participants acknowledged the skill that coroners have in collecting information to inform their findings but concerns were raised about the lack of visible clinical evidence in the reports. Participants also remarked on the variation between coroners in regards to their knowledge of mental health. The overall impact of the recommendations was portrayed as minimal given it was perceived by many of the participants that the recommendations rarely added new knowledge. This
contributed to some of the SMHS leaders’ doubt that coronial findings positively influenced suicide prevention. In regards to the implementation of recommendations, the SMHS clinical leaders did indicate that there was almost always some attempt to implement the recommendations if they were deemed appropriate. However, it was implied that the implementation was not always robust because getting the traction required to meaningfully make changes was difficult. This was considered to be particularly challenging if the recommendations were wide ranging and the identified issues were entrenched in the services. The participants also reported limited distribution of the findings beyond those involved in the inquiries. The majority of participants perceived that the wider dissemination of findings in SMHS could be potentially useful but how this would be achieved in a meaningful way whilst maintaining the privacy of those involved remained unclear. A high level of support for mandatory response to coroners regarding the recommendations was established, with the SMHS leaders citing quality improvement of the recommendations and accountability of the recipients as a rationale. The final category highlighted the negative side effects of inquiries on the staff involved. High levels of stress and burden were described, which was credited to negative experiences of coronial inquires.
Chapter 7: Family and Whānau Workers

Focus Group Results

This chapter reports on the results from the focus group of family and whānau workers from mental health advisory and support services. The participants were asked about the family experience of SMHS based on the sub-categories of the family category from chapter four (see Appendix 7). The content analysis of this group discussion produced three major categories.

The first category reports the participant perspective that SMHS have inadequate relationships with families. This includes participants’ reports of poor engagement and communication with families, as well as a description of a judgemental culture in SMHS towards families. In the second category, privacy issues are discussed as a significant barrier to working with families of mental health consumers. Participants describe families feeling shut out of the treatment of their loved ones when there is a non-disclosure status. In addition to this, infrequent renewal of disclosure and a perceived shortage of knowledge regarding privacy law were also raised as concerns. The final category, lack of progress, describes an apparent lack of learning regarding the issues that have been identified about how SMHS involve families. This includes concerns being raised regarding inquiry findings not being well distributed, policy not being practiced, staff training having a limited impact, and complaints not being validated.

Narrative from the focus group is used to evidence each of the three major categories described above. When identifiable information has been change it is identified by an asterisks.

Inadequate Relationships

In this major category participants describe inadequate relationships with families of mental health consumers. This includes three sub-categories comprising of poor engagement, inadequate communication and a judgemental culture.
Poor Engagement of Families

In this sub-category the family and whānau workers describe a lack of engagement of consumers’ families in treatment. Participants discuss the unwelcoming nature of SMHS and also identified some simple actions that they believed would enhance the engagement of families. A significant part of this discussion also revolved around clinicians having a perceived lack of empathy for what it was like for families when they are navigating SMHS for the first time. The first piece of narrative provides an example from one of the family and whānau workers practices that describes a family’s introduction to SMHS.

“Family of six were asked to come down by *crisis services because this was for the third attempt on this young mans' life. I escorted them in, the looks that they received in the reception was disgusting. That's the first thing that was off putting for them and I had to sort of sooth them to say it's okay to be here, this is where you're expected to be but that judgement already has pushed them further back. Secondly, the *crisis service told them to come down and didn't set up a room big enough so they were crammed into a tiny little space with no vent windows that could open. Thirdly, the water cooler was out and no refreshments were offered. The thing for me was, the clinician didn't even know that that whānau had been asked to come down to the *city and had no clue about what they were presenting for. So there was a lot of things that didn't actually happen pre their request to bring the whānau down here. So they don't want to come back again. They're actually managing the situation themselves with the support of us externally but that's just one point that they're not even geared up for whānau Māori and the attitudes are almost like forced to have to be there but really that's not the sense you get of it. It's just box ticking really.”

The above narrative highlights the consequences of a poor introduction to services for families. This includes a resistance for future engagement not only for the family but potentially the consumer as well. An additional point in the above narrative was the lack of refreshments offered to the family. Simple actions like this were identified as an aspect of engagement that could be easily provided but were described as rarely being offered. In the
following example, the participant comments that there is an awareness amongst clinicians of the benefits of these simple gestures.

“Well it's the same when we do training for staff, and we say what would you like to see when you come into the service? And they've all got the answers, a cup of tea, sit down, and listen to how it's been for us sort of thing... it's not happening.”

The next dialogue provides a further example of why the services are perceived as unwelcoming. The participants report that the staff in an inpatient environment avoid making eye contact with family visitors in an inpatient unit.

1. “You can go onto the units at *Acute Inpatient and stand there, it’s disgusting.”
2. “And watch the staff.”
3. “Then everybody looks the other way from where you are.”

Participants also discussed how frightening it was for families that were coming into contact with SMHS for the first time. The participants described the distress families feel because of the foreign system they are required to navigate and the uncertainty related to their loved ones mental status. Participants’ comments indicated that clinicians did not demonstrate an understanding of what this was like for families. This is portrayed in the next piece of narrative.

“And if the family's new to the service it's a foreign world. Families don't know what they don't know. They don't know what to ask, they don't know what to expect and I do wear a family hat and we were that family at 11 o'clock one night standing on the street with nothing and so, and I think the staff need to be mindful that yes this is their world everyday but not for families first coming in.”

The following participant expands on this by highlighting the importance of clinicians trying to actively engage families during the early phases of treatment given the difficult nature of the situation for them.
“And I think when we're talking about, I know we keep going on about engagement what happens at the beginning, but to me clinicians not only need to do it they need to do it really, really actively. They really have to go that extra mile because this is such a frightening situation.”

A number of the focus group participants made comments that indicated that the level of engagement with families was very much dependent on individual clinicians’ interpersonal skills. These remarks suggested that a family’s experience of engagement was determined by the clinicians that were assigned to their loved ones treatment. These points are illustrated in these final comments:

“I think some have better skills but at the engagement with people and how to approach things, how to word things and just get the buy-in from people.”

“It comes down to individual clinicians as to how they work rather than a consistent approach. And that's why there is varying degrees of satisfaction of services from families around their inclusion.”

This sub-category summarises the family and whānau workers reports of poor engagement of families in SMHS. The need for clinicians to be more welcoming and more active in trying to engage families was highlighted by the focus group response.

**Inadequate Communication with Families**

In this sub-category, poor communication was identified by the focus group as a significant issue for families of mental health consumers. The participants described a lack of communication resulting in high levels of frustration and anger for families. Participants again perceived that this emotional response of the families was not well understood by the clinicians, who were not perceived to act empathetically towards the families in these situations. Overall, a lack of communication was considered to be especially detrimental to the relationship. The following excerpts provide examples of participants’ reports of poor communication with families.
“I really don't think there's enough clear thinking at the beginning about how they're going to communicate with families.”

“It's not that we don't hear positive feedback because we do and we always encourage families to feed that back through, but we do hear a lot of the negative and again right at the outset it's the communication. The lack, of that is the problem.”

“And it often means that if they're not hearing enough, they don't feel they're in the loop, they're going to be ringing and trying to find out and then there are problems because they are ringing. It goes back to give us a time, give the time, make the time, a regular time to catch up.”

Focus group members discussed family members responding to poor communication in anger and frustration, which was considered a normal response to an unusual situation. However, the participants did not believe this to be well understood by the clinicians. The following narratives demonstrate this. A dynamic in the relationship is described where the clinicians react unfavourably to families’ distress by communicating less rather than seeing their behaviour as an acceptable reaction to the circumstances and responding with empathy.

“You see the worst of families a lot of the time and it's because of the fear and the miscommunication or misunderstanding or they haven't had the information that they need and I don't think, I was just saying this today, I don't think clinicians are aware of what that does to a family.”

“Are they over involved, annoying and destructive, dysfunctional and so then we don't talk to them. They need to be pushed back and so there is less communication then. When actually, probably it's more communication that is needed.”

“Families change when their family member becomes so unwell. And so the clinicians are only seeing the family that has been under pressure for
goodness knows how long and they're actually responding to that rather than thinking this family is stressed.”

The focus group also discussed apparent gate keeping of families making direct contact with psychiatrists. The next participant makes the point that families need to be made aware that they can communicate directly with a treating psychiatrist to receive information or discuss treatment.

“They're not empowered to know that they can ring the psychiatrist. Well a lot aren't. A lot of psychiatrists are very good but the family have the right to ring any clinician and there is gate keeping. ”

This final excerpt considers the power imbalance between families and mental health clinicians and how this impacts communication. This narrative implies that families are not given a fair opportunity to discuss their perspective regarding the treatment of their loved one because of the power imbalance in the relationship.

“And I think people are just more comfortable, you know clinicians hold a lot of power they've done their training and what have you, and mostly our members don't, they haven't done that training but there should be able to be, obviously families aren't always going to agree with the treatment or the side effects or any number of things but you should be still able to have a debate about that on a reasonably equal footing rather than it just being, this is the way it is you just have to live with it.”

In this sub-category, a lack of communication with families was described as a significant issue that impacts on the relationship with families of SMHS.

A Judgemental Culture

In this final sub-category the focus group participants describe a judgemental culture towards families in SMHS. The participants reported that clinicians demonstrate negative attitudes towards families and gave examples of labelling and blaming. A level of colluding amongst mental health staff was also portrayed, where by unwarranted labels
were passed on between clinical staff members. This culture was considered to be a significant issue that impacted on the engagement of families across services. The first account provides an example scenario from one of the family and whānau workers practice that illustrates how this culture can negatively impact the family.

“It does go back to that judgement thing too so this poor distressed father for example he's not looking after himself, he's looking a bit dishevelled and the judgement is made that he's not capable of having the normal shared custody he had of his children. Now for the want of bit of extra money, bit of extra food, some medical treatment, he's transformed into the parent, well he's not transformed he's once again able to parent in the way he was always able too. But just when he presented the judgement, that's just like destroying a family.”

The participants also frequently reported that families are judged on the way they react to the circumstances of their loved one being unwell. This is exemplified in the following narratives that describe families being labelled as annoying or over involved in these circumstances.

“I think that along with what you are saying is that when they get angry they get judged and then they're an annoying person...”

“It's just an easy way of describing a certain behaviour I suppose and when I hear the word “over involved” about a family member I think well if it was my family I'd be over involved too.”

There was also a consensus amongst the group that blaming of families occurs. The following dialogue demonstrates the participants’ belief that families feel blamed for their loved ones illness.

1. “The other thing to is that families feel that quite often that there's that thinking among the clinicians that we can understand why your child's like this considering the way that you behave. And the families walk out thinking they're actually pointing the finger at us.”
2. “Yeah, I've had that.”
3. “Mothers particularly.”
4. “Yes, I was blamed for my daughters' mental health problems.”

Participants also perceived that a high level of collusion occurs amongst clinicians, which involves negative labels being passed on between services or via clinical notes. This is described by the following participants:

“Sometimes families aren't able to come down the line of referrers and that's really difficult once as you know within the system once the labels gone on it stays on.”

“There's some staff will put opinion based information on those notes. That you're problematic.”

“I think sometimes what happens to families too when they're gone around and around the merry-go-round quite a few times they get a bit paranoid about the colluding. It's an awful lot of colluding by clinicians and professionals in the way that they come across and whether that's actually occurring or not doesn't matter, it's the way that it does come across.”

The above participant’s comments, as did others, indicate that the portrayal of adverse attitudes toward families is not direct in nature but rather an “undercurrent” to the interactions that families have with mental health clinicians. This was also considered by some to be the case for the relationship between family advisors and clinical staff. The next participant describes their experience of noticing clinical staff attitudes towards families advisors to the point they feel looked down upon.

“And I'd say from me being one of the newest in that advisory role, the feedback constantly is the attitude towards the family advisors. It's not looked upon as anything positive and so we're kind of all clustered together with *cultural, the family and consumer [advisors] and I was just like the poor cousins but there is a really big attitude about advisors
it's not just the advisors that have told me that that's going on you get a sense of it in some places you go.”

The final point comments on how clinical approaches are shaped by individuals’ values and how this leads to cultural inadequacies in the way services work with families from diverse backgrounds.

"Cultural inadequacies is definitely a massive one. And I'm not just talking of Māori. I'm talking across all culture inadequacies. Because the clinicians don't necessarily see who presents and some of them are coming in as their own little cultural values and standards and the way they move within their own dynamics. It's just the one sized glove fit all kind of thinking."

In this sub-category participants reported a judgemental culture towards families of mental health consumers, where by families feel blamed and labelled by mental health clinicians. This category, as did the previous ones, identified the perception that mental health clinicians may lack empathy towards families particularly when they react emotionally.

The Privacy Barrier

This major category describes privacy as one of the main barriers to SMHS working more inclusively of family. Current privacy law dictates that a consumer’s informed consent is required to share or disclose their health information, which extends to the sharing of information with next of kin. There are three types of disclosure, which include full disclosure, partial disclosure, and non-disclosure. Full disclosure gives the clinician the liberty to convey any relevant information to the family. In these circumstances what information is divulged is usually still discussed with the consumer. Partial disclosure involves the consumer stipulating what specific information they are comfortable with being shared. The third option, non-disclosure, means no personal health information can be released. There are some exceptions to this rule such as the ability to override non-disclosure to avoid imminent risk. Regardless of the disclosure status, clinicians are able to
receive information from families and provide non-identifiable information, for example general information about a mental health condition.

In the first sub-category participants describe families feeling shut out of treatment when they have no disclosure. In the second sub-category, participants also perceived a lack of effort on behalf of clinicians to encourage and revisit disclosure status. The final sub-category, reports on the perception that there is an apparent lack of knowledge amongst clinicians about some of the more intricate details of privacy law.

**Being Shut Out**

This sub-category, being shut out, illustrates the participants’ reports that families feel excluded when consumers have not granted disclosure of their health information. The participants described families being declined participation in treatment and receiving no information about what was occurring for their loved one based on non-disclosure status. Participants stressed that a level of involvement can and should still occur in these circumstances. The first dialogue provides two examples of when families have been declined disclosure by consumers and subsequently not been included in their treatment.

1. “It's as recently as last week, I had a family that were really upset, a member of their family had attempted suicide and they wanted an opportunity to speak with the clinicians alone and the clinician asked the consumer and the consumer said no I'm not happy with that and it didn't happen.”

2. “I've just recently spoken to a family who was in a similar situation and their daughter didn't want them involved in it although they had come to the *crisis service with her and no risk plan was done, the parents were out waiting for her, she told them she didn't want them spoken to so they didn't and so now they we have a death.”

The following excerpt reports that the above situation of being shut out of treatment does not just occur at the engagement phase but can become a long term arrangement for families.
“And this is happening not just to people coming into the services, its people that have been in the services for years as well. Where there's a history of that person coming into the services, going back to the family, and... nothing's disclosed to that family.”

The focus group participants considered not involving families when consent had been declined to be an inadequate response by clinicians. There was a consensus amongst the group members that clinicians should still spend time to listen to families and provide what information they can. The next passage provides an example of this being done in practice.

“It is a cop out even where there is no disclosure and wherever that person is at that time there can still be involvement with the family and engagement and that's just, and one of the nicest things I heard was from a family a few years ago, their family member was in *an inpatient unit and they said, and we were so upset that this lovely nurse she couldn't really tell us anything but she just sat with us and listened.”

This sub-category summarises participants’ reports that families are shut out of treatment when consumers consent is not given, which was perceived to be an unsatisfactory response by the family and whānau workers. The need to still listen and spend time with families in these circumstances was highlighted.

**Revisiting Disclosure**

This smaller sub-category reports on participants’ concerns that disclosure to family is not always revisited following consumers’ initial request for non-disclosure. Participants emphasise the need to regularly review consumers’ consent to disclosure in a way that it encourages the consumer to consider a more open release of information. The first passage describes how the participants advocate for the regular renewal of disclosure in practice and why it is considered important.

“If they say, I'm not saying that everybody says this, but a lot of people say, oh okay and that's it. And what we're telling people to revisit that quite frequently because things change particularly if a person's very,
very unwell when they come in they may not want someone, their family
might be the ones that they're actually a bit funny about but a week down
the track they might be okay about it and so it should always be revisited
and you should always try and get the family.”

The next example demonstrates the response that disclosure to families should also be encouraged by clinicians. This participant comments that clinicians should approach consumers about disclosure in a way that it supports family inclusion.

“All, it comes down to language we've found too that's open ended
questions on how families should be involved and do you want your
family involved you'll say speaking to a young person they'll say, no but
if you say, how would you like too and start from, well we like to engage
with family and we work this way better and your covering what we find
will help you better.”

The final point made, is the importance of informing family about the processes surrounding disclosure including the information that consent will be revisited at regular intervals.

“And also the families are told that it's going to be constantly
readdressed with the consumer so that they know it's all part of a
process. They're not just being sort of shut out and that's it, set in stone.
I think it's really important that families know that it gives them
confidence to stay involved.”

In this sub-category, participants reported a need to revisit disclosure at regular intervals in a way that it urges consumers to consider the benefits of family involvement. The need to keep families informed about the process was also remarked on.

A Lack of Knowledge

In this sub-category, the participants’ perception that clinicians have insufficient knowledge about the more intricate details of privacy law is conveyed. They describe
practices that indicate to them there is a “lack of knowledge” about the different types of disclosure and when the exemptions should be applied. The first two passages illustrate the perception that clinicians lack knowledge regarding privacy and use the example of applying partial disclosure in practice.

“I think that's what it is, it is the lack of knowledge, or shortage of knowledge isn't it. Because when you look at it from that point of view things like partial disclosure how much information can you give a family, how much can you receive, how much can you use in your notes and how do you affect your care planning as well. So from a nurse’s perspective yeah I think just a lack of knowledge and skill.”

“The partial disclosure even, because you can have partial disclosure at least knowing kind of what's happening but they don't need to know all the personal stuff that the person doesn't want. And they don't seem to understand what partial disclosure is either.”

The second aspect of privacy law that participants perceived clinicians to lack knowledge of was some of the relevant exemptions to consent for disclosure. The two examples provided included the need to consult with the principal caregiver under the Mental Health Act (1992) and the need to share information to mitigate risk. This is evidenced in the below narrative.

“I mean that is not right it's not followed where families should have that opportunity to meet with the clinicians. If he's under the Mental Health Act here you go, necessary and relevant information and but they're not aware of that.”

“Maybe around not understanding first of all that if there is a risk that you have an obligation really to tell the people that she's going home with. But also it's that risk plan not being written, they didn't actually know what to do with her when she came home.”
In this final sub-category, participants portrayed the perception that clinicians lacked knowledge about the more complicated details of privacy law. This was discussed as a contributory factor to privacy law acting as a barrier to family inclusion.

**A Lack of Progress**

This final major category describes a lack of progress and learning regarding family inclusion. This involves discussion of what has proven to be unsuccessful in tackling the identified issues of working with families, alongside an alleged inaction on behalf of the services and clinicians. The sub-categories include inquiry findings not being distributed, policy not being practiced, staff training lacking in impact, and complaints not being validated.

**Inquiry Findings Not Being Distributed**

In this sub-category, participants raise concerns about the lack of distribution of inquiry findings that relate to working with families. The focus group described their experience of being part of serious incident reviews that have uncovered shortcomings in the way families had been involved. However, they described in most cases these findings were not distributed beyond the investigating committee and management teams, which was deemed to be a wasted opportunity for learning. The following three extracts illustrate this.

“Yeah, they go through to the coroner, they go to the family but I mean they should be seen by the clinicians and all clinicians.”

“They've checked that the recommendations have been implemented and what's been done but no-one else really hears about it apart from the committee.”

“Now I mean I think everybody should read it because that's how we learn. It is a horrific thing, terrible things that are happening when someone dies and usually they go to directorate and sometimes they don't even go to directorate, no-one sees them.”
There was an agreement amongst the group members that this was a missed chance for clinicians to learn about what had gone wrong and potentially inform future practice. In the next paragraph, a participant who works in a community team believes that inquiry findings from other similar services have the potential to inform their services treatment delivery.

“So like if something like that happened in *Community Team A say... it would be actually quite good to know that because the same sort of thing could come up there. And it would be good for them to look at that and think okay well maybe we need to put something in place.”

The final passage describes a scenario of an internal review being distributed to staff within a clinical area. They conclude the benefit to this was that the report confronted clinicians to reflect about their own practice and what had occurred.

“Now for the first time ever, we had a case in *Youth Services where we had a young girl who died and it really needed to be seen. I mean it was pretty bad, a lot of family stuff and so we said right okay as a team we said we're putting it out to the whole service so every person in the service had to read it and tick off that they had read it... and so even to have it in black and white knowing that that resulted in death of a young girl, to be confronted that, I mean maybe some reflection on individuals’ practice.”

In this sub-category, the family worker focus group participants identified a lack of circulation of serious incident review findings to clinical staff. This was perceived as a squandered opportunity for clinical staff to learn about identified weaknesses regarding the inclusion of families and reflect on how it relates to their practice.

**Policy Not Being Practiced**

In this sub-category, participants report that organisational policy regarding families is not well practiced. There was a perception that clinicians practice policy in a superficial way that gives the illusion of family involvement without providing actual meaningful
interventions. Concerns were also raised about a lack of accountability for clinicians who did not practice in accordance with the policy. The first two excerpts demonstrate the perception of the focus group members that policy accurately outlines what is required yet it is not followed in practice.

“I think we have a framework that says the right stuff... it talks about everything being family inclusive, we have a policies around the families... We have all these things, yes, yes we need family involved but there's no oomph behind it is there, there's no oomph behind it.”

“And to me the policies and procedures for families are all there but who actually follows them. The number of families that say to us when we say now what happened at the discharge plan meeting. What, what's that? Never happens, you know these sort of things that are actually stopping the good healthy involvement with families.”

The next example depicts the perception that clinicians only superficially involve families, so that they can process cases without delay. This participant’s comments highlight the consequences of this type of approach.

“I also think that people just don't like the book right they just want box ticking and they just want to get done with it and move onto the next. In the process you're actually letting go of a very useful resource which is the family. They're going to help you care for them they're going to help you deliver the optimum desired goal that you're also looking at getting the job done.”

The final aspect of this sub-category is the participant perspective that policy regarding families is not well mandated. This participant reports there is an awareness amongst leadership that the policy is not being practiced, but also describes a lack of addressing the issue.

“It's got to be mandated, things have to be mandated, I mean they [leadership staff] just say, yes, yes this is how we should be. Anybody
who looks at it says oh okay, most people don't even know what the framework is and what it says… But it's just sort of like, yeah gosh we don't involve families do we and then oh we'll just send this out to everybody and tell everybody you need to involve family but nothing's mandated.”

In this sub-category participants reported that policy accurately outlined what was required of clinicians in terms of working with family; however, it was perceived not to be well practiced or enforced.

**Staff Training Lacking in Impact**

Family training targets how clinicians actively work with families. It aims to assist clinicians in recognising the value of family involvement, inform them of strategic national policy and provide them with strategies that they can apply when working with families. In this sub-category, the family and whānau workers report the perception that historically this training has had a limited impact on practice. Questions are raised about whether the clinicians who might benefit the most from this training were attending. The first passage articulates the perception that the training is having a limited impact. The group member also questions the expectations of the organisation regarding the training given the extent of the issue.

“Just to take the example of training again, the training that has to be approved by management right so the training we used to do that I alluded to earlier was seen to be not changing practice. This wasn't just from a family advisory but a consumer advisors perspective as well. So they want us to do something else which is great we want to do the training but what they expect a small group of people to change a whole culture. There has to be a commitment from the top, this is what we expect from you.”

The above comments suggest the training in isolation was never going to address the issues that have been identified without more commitment from the organisation. The participants also identified some other reasons training had a limited affect. The next example identifies
the point that potentially the wrong clinicians are attending the training because it is not compulsory.

“I mean the trainings that we do is just whoever wants to do them. It's not mandated, you don't have to do it. I mean the people that are doing it are actually really lovely people a lot of them know it anyway. You think well the people who really need it aren't coming”

The participants also reported that clinicians made comments that indicated that they confused working with families with providing family therapy which is a more specialised intervention. This final point was identified as a further issue regarding the training as outlined in the following narrative.

“Well, some of the feedback we've had is that, when we talk about working with families, they think we're talking about something else. And they say, oh but we're not trained to work with families. We're only trained to work with consumers.”

In this sub-category, training that targets the way in which clinicians were working with families was discussed. It was generally perceived that this training historically had been ineffective in changing the way clinicians practice.

**Complaints Not Validated**

This final sub-category discusses families’ reluctance to complain when they are dissatisfied with SMHS. Participants report that families are often discouraged from making complaints because of the stress they are already under and the complexity of the complaint process. In addition to this, previous experience of invalidated concerns was also highlighted as a deterrent for families wanting to make a complaint. The first two examples outline the focus group perspective that the process of complaint is often too difficult for families, because of how involved the process can be, as well as the emotional strain they are already under.
“So even if they had genuine concerns or complaints a lot of them are deterred by the fact that the process, the timeline and then they've got to chase it and they've got to be bear down on it and a lot of the time it fails at different stages through previous encounters anyway. So there's a lot of that, kind of, oh no we'll just let it go.”

“...not only do you have to contend with your loved one in a Mental Health Service and go through all the system there but then on the other side of it if you want to make a change or contribute to some sort of outcome that takes all the peoples resources to do that as well. So it's actually quite exhausting on either end and so if the family member that's supporting the Tangata Waiora [Consumer] already is worn out, they're already mentally exhausted to be able to pursue something else anyway.”

The next participant’s comments indicate that families can feel like they are not validated when they voice their concerns, which can further dissuade them from speaking up in the future.

“And again it usually makes a difference with maybe some of the families that have tried to speak up and are shut down or they are not validated, their concerns are not validated.”

Additional concerns were raised by the focus group about the potential repercussions of making a complaint. In the next dialogue, the participants describe families as being worried that voicing their dissatisfaction will negatively impact on the treatment delivered to their loved ones.

1. “They feel it's going to be held against them.”

2. “That’s exactly right because they fear a rebounding on their family member. If we upset staff how are they going to treat my child?”

The focus group concluded that families often just want their concerns acknowledged at a lower level without having to pursue the complicated complaint process. In the next dialogue the participants consider how a simple apology would suffice in many situations.
1. “…the other fear is that, you know I know that you can just lay a formal complaint but that's at low levels. But if it's not actually, hitting those markers then you can escalate and people don't want to go to the top of that they just simply want an answer or an apology or whatever it might be without it having to be such a drama.”

2. “Yeah that's a big thing actually, an apology.”

3. “I think that we don't apologise enough.”

4. “It's a fear of apologising. It's like admitting.”

5. “That could go a long way.”

6. “It's humility, apologise for their own humility and sincerity actually can settle a situation no problem.”

In this final sub-category, participants described families’ reluctance to speak-up about their concerns because of the stress they are under as well as the potential for a tiresome process to evolve from a complaint. Families feeling invalidated by SMHS responses to their concerns raised, further contributes to the overall picture of a service not learning from the mistakes being made with families of mental health consumers. An acknowledgement of their concerns by way of apology was considered as sufficient for many circumstances.

**Chapter Summary**

This chapter provided the family and whānau workers perspective of the major category of coronial recommendations that target working with families of consumers. The family and whānau workers described their own experiences of interacting with SMHS as family members and staff members, as well as reporting on the experiences of the families they work with.

The first two major categories, which discussed inadequate relationships with families and issues regarding privacy, were generally consistent with the coronial findings that were discussed in chapter four and the service leaders’ perspectives that were portrayed in the last chapter. This reinforced that issues, such as the way services involve, engage and
communicate with families, are present. The identification of a potentially judgemental culture towards families in SMHS had not previously arisen in the findings and may be another factor that needs to be taken into account when considering how to improve the ways SMHS are working with families. Privacy was also identified as a major barrier to the adequate inclusion of families in mental health care.

The final major category described a perceived lack of progress and learning being made regarding the issues that had been identified. This was substantiated by reports that policy was not well implemented, that complaints were not dealt with well, and that inquiry findings are not circulated to clinicians for learning. These points, alongside a perceived lack of impact from family training, suggest again that the difficulty is in knowing how to address SMHS shortcomings regarding family inclusion, rather than whether it is an issue.
Chapter 8: Discussion

It has been established that suicide is a significant health and social issue in New Zealand and that the improvement of services that cater for people that experience mental disorder is an area of focus for suicide prevention. Coroners’ recommendations directed to SMHS have the objective of enhancing these services in order to prevent further incidents of suicide occurring but the impact of these recommendations has not been well studied.

This thesis identified six major categories of coroner recommendations directed to SMHS regarding suicide. These included communication, restrictive management, staff education, working with family, risk assessment and management and service delivery. Further investigation of these categories from the perspective of SMHS leaders responsible for their implementation revealed the majority of the coronial recommendations were generally perceived as appropriate, apart from some concerns regarding the risk assessment and restrictive management categories. A focus group of people working with families of mental health service consumers also corroborated that coroners were accurately identifying problems with the way in which SMHS are working with family. Irrespective of the findings that many of the recommendations were accurately identifying issues, the SMHS leaders perceived the recommendations to have a limited positive influence on the delivery of SMHS and suicide prevention. However, the SMHS leaders considered the inquiries to have potential to constructively influence suicide preventative efforts if improvements to the current system are made.

Discussion of Findings

A key function of coronial inquiries into suicide is to promote learning (J. Moore, 2014b) and one of the major themes from the recommendations to SMHS was the use of coronial findings for learning purposes. Yet this thesis identified that there was a perceived lack of positive impact from coronial recommendations on the improvement of SMHS delivery and suicide prevention efforts. Why coronial recommendations are not meeting their educational functions in the SMHS context can be explored from both the perspective of the content of the recommendations and whether these have the potential to contribute to
the improved quality of SMHS, alongside how SMHS and Coronial Services of New Zealand (CSNZ) respond to these recommendations in order to facilitate organisational learning.

Part One: The Clinical Creditability of the Recommendations

Coroners have come under scrutiny in recent years because of concerns that their recommendations are not always well informed by research (Freckelton, 2005; J. Moore, 2014a). These concerns were also highlighted in this thesis findings. The SMHS participants acknowledged coroners’ skill in collecting facts from different sources and then formulating this information. However, it was also identified that coronial finding reports were usually deficient in referenced clinical evidence. This was further emphasised when coroners made recommendations that demonstrated a lack of understanding of the more complex details of mental health service delivery and treatments.

The recommendations that attracted the most discussion because of a perceived ill fit with the evidence were those that belonged to the risk assessment and restrictive management categories. The recommendations that were considered the most useful were those that targeted restricting access to means, communication, and the inclusion of family.

Risk and Restrictive Management

Coroners make a number of recommendations that aim to regulate how risk assessment is executed in clinical practice, as well as promote the use of restrictive measures such as increased nursing observation and enforcing compliance as a means of ensuring safety. But what is leading coroners to make these recommendations and how useful are they in improving the quality of services for those at risk of suicide?

It is hardly surprising that coroners focus on risk assessment and make recommendations that enforce the need for SMHS to carry out risk management practies, given it remains one of the leading discourses in mental health practice (Manuel & Crowe, 2014; Ministry of Health, 2003). This is evidenced by the abundance of governmental and organisational policies that are concerned with mitigating risk. The Ministry of Health (2003) provides guidelines on the assessment and management of people at risk of suicide. Whilst these
guidelines acknowledge that assigning risk as low, moderate or high is arbitrary in nature and that risk assessment is only a snapshot of a person’s risk at any given time, they also clearly enforce the need for risk assessments to be routinely carried out in practice. These guidelines suggest that the formulation of risk is critical because crisis interventions are then planned based on this assessment. The use of respite services and hospitalisation are highlighted as potential options for clinicians as a means of mitigating the risk of self-harm for consumers (Ministry of Health, 2003).

More recently, The Royal Australian and New Zealand College of Psychiatrists (Carter et al., 2016) and The National Institute for Health and Care Excellence [NICE] (2011) in the UK published guidelines for the management of persons that present to services following deliberate self-harm (including suicide attempt). There are some clear differences to the Ministry of Health (2003) somewhat outdated guidelines, that indicate a shift in focus regarding the assessment and management of suicide risk. These guidelines promote individualised psychosocial assessments of a person’s situation and treatment needs when presenting to services following self-harm including an assessment of modifiable risk factors such as the presence of mental health disorders, medical conditions, relationship difficulties, and social problems (Carter et al., 2016; National Institute for Health and Care Excellence, 2011).

This shift in focus is likely to be a result of the growing recognition regarding the difficulties inherent in predicting the risk of suicide. The limited abilities of clinicians to accurately predict the risk of suicide was identified by many of the SMHS participants as the main rationale for their trepidation regarding recommendations that focus on risk assessment. The claim that clinicians have limited abilities to predict risk are corroborated by the Ministry of Health (2003) practice guidelines, along with an extensive amount of other research studies and opinion papers (Appleby et al., 1999; Draper, Snowdon, & Wyder, 2008; Large, Sharma, Cannon, Ryan, & Nielsen, 2011; Mulder, 2011; Windfuhr & Kapur, 2011b). The National Confidential Inquiry that used a UK-wide national database of cases of suicide showed relatively low rates of accurate risk prediction. This study showed around 2% of people who die from suicide are considered an immediate high risk and 9% are deemed a chronic risk (Windfuhr & Kapur, 2011b). Similar low rates of prediction of around 3% were reported by Large, Sharma, et al (2011), when focusing on suicide in the year following discharge from psychiatric hospitals. This study also reported
that 60% of consumers who die from suicide were deemed low risk. Given this evidence, it is unsurprising that coroners often conclude that the risk assessment in cases of suicide are flawed.

Possible reasons for the low rates of prediction have been proposed. These include the changeable nature of suicide risk that only allows for a short period of validity of assessment (Draper, 2012; Large, Sharma, et al., 2011; Windfuhr & Kapur, 2011b) and mental health professionals’ adaption to the high risk population, which results in skewed assessments (Appleby et al., 1999). It can easily be argued that focusing on trying to regulate risk assessment processes through policy are unlikely to have an impact on these factors. One coronial recommendation rightfully identified that answers provided to clinicians by consumers are not always truthful. The suggestion by a coroner that consumers’ answers should always be challenged, clearly does not take into consideration the issues that this would pose for the therapeutic alliance that is required when working with people. However, it does highlight one of the intrinsic issues with suicide risk assessment. That is, that clinicians are required to make assessments based on the information that is given to them. As highlighted by Crowe and Carlyle (2003) and others (Szmukler & Rose, 2013), this requires the collaboration of the individual who may be mindful of the consequences of disclosing thoughts of suicide.

Unfortunately the development of assessment tools as a means of circumventing these types of issues that was subsequently suggested by the coroner in the above example have been shown to be an inaccurate means of assessment (Carter et al., 2016; Large, Sharma, et al., 2011; Quinlivan et al., 2016). Risk assessment tools consist of checklists of risk factors, symptoms or other contextual factors and are often used in practice as part of psychosocial assessment. These include locally devised structured proformas (documents or forms), or the use of published self-harm rating scales (Quinlivan et al., 2014). A systematic review of the diagnostic accuracy of these types of risk scales that are routinely used in practice, which included 98 600 hospital presentations of self-harm or attempted suicide, found that none of the scales perform sufficiently well enough to be recommended for clinical use (Quinlivan et al., 2016). A further example is a meta-analysis conducted by Large, Ryan, and Nielsen (2011), which examined the validity of risk assessment models that attempt to identify high risk individuals in inpatient services. They found that existing models include one or more factors not found to be associated with suicide and were
considered probable chance associations. These authors conclude that the categorisation of risk has no role to play in the prevention of suicide. Practice guidelines are also moving towards this perspective, through emphasising that risk assessment tools and scales do not mitigate the risk of future self-harm and therefore recommend that they should not be used as a basis for planning or allocating treatment (Carter et al., 2016; National Institute for Health and Care Excellence, 2011).

Alongside concerns regarding the validity of risk prediction there is also a strong argument that risk assessment and management practices are counter therapeutic and carry a number of costs to consumers, mental health clinicians, and services (Crowe & Carlyle, 2003; Large, Ryan, et al., 2011; Mulder, 2011; Szmukler & Rose, 2013). For example, a number of authors have commented on the detrimental impact that risk assessment and management have on traditional practices that endorsed the nature of caring (Buchanan-Barker & Barker, 2005; Crowe & Carlyle, 2003; Szmukler & Rose, 2013). Szmukler and Rose (2013) report that trust can be compromised when consumers become aware that health providers are concerned about risk. This can lead to people restricting disclosure to health professionals, opting out of mental health care, or not engaging in proposed treatment. The heavy focus on risk assessment may also inadvertently lead to increased discrimination and stigmatisation for people experiencing mental illness (Szmukler & Rose, 2013).

Despite the evidence that suggests risk assessment and management practices may be of little value and potentially damaging, it is maintained by some that it may be to “risky to dismiss suicide risk assessment” entirely and that a more conservative approach is still required (Draper, 2012; Goldney, 2012). Goldney (2012) reasons that studies such as that of Large, Sharma, et al. (2011), demonstrate that prediction of risk is in fact useful by showing that 3% of a high risk group will die by suicide. However, this author also concedes that this does not assist health professional in practice when they need to determine if there is an imminent risk. In these scenarios, Goldney (2012) suggests a conservative approach that errs on the side of caution. This author voices the concern that if risk assessment is dismissed completely health professionals may become complacent about the risk of suicide.
The opinions of Goldney (2012) and Draper (2012) are consistent with the position held in a number of the coronial recommendations and perhaps also congruent with a general reluctance in mental health services to let go of risk assessment practices. However, the suggestion that it may be too risky to dismiss risk assessment entirely poses another question; too risky for who? For this to be explored the wider context of why coroners are making recommendations regarding risk assessment and management needs to be considered.

Coroners fill a socially mandated role and the concept of risk management is a fundamental concept to modern society. Society, which includes social and political groups, mass media, and the predominant culture, is increasingly focused on the management of risk (Szmukler & Rose, 2013). Increasing amounts of information regarding potential risks is available and although such an emphasis on risk does not equate to actual increased risks, it does lead to the societal belief that risks should be mitigated (Giddens, 1999). When an adverse event occurs, the community demands that something be done to prevent it occurring again. Inquiries, such as those conducted by coroners, are a means in which the management of risk is enacted. The circumstances of the death are investigated thoroughly and areas of potential preventability are identified. Ostensibly, the public can then be comforted that something is being done to control the risk.

In particular, suicide is a moral issue that attracts significant public attention. The level of public concern regarding a risk is derived from the level of ‘moral outrage’ the risk induces (Szmukler & Rose, 2013). This dictates the justification of the use of resource to mitigate the risk, regardless of whether the interventions are successful. When the cause of the hazard is perceived to be malicious, reckless or negligent then the higher the level of outrage (Szmukler & Rose, 2013). SMHS have a socially mandated role to protect those at risk of suicide. When it is perceived that they have not upheld this responsibility, high levels of moral outrage ensue and they are able to be deemed negligent (Crowe & Carlyle, 2003). Accountability for the outcome is then highlighted during the process of inquiries, albeit it unintentionally or indirectly. This assignment of blame in turn assists with the social function of the inquiries by reassuring the community that there was a breach of responsibilities and therefore something can be done to manage the risk.
Szmukler and Rose (2013) also suggest the level of control people have over a hazard has particular significance. The risks that are beyond the control of those concerned result in higher levels of anxiety. The relevance of this to suicide is that this particular hazard is ultimately the result of the individuals actions and therefore beyond the control of public order or regulation. Yet, the idea that the risk can be calculated through assessment and therefore managed, means that the uncertainty regarding the risk can be brought under control (Szmukler & Rose, 2013). Risk assessment and management therefore serves the purpose of reassuring the public that adverse events such as suicide can and should be prevented through better assessment of the risk, even though the evidence may suggest otherwise.

Unlike the risk of violence, suicide is neither immoral nor illegal, yet it invites the same means of management (Rogers & Pilgrim, 2010). The use of coercive practices such as increased observation (Buchanan-Barker & Barker, 2005), hospitalisation (Mulder, 2011), and enforced treatment (B. Paterson, Wilkinson, & Smith, 2013) are also fuelled by concerns regarding risk. These types of restrictive interventions were also promoted by coronial recommendations. A number of the SMHS participants considered these recommendations undesirable because they demonstrate coroners’ unbalanced perspective towards societal and family views over consumer autonomy.

The most significant change to mental health practice over the last forty years has been the increasing expectation that consumers have an active role in their treatment (Lammers & Happell, 2003). The recovery model is based on the consumer perspective and is a guiding framework for contemporary mental health practice (Mental Health Commission, 2012). This model stipulates that for recovery to occur that consumers need to be given opportunities to be self-directed, to make choices, to succeed and to fail, even at times of illness (Davidson, O’Connell, Tondora, Styron, & Kangas, 2006). It is also argued by consumers that it is up to individuals to make decisions regarding risk and not up to health professionals to protect them (Mead & Copeland, 2000). It is therefore accepted in mental health practice that therapeutic risk taking is sometimes required. This involves taking a course of action that may create the opportunity for risk, in order to provide treatment using the least restrictive approach, which promotes recovery and empowerment of the consumer (Stickley & Felton, 2006).
Nonetheless, the restriction of mental health consumers rights is justified in a ‘risk society’ (Beck, 1992) that values safety at all costs. Those with chronic mental health problems are considered to pose a threat to social order and therefore attract both governmental and public attention for risk minimisation (Pilgrim, 2008). One of the recommendations openly endorsed a more coercive approach to mental health practice by suggesting that the “pendulum needed to swing more towards maintaining safety” than consumer autonomy and the less restrictive approach. These comments followed criticism that the level of observations had been set to low, a perspective shared by the family of the deceased. It could be argued however, that this stance is not only conducive to popular public opinion, but also a symptom of hindsight bias. As described by Szmukler (2000), with hindsight an outcome becomes to look inevitable when one traces a chain of events backwards in time. Retrospectively, ‘critical points’ (e.g. decisions regarding observation levels) become an argument of preventability; if x had done y, then this may not have happened. What is not considered is the multitude of other possibilities (Szmukler, 2000).

The way in which coroners focused on nursing observations was identified by the SMHS participants as being particularly unhelpful. The rationale given was the concern that these recommendations privileged the practice of observing consumers for risk management purposes, rather than engaging with them for therapeutic purposes. This argument is also consistent with debate in the literature (Bowers et al., 2006; Buchanan-Barker & Barker, 2005; Cutcliffe & Barker, 2002). Nursing observation, in its simplest form, involves mental health nurses sighting consumers on inpatient wards at certain time intervals and making note that they were seen and where, or if someone is deemed a very high risk of suicide having the person within sight or arms reach of a nurse at all times as a means of mitigating the risk of harm. The evidence suggests the use of intermittent observations may act to reduce the incidence of self-harm, but that constant observation is not as effective even when accompanied by engagement (Bowers et al., 2006). Critics suggest the practice of nursing observation is impersonal and of little use to the consumer, intrusive and reinforcing an outdated custodial approach to care (Cox, Hayter, & Ruane, 2010). It has been proposed that a re-focusing on the need to engage the consumer and inspire hope is required, which involves nurses forming relationships and connections, as well as listening and conveying an understanding of a suicidal person’s distress (Cutcliffe & Barker, 2002). Such important detail is usually missed in coroners’ recommendations as they tend to concentrate on the time intervals between nursing observations. This focus is most likely a
by-product of the fact finding nature of the inquiries (who did what and when). Yet, SMHS respond to these recommendations by increasing practices such as tick charts that demonstrate nurses have met their obligations to observe the person at the prescribed intervals. This type of practice only serves as a mechanism to protect the risk averse interests of the organisation and has very little value for the suicidal consumer (Buchanan-Barker & Barker, 2005).

SMHS clinicians are required to make a number of critical treatment decisions on a daily basis. This involves balancing the competing agendas of various concerned parties, including the need to consider their responsibilities towards the consumer, other involved third parties such as families and their risk averse employers (Manuel & Crowe, 2014; Pilgrim, 2008). Attempts to regulate clinicians practice and decision making through the proliferation of guidelines, protocol and so on, is imposed by political and health authorities (Szmukler & Rose, 2013) and certainly endorsed in a number of the coronial recommendations reviewed in this study. However, protocols, guidelines, or statistical methods cannot replicate the specialised mode of thought required to consider the detail required to inform these types of clinical decisions. In particular, the weighing up of the opposing agendas.

There is obvious tensions between the consumer recovery model of care, which endorses individual choice and freedom, the family perspective, and the social mandate for mental health professionals to protect people who are deemed vulnerable (Pilgrim, 2008). The latter two often sharing similar sentiments and both considerable influences during coronial inquiries. However, what was identified by one participant in this thesis was that coronial inquiries lack the perspective of the consumer. This leaves very little to counter influence public and family expectations regarding the mental health services role in the management of suicide risk. It is important to recognise that consumers and family members have different priorities in treatment, which are driven by different underlying motivations, values and beliefs (Bellack, 2006; Rowe, 2012). A protective stance may act to serve family and societal perspectives, as well as assist health professionals and organisations in the protection from blame, but it is not necessarily consistent with what consumers consider useful for recovery and can in fact act against it.
It is not argued that health professionals should dismiss concerns regarding suicide in the SMHS context, especially given the presence of mental disorder as a key risk factor (Hawton & Van Heeringen, 2009; Windfuhr & Kapur, 2011b), alongside suicide attempt and deliberate self-harm being a significant risk factor (Hawton, Zahl, & Weatherall, 2003) and the high rate of contact with SMHS prior to suicide (Ministry of Health, 2015a). However, shifting the preoccupation from managing risk, to ensuring all SMHS consumers receive adequate care, is more likely to have both therapeutic and suicide preventative benefits. The most recent review of effective suicide prevention strategies identified the treatment of psychiatric disorders as having anti-suicidal effects and that treatment needs to involve a combination of pharmacological and psychological treatments (Zalsman et al., 2016). Whilst most people presenting to SMHS will receive pharmacological intervention, they are less likely to receive psychotherapeutic treatment, even though clinical guidelines indicate that the latter is more effective for the management of deliberate self-harm (Carter et al., 2016; National Institute for Health and Care Excellence, 2011) and both used in combination are more effective for the treatment of depressive symptoms (Malhi et al., 2015).

What the above guidelines do not take into consideration is the financial implications of such suggestions. Currently, service standards are set by governmental departments to provide a recovery model of care (Mental Health Commission, 2012). For such standards to become a true reality in clinical services, it is essential that consumers are provided with the resource (including psychotherapeutic interventions) necessary to develop the skills required to live well, to be resilient and self-directed in the management of mental illness. However, governments fund a medical model of care (assessment, diagnosis, and pharmacological intervention) that endorses a risk management model (monitoring, observation, and custodial care) because it is relatively easy to deliver and serves the interests of the public. This model leaves little room for the suggested psychotherapeutic approaches, particularly for those that are deemed low risk but who in fact represent the majority of people that repeat self-harm (Kapur, 2005). Kapur (2005) comments that providing psychological interventions as suggested in the National Institute for Health and Care Excellence (2011) self-harm management guidelines is unrealistic in the current state of services in the UK given a lack of availability of such interventions. This could also be said for the state of mental health services in New Zealand.
What became apparent was that coroners have a tendency to take a protective and custodial stance, which was reinforced by societal and family expectations and organisational policy and guidelines. However, the consumer perspective, expert opinion and clinical research evidence were found to be lacking, which leaves little to counteract these influences that enforce the risk discourse. Given this lack of balance, it is unsurprising that a number of the recommendations promoted safety over the use of less restrictive measures and consumer autonomy. Arguably recommendations that focus on risk and containment do little to improve the overall care provided by services and work to perpetuate the risk discourse that is already prevalent in mental health services. Interestingly, the SMHS participants indicated that these recommendations were likely to be implemented, possibly because they align with organisational risk-averse interests. Coronial recommendations do not target the need for more adequate resource and treatments, perhaps because it goes beyond the scope of the inquiry. However, by focusing recommendations on risk assessment and management, the attention and funding required from government and SMHS is directed away from what is probably more therapeutically useful for consumers and therefore more likely to actually contribute to suicide prevention.

**Restricting Access to Means**

One sub-category, access to means of suicide, was singled out from other restrictive management coronial recommendations by the SMHS participants are being useful and potentially an area that coroners could address more often. The rationale given by the SMHS clinicians was that this has been proven to be an effective suicide prevention strategy. The World Health Organization (2014) executive summary of suicide prevention methods clearly outlines that restricting access to means works to prevent suicide and it is also identified in the 2006-2016 New Zealand Suicide Prevention Strategy as a key initiative (Associate Minister of Health, 2006). These assertions are also well supported by the research including a recent major systematic review of the evidence of suicide prevention strategies (Zalsman et al., 2016).

Suicidal impulses are often changeable and people are thought to have a high level of ambivalence about acting on suicidal thoughts. This may be a factor that makes suicide difficult to predict but it also means that the availability of means can influence the occurrence and outcome of suicide (Hawton, 2007). Research findings also indicate that
the loss of availability of the preferred means, does not usually result in the substitution of
another means (Hawton, 2007). A convincing example given by Hawton (2007) is the
change in domestic gas supply in the UK during the period between the 1950s and 1970s.
Following a change from carbon monoxide to natural gas, a significant drop in suicide by
carbon monoxide poisoning occurred and only a small increase in the use of other means
was seen. Therefore, the prevention of many thousands of suicides occurred due to this
single measure (Hawton, 2007). Another example is the erection of barriers on Grafton
Bridge in Auckland, New Zealand. Following the completion of the bridge in 1910, it
became a renowned place for suicide. In 1937 steel barriers were constructed as a result of
a coronial recommendation, which reduced the incidence of suicide (Beautrais, Gibb,
Fergusson, Horwood, & Larkin, 2009). However, in 1996 they were removed again by the
council following public complaints that the barriers were unsightly and impeded attempts
to rescue people who had were attempting to jump from the bridge. Subsequently, a
significant increase in the incidence of suicide from the bridge occurred. This prompted
coroners and researchers to lobby to the council to re-erect a barrier and consequently a
more secure perspex barrier was installed in 2003. There have been no further incidents of
suicide at the site since this time (Beautrais et al., 2009).

The SMHS participants commented that restricting access to means was an area that
coroners were in a position to make more headway on, given the broad overview of cases
that they review and their ability to influence social change and public policy. Yet, only
five of the 136 recommendations that were included in this study pursued this aspect of
treatment. The research and examples provided above reinforce the participants’
perspective that this is an area of suicide prevention that has the potential to be further
maximised by coroners.

**Communication and Collaboration**

Just over a quarter of all the recommendations to SMHS during the period sampled
targeted communication. In these cases coroners uncovered sub-optimal inter-agency
communication between SMHS and other providers, as well as concerns regarding internal
communication and the quality of documentation as a means of exchanging information.
These recommendations suggested the need to strengthen the links between various
providers and internal services by increasing collaboration and sharing of information.
These suggestions are well supported by the literature as important aspects of health care delivery (Darlington, Feeney, & Rixon, 2005; Glasby & Lester, 2004; Minister of Health, 2016). The SMHS clinicians also acknowledged that these recommendations were legitimately identified and that they acted as good reminders about the importance of adequate communication.

Having a more cohesive team approach across health and disability services has been identified as one of the key objectives in the New Zealand Health Strategy (Minister of Health, 2016). This government policy stipulates that in order to achieve a collaborative approach, organisations need to work towards shared goals and work beyond organisational boundaries. An enhanced team approach to health care will mean that health care consumers will experience an improved journey through the system and “joined-up” care that shows different organisations are working as one unified team (Minister of Health, 2016). Other advantages of enhanced collaboration include co-ordinated resourcing, greater accountability and reduce organisational fragmentation (Glasby & Lester, 2004). A review of the evidence for suicide prevention interventions also found that better structure and collaboration between services, hospitals, and teams during post suicide attempt follow-up care may improve compliance with treatment and decrease the occurrence of new attempts (Mann et al., 2005).

Although the benefits to collaborative ways of working in healthcare have been well integrated into government policy with a number of benefits documented including the potential to reduce suicide attempts, it is well recognised that effective inter-professional/agency communication is difficult to achieve due to a number of perceived barriers (Darlington et al., 2005; Glasby & Lester, 2004; Hudson, Hardy, Henwood, & Wistow, 1999). This may account for the SMHS reports that recommendations that target communication and collaboration are difficult to implement. The barriers to implementation described by the SMHS participants included the fragmented health system, time and resourcing constraints in practice, poorly integrated technology and privacy issues. All of these points are substantiated by the literature as authentic hindrances to effective communication (Darlington et al., 2005; Glasby & Lester, 2004). Beyond these structural, procedural and financial obstacles, professional barriers such as self-interest, inter-professional competition (Glasby & Lester, 2004), and a lack of common language...
between various health professionals (Hall & Slembrouck, 2009), have also been identified as possible reasons for poor communication.

Coronial recommendations that target communication both internally in SMHS and across organisational boundaries have been substantiated as being reasonable and in accordance with government policy. However, the impact of these recommendations is limited due to the SMHS limited abilities to act on the recommendations because of the previously described barriers. Suggestions of how to overcome these hurdles tend to promote an organisational approach. For example, Hudson et al., (1997, as cited in Glasby & Lester, 2004) proposes that in order to strengthen an organisation’s strategic methods of collaborative ways of working, organisations need to have shared visions, clarify roles and responsibilities, have incentives for staff and monitor achievements made. A wider systematic approach to the issues identified with communication may therefore be required.

**Family Inclusive Care in Specialist Mental Health Services**

A further significant issue that was identified by coroners was the way in which SMHS are working with family. It has been overwhelmingly shown in the research that there are considerable economic, social and clinical benefits to providing mental health services in a family inclusive way (Royal Australian and New Zealand College of Psychiatrists, 2000). Yet, the fact that the need to improve family inclusion is a major theme of coronial recommendations in New Zealand regarding suicide and the SMHS reports that this is an ongoing issue, strongly suggests that these services are not performing well in this area of practice. More concerning were the focus group findings that suggest the presence of deep seated issues regarding the way in which mental health clinicians are engaging and communicating with family, with cultures of negative and judgemental attitudes being identified.

Such findings are not new or confined to New Zealand. A recent international systematic review of the literature conducted by Rowe (2012) had similar findings. Obstacles to effective family caring identified in this review included families being discouraged by SMHS, not being listen to, ignored, judged and blocked out of treatment because of privacy, all of which strongly resonate with the findings of this study. Moreover, The
Mental Health Foundation of New Zealand published the findings of a qualitative study that sought to explore discrimination towards families of mental health consumers (Barnett & Barnes, 2010). The most prominent theme that emerged in this study was that discrimination towards family came from mental health services. Some of the issues that were identified included a lack of consultation, inclusion and information sharing, race and age discrimination, an over dominant medical model of practice and criticism or blaming of the primary support person (Barnett & Barnes, 2010).

Privacy was identified in this study as a significant barrier to the involvement of family, as it has been in other research (Gray, Robinson, Seddon, & Roberts, 2008; Rowe, 2012; Wynaden & Orb, 2005). Coroners encouraged information being obtained and disclosed with families, yet the SMHS participants and family and whānau workers reported privacy law to be a key barrier to this occurring. The New Zealand guidance notes for involving families published by the Ministry of Health (Royal Australian and New Zealand College of Psychiatrists, 2000) stipulate that when disclosure has been withheld by consumers, family members are still entitled to share information with mental health services and to receive support and general information that does not compromise confidentiality. However, the family and whānau workers interviewed in this study reported that families are blocked out of treatment due to privacy and that mental health clinicians appeared to lack the understanding that family can still be involved when there is a non-disclosure status. This is consistent with other research findings that describe professionals hiding behind ‘confidentiality smokescreens’ (Gray et al., 2008) or being unwilling to work with families because of privacy issues (Wynaden & Orb, 2005).

Proposals have been made about how poor family inclusion can be addressed, yet progress thus far appears to be less than desirable. Training and education for mental health clinicians has been suggested as a means of circumventing some of the issues identified (Gray et al., 2008). However, findings reported in in this thesis and by others (Rowe, 2012), have found there is a lack of progress being made and that training and initiatives have only resulted in minimal improvements. Families are entitled to respect, empathy, and recognition and mental health clinicians have responsibilities in ensuring they are well supported as partners in treatment (Rowe, 2012). Considerable progress is required for this to occur, including the need to shift the mental health organisational culture towards more positive family inclusive care (Gray et al., 2008).
Organisational learning describes the process of an organisation developing and using knowledge to change and improve themselves on an ongoing basis (Iles & Sutherland, 2001). Inquiries, such as those conducted by coroners, can be a catalyst for organisational learning to occur; however, this study’s findings suggest that the full potential of these educational benefits are not being achieved in SMHS in New Zealand. Similar findings have been made in other studies, such as Moore’s (J. Moore, 2014b) research that involved interviews with New Zealand coroners and recipients of recommendations. This study found that there was an overall perception that the prophylactic function of coronial inquiries was not being maximised. Likewise, a study that was conducted in England that explored what change occurs in the public health system following coroners’ recommendations found very little evidence that organisational learning is generated by coroners’ findings (Claridge et al., 2008). This lack of change engenders high levels of frustration for communities, families, services and coroners, particularly when the same issues are repeatedly occurring (Freckelton, 2005; Ranson, 2005).

There are a number of different factors that can contribute to wider organisational learning. The points for further discussion include implementing evidence-based practice and organisational culture, the application of therapeutic jurisprudence to coronial inquiries, the duplication of findings, the lack of obligation of recipients to respond to the recommendations, and how the findings are disseminated in SMHS.

**Implementing Evidence-Based Practice**

The effective integration of evidence-based practices [EBP] into mental health treatment can often take many years and in fact has been shown to take up to 20 years in some cases (Aarons, Wells, Zagursky, Fettes, & Palinkas, 2009; Drake et al., 2001). This is consistent with the SMHS participants’ reports that gaining the traction required to make effective change in clinical practice is particularly difficult. Meanwhile, existing practices that rely heavily on tradition, clinicians’ preference, political factors and clinical wisdom, can be potentially damaging consequences (Drake et al., 2001). It is firstly important to clarify what constitutes evidence, followed by considering what factors may be effecting the implementation of coronial recommendations that are conducive to research. This includes
how organisational culture effects change. Finally, how implementing EBP might be systematically approached is considered.

There are some clear differences in what is considered evidence by the courts and what is considered evidence in a clinical setting. EBPs are interventions that have reliable scientific evidence that shows they improve consumer outcomes (Torrey et al., 2001). The threshold for what constitutes scientific evidence can vary, but in general the highest standard of proof is the combination of many trials or studies, such as through meta-analysis (Torrey et al., 2001). The coroner comes from a legal position and must focus on what they are required to find pursuant to statute, which includes determining the circumstances of the death and identifying areas of future preventability (Freckelton & Ranson, 2006). ‘Facts’ in this regard involve determining the sequel of events that occurred leading to the death or in other words who did what and when. This does not meet the standard of proof required for clinical evidence, yet it is what informs coronial recommendations that potentially influence clinical practice.

For coroners to formulate well informed recommendations that are conducive to implementation they are required to assimilate vast amounts of information into their findings. Freckelton and Ranson (2006) highlight that this requires non-judicial skills akin to those of senior researcher analysts or policy developers found within high level bureaucracies. Currently the only accessible avenue for coroners to obtain clinical evidence is through the use of expert opinion. In the context of EBP implementation, the collection of expert opinion is considered the lowest form of evidence because it is not necessarily qualified by research (Torrey et al., 2001). Although expert opinion has the potential to improve the findings (particularly if the expert is well informed by the research), it is also possible that an experts perspective could be flawed based on the bias and knowledge of the individual. An example from earlier in the discussion is the ongoing use of risk assessment tools in practice. These methods are likely to be endorsed by an expert because they remain an accepted part of clinical mental health practice despite the more recent evidence that demonstrates the accuracy of these methods is poor. This highlights the earlier point that the assimilation of evidence into practice can be significantly delayed but also that the political influence of coroners can further compound the issue if their recommendations are not well informed. Ideally, coroners would benefit from further resourcing to ensure recommendations are evidence-based, but it is also the responsibility
of the recipient originations to evaluate the evidence-base of the recommendations before considering implementation.

Family inclusive treatment and enhanced communication are two categories of recommendations that have been clearly identified as fitting with the evidence-base. Yet significant progress is still required if the intent of these recommendations are to be fulfilled. This requires a more systematic response from organisational and governmental health departments to target the change to practice required. The need to identify potential barriers to implementation has been identified as an important step in the process of implementing EBP (Grol & Wensing, 2004). Earlier in the discussion the benefits for and barriers to family inclusive treatment and effective inter-agency communication were considered. These included infrastructural, economic, legal, political and cultural factors. This process is similar to a barriers to and incentive for analysis, which is a part of the process adopted in theoretical frameworks for implementing EBP (Grol & Wensing, 2004).

One of the identified issues with family inclusive care was a perceived negative culture in SMHS towards families. Organisational culture has been identified as a key factor that effects the implementation of EBPs (Aarons & Sawitzky, 2006). Culture describes the normative beliefs and shared behavioural expectations of a collective group of individuals (Glisson, 2002). The culture of an organisation is thought to be conveyed through employee behaviour. Such behavioural expectations are not only molded by organisations’ upper management values and beliefs, but are also a reflection of the demands of the work environment and the realities that workers face on a daily basis (Glisson, 2002). Therefore the social context of a work environment can determine how work is approached, prioritised, and committed to, as well as how individual members of the organisation socialise each other and interact with the clients (Glisson, 2002). High levels of stress and poor psychological well-being have been found among mental health professionals (K. Moore & Cooper, 1996; Reid et al., 1999). This may be an indication of the special demands of the work including regular exposure to highly emotive situations. If staff are feeling disempowered, stressed and burnt out, it is more likely to be conveyed in the work that they do. The identified negative culture towards families of mental health consumers may be a symptom of this.
A positive organisational culture and structure is central to how EBP are implemented (Aarons & Sawitzky, 2006; Glisson, 2002). Constructive cultures, that support the psychological safety of workers (Edmondson, 2004), that are low in emotional exhaustion and high in formalised support and trust, are required to allow clinicians to adhere to protocols that are demanding in energy and commitment to provide (Glisson, 2002). Aarons and Sawitzky’s (2006) study examined the association between organisational culture and mental health professionals’ attitudes towards implementing EBP. The findings of this study indicated that a positive organisational culture was associated with a more positive and open attitude towards EBP. Conversely, negative organisational cultures, characterized by emotional exhaustion, high levels of role conflict and depersonalisation, were associated with a divergence between the evidence-base and practice (Aarons & Sawitzky, 2006).

Similar findings have been made about organisational culture in the context of learning from adverse events. On the surface adverse events can appear to be largely clinical, such as inadequate treatment or misdiagnosis; however, the problems that are almost always uncovered are more entrenched, such as weak leadership, closed cultures, a lack of transparency, poor communication and disempowered staff that do not feel they can share concerns openly (Walshe, 2003). Such cultural factors are considered powerful inhibitors of learning and change (Iles & Sutherland, 2001).

Leadership, at executive, middle and informal levels, is considered by many authors as one of the key factors that shapes a constructive culture (Carroll & Edmondson, 2002; Edmondson, 2004; Iles & Sutherland, 2001). It is essential that leaders role model what is expected of individuals, that they communicate a compelling vision or purpose (Carroll & Edmondson, 2002; Iles & Sutherland, 2001) and provide empathy, support and advocacy (Iles & Sutherland, 2001). This also involves leaders demonstrating and rewarding reporting behaviour and avoiding individual blame or covering up of bad practice (Carroll & Edmondson, 2002).

The importance of organisational culture is also reflected in frameworks that aim to guide the implementation of EBP. For example, Michie and Colleagues (2005) suggest that the success of implementation relies on human behaviour. These authors draw on psychological theories of human behaviour to create a theoretical framework that includes
12 domains that can be used to initiate and structure the implementation of EBP. Some examples of these domains include; the nature of the behaviour (what needs to be changed); the knowledge and skills of the individuals involved; goals (what to aim for and how to achieve it); beliefs about consequences, capabilities and guidelines; the social and physical environment; and the stress and emotion involved in the change (Michie et al., 2005). Frameworks such as this may be useful when organisations and governmental health departments are considering how change can be initiated and maintained.

It is feasible to suggest that many of the coronial recommendations reviewed in this study require a more systematic response from mental health organisations and governmental health departments that goes beyond the service level they are directed at. The first step to change is the evaluation of the evidence that supports the proposed area of reform. This is particularly important when evaluating coronial recommendations given the previously described differences in what constitutes evidence in the courts, opposed to clinical evidence. Planning then needs to take into account potential barriers, the characteristics of the individuals effected by the change, as well as the social, organisational and political environment in which the change is going to occur (Grol & Wensing, 2004). The use of theoretical frameworks, such as the one devised by Michie et al. (2005), may also assist in the systematic approach required to make sustained change to practice.

**Therapeutic Jurisprudence**

A fundamental component of the inquest is that the findings will have pro-therapeutic outcomes (Freckelton & Ranson, 2006). This is at odds with individuals such as witnesses having negative experiences that are potentially harmful to their psychological wellbeing (Freckelton & Ranson, 2006). The role of the coroner is a difficult one. They are required to maintain a balance between rigorous, factual based decisions and the achievement of health-orientated objectives, whilst avoiding any unnecessary harm to those involved in the process (Freckelton, 2007). Recent legal literature has suggested that the principles of therapeutic jurisprudence need to be better integrated into coronial inquiries (Freckelton, 2007; King, 2008; Tait, Carpenter, Quadrelli, & Barnes, 2016). This involves the promotion of the behavioral science findings in legal proceedings as a means of reducing the negative effects of those involved in court processes (King, 2008). In more traditional court settings this
engages the use of mediation, restorative justice, and problem solving, but its application in the coronial setting more often relates to the emotional needs of families.

A finding made in this study was the perception of the SMHS leaders that the inquiries were justified even if they were not contributing to organisational learning and suicide prevention because they attended to the needs of the grieving families. The SMHS participants reflected that it was important for the family to have the death investigated by an external body, as well as have a forum to express their perspective about what had happened. It is hard to deny that in circumstances such as suicide, there is a need for grieving families to understand what has happened and to also voice their perspectives about what could be done differently to avoid others experiencing similar tragic outcomes. Yet, one could question if the needs of the family is adequate justification for coronial inquires on its own, particularly given this does not meet the objectives outlined in the The Coroners Act (2006). Additionally, the high cost (J. Moore, 2014b) and considerable effort that is expended during these inquires (Freckelton, 2005) demand additional benefits.

There is an increasing awareness that coronial inquiries can exacerbate the family of the deceased’s pain and reinforce the trauma already experienced (Biddle, 2003). It has been suggested that the more traditional approach of coroners separating themselves from the emotions of the family may not best serve all those involved and that alternatively the principles of therapeutic jurisprudence should be applied through coroners responding to families in a compassionate and caring way (Tait et al., 2016). Moreover, King (2008) goes further to suggest the creation of a pathways system that attends to individual families emotional needs, with interventions such as support officers, psychology or counselling input, and intensive case management being offered in certain circumstances. However, the fact that families are requiring such high levels of support from the coronial system, suggests that their needs are not being adequately met by potentially more suitable avenues of support and that despite the courts’ best efforts it is unlikely that the support provided will fully meet the complex needs of families bereaved from suicide. Families bereaved by suicide have been shown to experience higher levels of stigma, guilt, rejection and blaming (Sveen & Walby, 2008) and as a result, many people bereaved by suicide will require more specialised input (Hawton & Simkin, 2003). This may include the assistance of
bereavement services, suicide survivors support groups, and/or individual, group and family therapy or counselling (Hawton & Simkin, 2003).

Findings from this thesis also indicated that mental health clinicians experience high levels of stress and burden during coronial inquiries because of adverse experiences at inquest of being heavily criticised. This unwanted side effect of inquiries has been identified in other studies (Chiplin, Bos, Harris, & Codyre, 1998; Krawitz & Batcheler, 2006; Manuel & Crowe, 2014) and is also acknowledged by inquirers (R. Paterson, 2008).

Coronial inquiries are no longer interested in determining criminal liability, yet the fact finding nature of the process is misleading in that the purpose of the inquiries seem adversarial in nature (Freckelton & Ranson, 2006). A study conducted by Langer, Scourfield, and Fincham (2008) that reviewed suicide coronial case files in Britain revealed that all those involved in the inquiries were concerned with abdicating responsibility for the outcome. This included witnesses who had known the deceased, who in evidence highlighted that the suicide could not have been foreseen, medical professionals, who argued it was beyond their control, and the deceased, who left suicide notes that asserted they had no other choice. The authors note this finding is interesting given the inquest is not concerned with guilt, and suicide is not a criminal offence. Yet, the process is conducted within the confines of the legal system, which inevitably prompts those involved to present their involvement as favourably as possible (Langer et al., 2008).

Further exacerbating the defensive stance of those involved, is the desire for blame to be attributed during proceedings. The dynamics of coronial inquiries are complex and emotive. There is generally grief because someone has died and this grief can turn vengful, with individuals seeking retribution for those believed to be responsible (Freckelton & Ranson, 2006). A heavy influence from family during coronial inquiries has the potential to hinder organisational learning because of families’ expectations that accountability will be determined at the conclusion of coronial inquiries. Families’ desires to determine individual fault, which was established in Biddle’s (2003) research, is likely to perpetuate cultures of individual blame. Individual blame has been shown to be detrimental to organisational learning by increasing defensiveness and secrecy of those involved (Carroll & Edmondson, 2002).
The repercussions of clinicians' negative experiences also go beyond the immediate distress of being involved in the inquiries because encounters such as these has been found to increase defensive practice (Krawitz & Batcheler, 2006; Manuel & Crowe, 2014; Mullen, Admiraal, & Trevena, 2008). Defensive practice describes health professionals’ tendency to give priority to self-protection from blame over what is considered to be in the best interest of the consumer (Mullen et al., 2008). In mental health practice defensive practice often manifests as unnecessarily limiting consumers autonomy over concerns regarding risk. If clinicians’ decision making is unduly scrutinised during coronial inquiries, this will only work to further increase the pervasiveness of the risk discourse by promoting defensive practice.

There is potential for coronial inquiries to be pro-therapeutic in nature; however, this requires maintaining a balance between the objectives of the inquiries and the various agendas of the those involved. Firstly, it is essential that the needs of the family are balanced against the need for an inquiry environment that is conducive to learning. This may be better achieved if the families’ needs for support and specialised input are being more adequately met outside of the inquiry process. Coroners also have a responsibility to exercise caution to avoid individual blame if they want to promote learning and transparency from health organisations. Mok (2014) states that this can be executed by coroners consistently adopting a focus on the wider systemic context of what appears to be individual failures. Lastly, it is pertinent that a positive organisational culture is promoted by SMHS to reduce the negative effects of the inquiries on staff. This could be executed by the organisations role modelling a transparent approach and providing a high level of formalised support for those involved in the inquiries.

**Duplication of Findings**

Potentially the most emphasised point made by the SMHS leaders was that the inquiry findings were not contributing new knowledge. The SMHS leaders reported that in most cases they already had an awareness of what the services shortcomings were because they had been identified by the services themselves or other inquiries. The duplication between CSNZ and other investigatory authorities’ functions is a potential explanation for the lack of novel information being generated by coroners. This was also highlighted as one of the primary catalysts for the recent coronial reform (J. Moore, 2014b).
SMHS can be subject to a number of avenues of inquiry following a suspected suicide (Hobbs, 2001), most of which have educational purposes that aim to improve the overall quality of care in mental health services. Possibly the most extensive investigation that occurs following a suicide is the SMHS internal review. In New Zealand all DHBs use a consistent approach to reviewing adverse events in SMHS. The process used is call the Systems Analysis of Clinical Incidents: The London Protocol (Taylor-Adams, Vincent, & Street, 2004). This protocol was adopted specifically for mental health investigations because of the fit of the process for investigations of suicide. The purpose of the protocol is to ensure the investigation goes beyond identifying a particular root cause of an incident or individual faults, to a more thoughtful analysis of all the factors that may have contributed to the outcome. Recommendations that address the identified systems weaknesses are then generated and used to build an action plan (Taylor-Adams et al., 2004).

This thesis identified that a number of coronial recommendations were perceived to be purely endorsements of the findings produced by these internal investigations. Because these investigations are comprehensive and have been chosen specifically in New Zealand for mental health incidents, it begs to question whether coroners need to further duplicate the investigation from the judicial perspective or whether it is merely a bureaucratic process (Mok, 2014).

It is argued however, that coronial inquiries are still justified in these circumstances. Coronial recommendations that are a direct result of the internal findings may act to reinforce what the issues are and to provide services with some political footing to make changes, as suggested by the SMHS participants in this thesis. However, the main justification is the need to conduct the investigation from an external perspective to enable public confidence that the findings are unbiased (Freckelton & Ranson, 2006; Mok, 2014). What this emphasises is the fact that coronial inquiries are a social constitution that serve the needs of the public.

**Mandatory Response to Coronial Recommendations**

The lack of mechanisms in place for follow-up once coronial inquiries are closed has been repeatedly identified as a factor that contributes to a lack of organisational learning occurring (Claridge et al., 2008; Ranson, 2005; Walshe, 2003). Once inquiries are closed,
media attention and outside scrutiny reduces and the crucial process of implementing recommendations and making the changes required is not always followed through comprehensively (Walshe, 2003). This lack of follow-up was reflected in the SMHS leaders comments that implementation of coronial recommendations is not always robust because of the inability to gain the momentum required to make substantial change. Walshe and Shortell (2004) suggest that a more forceful approach is required if inquiry findings are going to be truly implemented.

There has been much debate in New Zealand and internationally about the formalisation of recipient written response to coroners’ recommendations (Mok, 2014; J. Moore, 2014b; Ranson, 2005). Such a response would outline the steps an organisations has taken or intends to take in response to the recommendations or the rationale for not taking action. With the recent changes from the The Coroners Amendment Act (2016), recipients of coronial recommendations will have a 20 day time frame to comment on proposed recommendations before the findings are finalised by the coroner. This response is not mandatory, nor is there any requirement for recipients to reply to coroners about the implementation of recommendations. Such a consideration was excluded from the reform because of the cost to the Government that such a change would incur (J. Moore, 2014b), as well as the perception held by Government that recipients of recommendations routinely respond without it being obligatory (New Zealand Government, 2016). However, findings from this thesis, along with other research (Freckelton, 2005; J. Moore, 2014b), support further investigation of a change in legislative requirements for recipients to respond formally to coroners’ recommendations.

One of the perceived advantages of mandatory response reported by the SMHS leaders interviewed in this study was the provision of feedback to coroners to improve the quality of recommendations. The absence of recorded information following the closure of inquiries has been identified as a contributory factor to coroners’ preventative functions not being maximised (Freckelton, 2005; J. Moore, 2014b; Ranson, 2005). The systematic collection of this information by CSNZ could be used to inform future recommendations, thus enhancing their potential to make recommendations that assist in the prevention of suicide. For example, if CSNZ received repeated replies that recommendations that targeted risk assessment were considered to have little value, coroners may be less inclined
to focus as much attention on this aspect of care in future inquiries, therefore increasing the chances of identifying issues that have more worth.

The second benefit of mandatory response cited by the SMHS leaders was increasing the accountability of recipients to take action. This has particular relevance given it was also implied by these participants that implementation was not always robust. Having a level of accountability to report on implementation action for well evidenced recommendations may influence services to consider how more meaningful change could occur, particularly when it is a repeatedly identified issue. Additionally more open communication about what is inhibiting progress on the issues identified may result in enhanced learning for the organisations and coroners.

**Dissemination of Findings**

The final factor that requires consideration is the dissemination of coronial findings in SMHS. This study findings uncovered that coronial inquiry findings are rarely shared beyond SMHS management and the staff involved in the inquiry. Such a lack of dissemination of inquiry findings has been cited as a significant factor that impinges learning from health care failures (Leape et al., 2009; Walshe & Shortell, 2004). The hesitation in healthcare to distribute inquiry findings has been attributed to cultures of defensiveness, secrecy and blame (Walshe & Shortell, 2004). It is argued that in order to promote a culture of learning and safety a high level of transparency is required. This involves the need for clinicians and organisations to readily share lessons about failures with each other, with consumers, across organisations and with the public (Leape et al., 2009).

Concerns were raised by the SMHS leaders in this study that the privacy of the clinicians involved acted as a barrier to openly sharing inquiry findings. However, if cultures of learning, collective responsibility and transparency were promoted in organisational culture, individual clinicians may feel less vulnerable when inquiry findings are shared. Coroners’ responsibility to avoid individual scrutiny and blame in the reports would also be essential to avoid clinician anxiety regarding accountability being exacerbated by wider distribution of the findings. It is also argued that the more open sharing of information could actually support learning, encourage a more positive culture, and ultimately avoid
further costly inquiries by preventing similar future events occurring (Carroll & Edmondson, 2002).

The privacy of the deceased and the family was also highlighted as a concern when considering the wider dissemination of inquiry findings amongst mental health staff. The unwarranted invasions of privacy of the deceased and their family needs special consideration, particularly given the potential for the exacerbation of the family’s distress and trauma (Mok, 2014). An obvious consideration is the exclusion of identifying information from reports prior to distribution, which is common practice in educational settings when cases studies are used for learning purposes. In addition to this, the distribution of findings could be decided on an individual case basis, depending on the projected learning benefits and whether it is conducive to the families’ wishes.

This section has argued that in order for coronial recommendations’ educational objectives to be maximised in the SMHS context, SMHS need to consider how organisational culture impacts on the ability of the services to learn from the inquiries including the importance of effective leadership, high staff morale, trust and transparency. Moreover, the literature also suggests that coronial findings should be more widely distributed in SMHS and beyond. Coroners also have a role in promoting organisational learning by focusing on the wider systematic context of mental healthcare failures and CSNZ could consider how the needs of the family are balanced with the educational purposes of the inquiries and whether mandatory response to coronial recommendations should be given more consideration.

Implications for Specialist Mental Health Services

There are a number of important implications from the findings for SMHS. This includes the need for special consideration regarding the clinical credibility of coronial recommendations prior to implementation and the identification of areas of mental health service delivery that have been clarified as requiring attention. Moreover, it has been highlighted that SMHS need to consider how they could improve their response to coronial recommendations that have merit by promoting a more positive, learning and transparent organisational culture and having a wider systematic response to implementing change. The dissemination of the inquiry findings also needs special consideration.
Firstly, the findings indicate that coronial recommendations that target risk and restrictive practices are routinely implemented, which is influenced by a perceived socio-political pressure to do so. This is despite the body of literature that suggests risk assessment is often inaccurate (Windfuhr & Kapur, 2011b), potentially has no discernible effect on suicide statistics (Large, Ryan, et al., 2011) and that many of the interventions used to manage the perceived risks may have damaging consequences (Szmukler & Rose, 2013). One participant admitted to implementing a nursing observation recommendation that they had misgivings about because of the perceived political pressure. The participant conceded that this change in practice probably had detrimental effects on the treatment of consumers. What this highlights is the need for SMHS to reflect more on their decisions whether to implement coronial recommendations to ensure they are based on the clinical credibility of the recommendations rather than being driven by socio-political factors.

A number of areas of concern regarding the delivery of care to consumers of SMHS were also identified. The findings established that families need to be more genuinely involved in the care and treatment of mental health consumers, internal and inter-agency communication in SMHS requires improvement, and SMHS need to provide clear and accessible pathways to appropriate care for suicidal consumers and avoid delays to treatment. However, the findings also indicate that SMHS may not be taking full advantage of these lessons and that a more systematic response to successfully implement evidence-based practices may be required.

A beginning point for change may be the consideration of whether the organisational culture is acting as a hindrance to the services making more meaningful change and if so how a more constructive culture of high staff support, enhanced leadership and transparency can be promoted in SMHS. For example, the discriminatory and judgemental culture towards families reported in this thesis could well be a symptom of a more entrenched negative culture. This indicates the need for a broader response that targets the overall morale of staff though enhanced leadership. If members of the workforce feel valued, receive adequate resourcing and education and are recognised for the work they do, an environment is created that allows for improvement (Leape et al., 2009). The construction of a more positive culture could then translate to more positive interactions with family, as well as consumers and the public alike.
It is also crucial that a culture of wider organisational learning rather than individual fault finding is promoted by SMHS, given the evidence suggests blame inhibits organisational learning and change (Carroll & Edmondson, 2002). It was uncovered that mental health clinicians experience high levels of stress and burden as a result of being involved in inquiries because of feeling scrutinised. It is therefore essential that SMHS staff are well informed about the purposes of coronial inquiries to discredit the common perception that they are about individual accountability. Mental health clinicians need to have an understanding that the majority of the information collected from them during the inquiries is to assist the coroner in determining the circumstances of death, rather than trying to find fault. Furthermore, it is important that mental health clinicians are well supported by SMHS during the process of coronial inquiries to minimise the distress that can occur. This information and support may assist clinicians in shifting their focus from their own accountability to what can be learnt from the unfortunate outcome.

The findings also support the need for more transparency through the sharing of coronial findings. This includes the dissemination of the findings beyond those involved in the inquiry to the wider SMHS staff and the collection of coronial inquiry findings to gain a cumulative understanding of health care failures across a series of events (Leape et al., 2009; Walshe, 2003). It is essential that SMHS staff are informed of inquiry outcomes so that they have an awareness of what the repeatedly identified issues are so that they work towards improving those areas of practice. Furthermore, for true transparency and learning to occur the findings need to be shared with consumers and their families, across DHB boundaries, and the wider public (Leape et al., 2009). All of which needs to be done in a way that maintains the privacy of the deceased and their family and is considerate of the staff involved in the inquiries.

Given the issues that have been identified and above suggestions for change are not specific to individual settings, the motivation and drive for change needs to come from a national level. A systematic approach to change requires extensive planning and forethought, implementation and evaluation (Iles & Sutherland, 2001) Additionally, for sustained change to be achieved ongoing resourcing, supervision and feedback is required (Torrey et al., 2001). A shift in paradigm is needed through the adoption of a new approach that focuses on the individual needs of consumers and their families rather than treatment dictated by risk status. For this to be actualised, a reorganisation of services would be
required with a shift in focus from a medical and risk model of care to one that truly promotes the recovery model. This can occur at local levels but services need to be well equipped to make the changes necessary. This requires direction, encouragement, assistance and resourcing from governmental departments, as well as collaboration from the wider social context of health delivery including coroners.

**Implications for Coronial Services of New Zealand and Coronial Law**

There are also a number of implications of the findings for CSNZ and New Zealand coronial law. This includes the need for better resourcing of CSNZ to ensure all recommendations have clinical credibility, the need for a more balanced approach between safety and mental health consumer autonomy from coroners, further consideration of how grieving families’ needs can be met and further contemplation of statutory obligation of recipients to respond to recommendations.

The first implication relates to the need for better resourcing of CSNZ to ensure coroners’ recommendations are well evidenced based. Although a number of the coronial recommendations received by SMHS were considered appropriate, concerns were raised that at times coronial recommendations demonstrated a lack of understanding on behalf of the coroner regarding the more intricate details of mental health service delivery. It was perceived that a large variation was seen in the knowledge of coroners regarding mental health and suicide prevention and that the quality of the recommendations depended on which coroner was conducting an inquiry. This suggests the need for better resourcing to ensure that the recommendations made by coroners are of consistent quality and based on research rather than individual knowledge.

Ideally, the adoption of a system that is similar to that of the state of Victoria, in Australia would assist coroners in fulfilling their preventative functions. This model includes a specialised unit called the Coroners Prevention Unit (CPU) which was created to enhance the preventative aspects of the system by providing coroners with expert advice (J. Moore, 2014b). A multi-disciplinary team works in the unit including persons trained in law, medicine, public health, and the social sciences. The tasks of the unit involve the collection
and analysis of data that relates to reportable deaths, consultation with key stakeholders and the assessment of relevant policies (J. Moore, 2014b). This team and the information they provide assists coroners during their investigations, when they are developing recommendations and following the inquiries by collecting responses to recommendations (J. Moore, 2012). This type of resource would inarguably lead to enhanced recommendations and is also supported by other researchers (J. Moore, 2014b).

If the adoption of a system such as this is not viable for CSNZ, at the very least it is essential that coroners employ the services of experts when making recommendations to SMHS, especially when they have implications for clinical care. A coroner can have cultural, legal, medical or other specialists sit with them for advice during an inquest (The Coroners Act, 2006) and as described by SMHS in this study, the employment of these services is perceived to increase the validity of the recommendations being made. It is also important that the use of expert opinion is not constrained to medical experts such as psychiatrists because input from other advisors, such as cultural, consumer or family, may allow for a more balanced perspective from coroners when generating their recommendations.

Concerns were also clearly raised in the findings about recommendations that target risk, safety, and restrictive interventions. This is because these recommendation have a role in fuelling the prevailing risk discourse by igniting organisational, clinician, and societal anxiety and yet the majority of them appear to contribute very little to what might be more useful to consumer’s recovery. Given clinicians’ limited capabilities to correctly identify suicide risk, the literature suggests suicide prevention strategies are better targeted at looking at the treatment and care of people experiencing psychiatric difficulties (Appleby et al., 1999). To better achieve the objective of contributing to suicide prevention, the findings have enforced the need for coroners to focus less on risk and safety and more on what is consistent with the literature as being therapeutically useful. Less scrutiny from coroners regarding risk assessment and a more balanced approach between safety and consumer autonomy could potentially de-escalate the risk discourse in mental health clinical contexts, resulting in SMHS and clinicians focusing on interventions that are more therapeutically useful for the consumer.

An area of potential focus from coroners that was highlighted as being particularly useful was the targeting of restriction to means. A small number of recommendations were
directed at this well evidenced suicide prevention strategy. As emphasised by the SMHS participants, coroners are well placed to make these recommendations because of the broad overview of cases of suicide that they review. Furthermore, the high public attention that the inquiries incur and their ability to influence public policy means they have the political footing required to generate change. Given the strong evidence base of this intervention for suicide prevention, restricting access to means may be an area in need of additional focus for coroners. This potential could be further enhanced if coroners were assisted by better resourcing.

The findings also highlight that coroners have an important role in promoting organisational learning by avoiding individual blame. It was uncovered that mental health clinicians still experience high levels of individual scrutiny and criticism during coronial inquiries. This type of individual blame is known to be detrimental to organisational learning because clinicians remain preoccupied with accountability rather than learning (Carroll & Edmondson, 2002). Concerns over accountability also reinforce the risk discourse by encouraging clinicians to practice in defensive and ultimately more coercive ways as a means of avoiding the potential for criticism (Passmore & Leung, 2002). It therefore is essential that coroners adopt a wider systematic focus during their investigations and avoid closely examining individual practices.

The findings also established the perception held by SMHS that the main function of coronial inquiries was to serve the needs of grieving families, as opposed to learning and suicide prevention. This suggests the needs of families bereaved by suicide may not be well balanced with the need to achieve the learning functions of the inquiries. It is recommended that further investigation is made regarding the needs of the family and whether these could be better met in other more suitable forums outside of the inquiry process.

The final implication from the findings is relevant to recent coronial law reform and the debate regarding mandatory response to the recommendations being made. Clear support for mandatory responses to coroners regarding their recommendations was established, with the rationale that responses would increase the quality of the recommendations being made through feedback to coroners, as well as ensuring accountability of the recipients to act in response to viable recommendations. The further investigation of recipients’
obligations to respond to recommendations is also supported by other research findings. This includes Moore’s (2014b) study that found a compulsory regime was favored by New Zealand coroners and a variety of other recipient organisations and Watterson et al. (2008) study that suggested an enforced approach may reduce the incidences of lost or mishandled recommendations. Given the large expenditure already outlaid on the inquiries, there is a need to enhance the benefits of the system by increasing the quality of recommendations and meaningful subsequent action. Mandatory response could be considered as a factor that could potentially assist in achieving such heightened benefits.

**Limitations and Strengths of the Study**

There are a number of limitations to this study that require consideration when evaluating the findings. The primary limitations relate to the research aims of the study. Confining the investigation to cases of suicide gave the study a specific focus but this did not allow for the collection and discussion of recommendations that are directed to SMHS as a result of other outcomes, such as homicide or death by physical illness or injury. Moreover, the scope of the investigation only aimed to gain the SMHS and family and whānau worker perspective of the first phase results, which did not include the consumer, coroner perspective, or families of individuals that have died from suicide. Although the consumer perspective was considered in the discussion of the findings, consumers were not interviewed about the recommendations that are made. Gaining the consumer viewpoint may have contributed further insights into how well coroners’ recommendations fit with current mental health philosophies and establish if the consumer perspective is being captured in coronial inquiries. The coronial perspective was portrayed through the analysis of their recommendations in the first phase of the study; however, interviews with coroners may have also added further understandings. Not interviewing families of the deceased is a further limitation of the study. The investigation of the family and whānau worker perspective provided corroboration of the recommendations, as well as some further insights regarding the issues that are apparent with family inclusive treatment in SMHS. However, this line of enquiry was limited in that it did not explore the families bereaved of suicide perspectives of the recommendations or their experiences of coronial processes.
The Likert-Type scales allowed for the systematic collection of information during the second phase of the inquiry and provided an overview of the SMHS participants’ responses. However, the scales were rated based on the SMHS leaders’ estimations and retrospective memory so the results need to be interpreted cautiously. This is particularly relevant to the rates of implementation findings, which could not be based on recorded data due to the lack of availability of such records. This may have been a factor in the higher rate (n=5) of non-applicable answers for question five of the SPCRIS that focused on implementation. It was also noted that a higher rate of neutral responses were provided for the risk assessment and management and restrictive management categories, while the qualitative answers indicated a higher rate of disagreement to the appropriateness of these recommendations. A possible explanation for this is the use of the neutral answer as a means of avoiding what the participants might perceive as a less socially acceptable answer. The tendency for participants to do this is a known limitation of Likert-Type scales (Johns, 2010). The use of Likert-Type scales potentially may have limited the amount of qualitative data collected; however, the use of open ended unstructured questions alongside the rating scales potentially circumvented this issues.

It is also acknowledged the researcher’s identity would have influenced the generation of the findings. This is an accepted part of a qualitative research process (Gerrish & Lacey, 2006). The inclusion of the researcher’s position in the methods chapter allows for the reader to interpret the findings in this context and the described methods were applied rigorously to reduce the impact of the researcher.

The invitation for SMHS to participate included all 20 DHBs in New Zealand and 16 people from 12 DHBs were recruited. This is reasonable given the small purposeful sample and the qualitative dominant nature of the inquiry. Recruitment for the family and whānau focus group was restricted to one geographical area which could have biased the findings. However, the results were validated by other research findings.

Despite these limitations, the study also had strengths. It is the first study to systematically analyse coroners’ recommendations directed to SMHS regarding suicide in New Zealand. This provided a national overview of what coroners are identifying as areas in need of improvement in the delivery of SMHS. Exploring these findings from the SMHS and family perspective, as well as in the context of the clinical research, established some
aspects of service delivery that require attention. Given the improvement of care for people experiencing mental illness has been identified as a key action for suicide prevention in New Zealand, these findings have important implications. The investigation of the SMHS perspective of coronial processes also contributes to the emerging body of research that is examining how these inquires could better achieve their aims.

**Implications for Further Research**

Given this is the first study of its kind to explore the topic, it is also essential that further research is conducted to corroborate and further explore the findings. The areas suggested for further investigation include the exploration of coronial recommendations to SMHS that are a result of deaths other than suicide, gaining the consumer, family and coronial perspective of the topic, studying the impact of the inquiries on SMHS service delivery and suicide prevention in more depth, and the ongoing need for further research into suicide.

The first point relates to the limitations of the scope of this study that have been previously outlined, including the restriction of cases to suicide and the second phase aims. It would be useful to further explore what recommendations are being made to SMHS regarding deaths that have occurred due to other outcomes such as homicide or physical illness and injury. This would further ascertain if there are other areas of SMHS delivery that stand-out as requiring attention. Moreover, as previously mentioned the current study did not interview consumers, coroners or families bereaved of suicide, which is also warranted if a full understanding of the issues identified are to be completely explored.

The findings also suggest the need for further exploration of how coronial inquires impact on mental health service practice in New Zealand. This includes the need to more specifically investigate what systems are used to follow-up once inquiries are closed, as well as further exploring what organisational learning and change occurs as a result of the inquiries. This may involve gaining the perspective and experience of clinical staff to ascertain what individual learning occurs as a result of coronial inquiries. The findings have also indicated that coronial inquiries can induce a stress response in clinical staff. A more in-depth investigation into this aspect of the findings may be useful to better
understand why this is the case, how this influences clinical practice and what could be done to mitigate this negative consequence of the inquiries.

Lastly, it has been highlighted that there remains major gaps in our knowledge about how suicide can be prevented in the mental health service context. Given around 40% of individuals that die from suicide have had known involvement with SMHS in the year prior to death (Ministry of Health, 2015a), the relationship between SMHS delivery and suicide is an ongoing important consideration for future research.
References


Reid, Y., Johnson, S., Morant, N., Kuipers, E., Szmukler, G., Thornicroft, G., . . .


Appendices
Appendix 1:
University of Otago Ethics Approval Letters
Professor M Crowe  
Department of Psychological Medicine (ChCh)  
Terrace House, 4 Oxford Terrace  
University of Otago, Christchurch

30 August 2013

Dear Professor Crowe,

I am again writing to you concerning your proposal entitled “The Mental Health Service Response to Coroner Recommendations”, Ethics Committee reference number H13/015.

Thank you for your email of 27 August 2013 providing your revised documentation and evidence of Maori consultation. Thank you for the amendments made to your Information Sheet and Consent Form.

On the basis of this response, I am pleased to confirm that the proposal now has full ethical approval to proceed.

Approval is for up to three years from the date of this letter. If this project has not been completed within three years from the date of this letter, re-approval must be requested. If the nature, consent, location, procedures or personnel of your approved application change, please advise me in writing.

Yours sincerely,

Mr Gary Witte  
Manager, Academic Committees  
Tel: 479 8258  
Email: gary.witte@otago.ac.nz

c.c. Professor R Mulder  Head  Department of Psychological Medicine (ChCh)
Professor M Crowe
Department of Psychological Medicine (ChCh)
Terrace House, 4 Oxford Terrace University of Otago, Christchurch

Dear Professor Crowe,

I am again writing to you concerning your proposal entitled “The Mental Health Service Response to Coroner Recommendations”, Ethics Committee reference number H13/015.

Thank you for recent request to amend the above study.

The Committee notes that it is your intention for the second phase of the study to include a focus group interview of local family advisers and support workers in addition to the semi-structured interviews that will be conducted with Mental Health Nursing Directors and Chiefs of Psychiatry from all NZ District Health Boards as outlined in the original submission.

The Committee accepts and approves the amendment requested. Your proposal continues to be fully approved by the Human Ethics Committee. If the nature, consent, location, procedures or personnel of your approved application change, please advise me in writing. I hope all goes well for you with your upcoming research. Yours sincerely,

Mr Gary Witte
Manager, Academic Committees
Tel: 479 8256
Email: gary.witte@otago.ac.nz

c.c. Professor R Mulder  Head  Department of Psychological Medicine (ChCh)
Appendix 2:
National Coronial Information System Access Agreement
Access Agreement
for the National Coronial Information System

Department of Justice for and on behalf of the State of Victoria

and

University of Otago

Through the

Department of Psychological Medicine

<NZ002>
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PARTIES:

The Department of Justice for and on behalf of the Crown in Right of the State of Victoria

(Department)

and

University of Otago, through the Department of Psychological Medicine

(Authorised Organisation)

1. Background

A. The National Coronial Information System, previously known as the National Coroners Information System, (NCIS) is a national data storage and retrieval system for coronial information that has been designed to provide a high quality information system to Australian and New Zealand Coroners, their staff, public sector agencies, and researchers with an interest in public health and safety.

B. Pursuant to a Licence Agreement entered into between the Department and each Participating Jurisdiction, the Department is authorised to:

1. Store and access Data on the NCIS; and
2. Allow Authorised Users and Third Parties to access Data in accordance with the Access Rules attached to the Licence Agreement.

C. The Authorised Organisation wishes to gain, and has applied to the Department for, access to those items of Data specified in the Application. Access to the specified items of Data will assist the Authorised Organisation in complying with the purposes set out in Schedule 2.

D. The Application has been approved by the Ethics Committee and/or other Approving Parties, subject to the Authorised Organisation entering into this Agreement, including any Special Conditions set by the Ethics Committee and/or other Approved Parties.
GENERAL CONDITIONS

2. Interpretation

2.1 These definitions apply to this Agreement, unless a contrary intention appears:

“Access Permissions” means a user name and password to enable access to Data via the internet only at the level of data access that has been approved by the relevant Ethics Committee/s and/or other Approving Parties.

“Access Rules” means the rules relating to access to the Data set out in the schedule to the Licence Agreement.

“Access Agreement” means this agreement executed in writing between the Department and a third party which entitles that third party to access the Data, either via online access or such other means as agreed between the parties, subject to any specified terms and conditions.

“Application” means an application for access to Data in the form approved by the Ethics Committee and/or other Approving Parties, which is completed by the Authorised Organisation when it wishes to access Data, or parts thereof.

“Approving Parties” means the Chief Coroner of New Zealand.

“Authorised Organisation” means a third party organisation with which the Department has entered into a written Access Agreement.

“Authorised User” means an employee, servant or agent of the Authorised Organisation nominated in Schedule 6 and approved by the Department or such other employee, servant or agent subsequently nominated in writing by the Authorised Organisation and approved by the Department;

“Coroner” means the State Coroner, the Chief Coroner, or the Chief Magistrate responsible for coronial matters.

“Data” means the coronial information provided by Participating Jurisdictions and compiled, collated and stored in the NCIS, and includes personal information.

“Ethics Committee” means a Health and Disability Ethics Committee (HDEC), which is a Ministerial Committee established under section 11 of the New Zealand Public Health and Disability Act (2000), whose function is to ensure that the research meets or exceeds established ethical standards.

“Identifying Data” means any data, whether information or an opinion and whether true or not, which does or may tend to identify an individual, whether or not that individual is the subject of the coronial investigation or otherwise.

“Licence Agreement” means one of the licence agreements entered into by the Department with each Participating Jurisdiction.
“NCIS” means the National Coronial Information System, being a remote data entry and retrieval system, managed by the Department.

“NCIS Privacy Protocols” means the NCIS Privacy Protocols developed by the NCCCI for the NCIS and endorsed by the Standing Committee of Attorneys-General on 27 July 2000, and any amendments to that document subsequently endorsed by the Standing Committee of Attorneys-General.

“Participating Jurisdictions” means those jurisdictions that provide coronial information to the NCIS.

“Parties” means the parties to this Agreement.

“Relevant Coroner” means the State or Chief Coroner of the jurisdiction which specific Data originated.

“Schedule” means a Schedule to this Agreement.

“Special Conditions” means reference to any conditions specified by the Ethics Committee or other Approving Parties outlined in Schedule 1 of this Agreement.

“Third Party” means any individual, organisation or agency with a statutorily mandated statistical function or with a role in research into, or development of, policy for public health and safety.

2.2 Words importing the singular number include the plural and words in the plural include the singular.

2.3 Words importing a gender include any other gender.

2.4 Clause headings are for a convenient reference only and have no effect in limiting or extending the language of the provisions to which they refer.

2.5 A reference in this Agreement to a statute or a section of a statute includes all amendments to that statute or section referred to or incorporating any of its provisions.

2.6 No rule of construction will apply to a clause to the disadvantage of a Party merely because that Party put forward the clause or would otherwise benefit from it.

2.7 The Background and the Schedules form a part of this Agreement.

3. Term

3.1 This Agreement operates for the term specified in Schedule 1, unless otherwise varied or terminated in accordance with this Agreement.
4. **Purpose**

4.1 The Authorised Organisation warrants that all Data obtained from the NCIS will be used solely for the purposes specified in the Application.

5. **Access**

5.1 The Authorised Organisation is granted the right to access the Data items specified in Schedule 3, in accordance with the terms and conditions set out in this Agreement, including the Special Conditions noted in Schedule 1, and the Access Rules.

5.2 The Authorised Organisation will ensure that it and the Authorised Users will neither alter nor modify in any way original items of the Data to which they have access.

5.3 The Authorised Organisation acknowledges that a Coroner responsible for a particular case may determine that access to Data relating to that case be restricted to specified persons, and that the Department is bound by such a determination.

5.4 The Authorised Organisation acknowledges that if a Licence Agreement between the Department and one or more Participating Jurisdictions is terminated, the Authorised Organisation’s right to access Data provided by those Participating Jurisdictions will be terminated by the Department, and the Authorised Organisation may be required to return or destroy all originals, or copies, of such Data.

5.5 The Department will notify the Authorised Organisation in writing of any requirement to return or destroy Data in accordance with clause 5.4, specifying the date by which the Authorised Organisation must return or destroy Data.

6. **Other Information Requested**

6.1 If the Authorised Organisation requests access to coronial information other than the Data, the Authorised Organisation will direct such request to the Department and not to the Coroner’s Office of the Participating Jurisdiction.

7. **Access Fee**

7.1 The Authorised Organisation agrees to pay the fee or fees for access set out in Schedule 4.

8. **Security Obligations**

8.1 The Authorised Organisation warrants that it has in place in its organisation, and will comply with, for so long as the Data is in the possession or control of the Authorised Organisation, the security measures specified in Schedule 5.

9. **Authorised Users**

9.1 The Department may grant Access Permissions to one or more Authorised Users nominated by the Authorised Organisation where such persons are employees, servants or agents of the Authorised Organisation.
9.2 The Authorised Organisation nominates the persons set out in Schedule 6 to be Authorised Users.

9.3 If an Authorised User:

9.3.1 no longer requires Access Permissions for the purposes of their employment or service; or

9.3.2 leaves the employment or service of the Authorised Organisation,

the Authorised Organisation must immediately notify the Department in order that the former Authorised User’s Access Permissions be discontinued.

9.4 The Authorised Organisation may from time to time during the operation of this Agreement, nominate in writing replacement or additional employees, servants or agents to be Authorised Users.

9.5 The Authorised Organisation warrants that:

9.5.1 the Authorised Users nominated in Schedule 6 will not disclose their Access Permissions or any part thereof to any person whatsoever; and

9.5.2 whenever Data is left unattended by an Authorised User, it will be stored in a secure environment, such as a secure network file system, locked drawer or locked filing cabinet.

10. Disclosure, Release or Publication of Data

10.1 The Authorised Organisation warrants that neither it nor its employees, servants or agents (including but not limited to the Authorised Users) will disclose, release or publish Data to any other person or organisation, except as authorised by this Agreement.

10.2 The Authorised Organisation agrees that where it or its employees, servants or agents (including but not limited to the Authorised Users) disclose, release or publish Data, or reports based on Data, pursuant to clause 10.1, such disclosure, release or publication will represent the Data in an accurate and truthful manner and will not represent the Data in a manner that may be misleading.

11. NCIS Privacy Protocols

11.1 The Authorised Organisation agrees that it and all its employees, servants and agents will be bound by the terms of the NCIS Privacy Protocol, a copy of which is attached at Schedule 7.

12. Approval of Access

12.1 The Authorised Organisation agrees that it and all its employees, servants and agents will be bound by all and any of the Special Conditions in relation to the Authorised Organisation’s Application as outlined in Schedule 1.
12.2 The Authorised Organisation acknowledges that continued access pursuant to this Agreement is subject to the continued approval of the Ethics Committee and/or other Approving Parties.

13. **Contact with Next of Kin**

13.1 The Authorised Organisation agrees that neither it nor its employees, servants or agents will contact or seek to contact the next of kin or other family member of a deceased person to whom Data relates, without the prior express written permission of the Relevant Coroner.

14. **Identification of Issue of Concern**

14.1 If, in the course of accessing, reviewing or analysing Data, an Authorised Organisation or an Authorised User becomes aware of any issue of concern to public health and safety as defined in the “Guidelines Relating to Issues of Concern to Public Health & Safety” determined by the Coroners, the Authorised Organisation must immediately notify the Department.

15. **Data Matching**

15.1 The Authorised Organisation agrees that neither it nor its employees, servants or agents will attempt to match any Data with any other information for the purposes of attempting to identify individuals for any purpose other than Data verification.

16. **Publication of Identifying Data**

16.1 The Authorised Organisation agrees that it will not, without the express written permission of the Relevant Coroner or Coroners, publish any Identifying Data.

17. **Acknowledgement of Source Data**

17.1 The Authorised Organisation agrees that where it publishes any report or document, the content of which is based wholly or partly on Data, the Authorised Organisation will acknowledge:

- (a) The Department as the source organisation of that Data; and
- (b) NCIS as the database source of Data.

18. **Copies of Reports and Publications**

18.1 The Authorised Organisation agrees to provide to the Department a copy of all and any reports or documents produced using Data obtained pursuant to this Agreement prior to those reports being published.

19. **Copyright and Intellectual Property**

19.1 The Authorised Organisation acknowledges that copyright and intellectual property in the Data is at all times vested in the Participating Jurisdiction from which the Data originated.
20. **Disclaimer and Release**

20.1 The Authorised Organisation acknowledges and agrees that the Data has been acquired from various sources and therefore is recorded and stored at different levels of reliability.

20.2 Neither the Department nor any Participating Jurisdiction from which Data originated warrants that the Data is accurate or reliable and the Authorised Organisation agrees that the Department and any Participating Jurisdiction shall be in no way liable for any loss, damage or injury suffered by it or any other person or corporation consequent upon the existence of any errors in the Data.

20.3 The Department does not warrant that the Data when accessed will be capable of being processed on any computer equipment owned or used by the Authorised Organisation.

21. **Breach**

21.1 Where an Authorised Organisation or an Authorised User becomes aware of any unauthorised access or any breach of any of the provisions of this Agreement, the Authorised Organisation must immediately notify the Department.

22. **Suspension**

22.1 The Department may immediately and without notice suspend the Access Permissions of the Authorised Organisation where:

(a) required to do so by the written direction of a Relevant Coroner; or
(b) the Department becomes aware of any known or suspected breach of the provisions of this Agreement.

22.2 Where Access Permissions have been suspended in accordance with clause 22.1, the Department must:

(a) notify the Authorised Organisation in writing of the reasons for the suspension; and
(b) give the Authorised Organisation all reasonable opportunities to either disprove the known or suspected breach or to rectify the breach to the satisfaction of the Department and the Relevant Coroner.

23. **Termination**

23.1 This Agreement may be terminated:

(a) by the Department immediately and without notice where the Authorised Organisation itself, or through any of its employees, servants, agents or Authorised Users, is in breach of a condition of this Agreement;
(b) by the Department immediately and without notice where directed in writing to do so by any Coroner;
(c) by the Department at any time by giving notice in writing to the Authorised Organisation that the Department no longer has the capacity to provide the Data;
(d) by the Authorised Organisation at any time by giving notice in writing to the Department; or
(e) by the Authorised Organisation discontinuing use of the Data and so notifying the Department.

23.2 If this Agreement is terminated pursuant to clause 23.1, all rights of access by the Authorised Organisation to the Data shall be withdrawn by the Department and the Authorised Organisation shall destroy all copies of Data in its possession or control and then certify in writing to the Department that through its best efforts and to the best of its knowledge, all copies of the Data have been destroyed.

24. **Indemnity**

24.1 The Authorised Organisation indemnifies and will keep indemnified the Department and Participating Jurisdictions from and against any claim, demand, action, suit or proceeding that may be made or brought by any person in respect of:

(a) personal injury;
(b) death;
(c) loss of or damage to property; or
(d) any other loss or damage,

arising out of a breach of this Agreement, an unlawful act, or negligent act or omission in the performance of this Agreement by the Authorised Organisation or its partners, employees and agents and also for any costs and expenses that may be incurred in connection with any such claim, demand, action, suit or proceeding.

However, the indemnity shall be reduced proportionately to the extent that any negligent or other tortious act or omission of the Department has through its employees, agents or contractors contributed to such loss, cost, expense or liability.

25. **Relationship Between the Parties**

25.1 Nothing in this Agreement constitutes any fiduciary relationship between the Parties or any relationship of employer or employee, principal and agent, or partnership between the Parties.

26. **Jurisdiction**

26.1 This Agreement shall be governed by the law for the time being in Victoria and Victorian courts have jurisdiction.
27. **Survival**

27.1 Clauses 10, 11, 16, 17, 18, 19, 20, 23.2, 24, 25 and 26 survive the expiry or termination of this Agreement.

28. **Variation**

28.1 This Agreement, including all Schedules, may be varied by mutual agreement evidenced in writing between the Parties.

29. **Entire Agreement**

29.1 This Agreement forms the entire agreement of the Parties on the subject matter. All representations, communications and prior agreements in relation to the subject matter are merged in and superseded by this Agreement.

30. **Severability**

30.1 Any provision of this Agreement which is invalid or unenforceable will be read down, if possible, to be valid and enforceable. Where that provision cannot be read down it will, to the extent that it is capable, be severed without affecting the remaining provisions of the Agreement.

31. **Notices**

31.1 A notice given under this Agreement must be in writing, addressed to the relevant Party as set out in Schedule 1, and signed by or on behalf of the Party giving it.
EXECUTED as an agreement on the date set out at the commencement of this Agreement.

SIGNED by NEIL TWIST, Director, Planning, Performance and Projects for and on behalf of the Department of Justice for and on behalf of the Crown in Right of the State of Victoria in the presence of:

(Signature of Authorised Person) (Signature of Witness)

(Name in Print) (Name in Print)

On the day of 2014

SIGNED by PROFESSOR PETER JOYCE, for and on behalf of The University of Otago in the presence of:

(Signature of Authorised Person) (Signature of Witness)

(Name in Print) (Name in Print)

On the day of 2014
SCHEDULE 1

1. Address for Service

University of Otago
Department of Psychological Medicine
2 Riccarton Avenue
Private Bag 4733
Christchurch 8140 New Zealand

2. Term of Agreement

20 March 2014 to 19 March 2017

3. Special Conditions

Approving Parties’ Conditions:
1. That there be a review of the Authorised Organisation's access after three years;
2. That the Authorised Organisation notifies the Department if it becomes aware of any unforeseen events that may warrant changes to the purpose for which access was approved;
3. That any proposed changes to the purpose for which access to Data was approved be referred back to the Department for approval before such changes are implemented;
4. That the Authorised Organisation submits an annual report every 12 months providing a brief summary of the outcomes of its use of Data, and a completion report at the conclusion of the research.
5. That the Authorised Organisation submits copies to the Department of any relevant publications, papers, theses, conference presentations or audiovisual materials that result from this research.
SCHEDULE 2

**Purpose for which Access is sought**

The Authorised Organisation seeks access to the Data for the purposes set out in NCIS Application Number NZ002, in particular, to analyse Coroners’ recommendations regarding mental health services relating to cases of Intentional Self Harm (Phase 1 of overall research).

Specifically, NCIS data will be used to identify relevant cases and analyse recommendations using an inductive content analysis methodology.

This will assist in answering the following research questions:

1. What are the emergent themes in New Zealand Coroners’ recommendations to Specialist Mental Health Services relating to Intentional Self Harm?
2. What factors influence the implementation of New Zealand Coroners’ recommendations in Specialist Mental Health Services?
3. How do New Zealand Coroners’ recommendations impact upon Specialist Mental Health Services?

Results will inform the second phase of research involving interviews of Coroners and District Health Board policy makers about the implementation of the recommendations.

A full report will be included in a PhD held at the University of Otago, and most likely in relevant research / medical publications.
SCHEDULE 3

Data to which Access has been approved by the Ethics Committee and / or Approving Parties

- **Level 1** Access for New Zealand:
  - Identifying information from closed cases.
SCHEDULE 4

Access Fees

The Authorised Organisation confirms its intention to request the following NCIS product/services:

Annual Online Subscription: 1 User Licence for Post Graduate Studies

As the NCIS is being used as part of the researcher’s post graduate studies, full fee relief has been granted by the NCIS Unit for 1 online user licence.

A new fee relief application will need to be submitted by the researcher for consideration by the NCIS Unit following the first 12 months of this Agreement.
SCHEDULE 5

Security Measures

Data will be extracted from the NCIS by the student researcher via user-specific system login from a University owned laptop housed on the secure local server. The laptop is encrypted with software installed by the University IT department.

NCIS direct access and case de-identification will occur only at the University; however the researcher may be required to conduct analysis (on the de-identified cases only) at her place of residence.

Files and folders on the laptop are password protected and the laptop is accessible only to the student and principal researchers via username and password. The laptop will not be used for any other purpose than this research.

Individual identifiers will be removed from stored case records by the student researcher and replaced with de-identified research codes (ie CR001). Research codes will not be linked to original identifiers. The electronic information will be stored for the duration of the project. Once completed, data will be stored on a secure encrypted university database (used for the confidential storage of university research data) for 5 years. This information is accessible via a password code to the student and principal researcher only.
### SCHEDULE 6

**Nominated Authorised Users**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Jenni Manuel</th>
</tr>
</thead>
<tbody>
<tr>
<td>Position:</td>
<td>PhD Researcher</td>
</tr>
<tr>
<td>Responsibilities:</td>
<td>Primary Researcher – NCIS Online Access</td>
</tr>
<tr>
<td>Period of Time with Organisation:</td>
<td></td>
</tr>
<tr>
<td>Postal Address:</td>
<td>University of Otago, Department of Psychological Medicine, Private Bag 4733, Christchurch 8140 New Zealand</td>
</tr>
<tr>
<td>Tel:</td>
<td>64 3 339 1126</td>
</tr>
<tr>
<td>Fax:</td>
<td>64 3 339 1127</td>
</tr>
<tr>
<td>Email:</td>
<td><a href="mailto:Jenni.manuel@cdhb.govt.nz">Jenni.manuel@cdhb.govt.nz</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name:</th>
<th>Professor Marie Crowe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Position:</td>
<td>Professor, Department of Psychological Medicine, University of Otago</td>
</tr>
<tr>
<td>Responsibilities:</td>
<td>Principal Researcher – No NCIS Online Access.</td>
</tr>
<tr>
<td>Period of Time with Organisation:</td>
<td></td>
</tr>
<tr>
<td>Postal Address:</td>
<td>University of Otago, PO Box 4345, Christchurch 8140 New Zealand</td>
</tr>
<tr>
<td>Tel:</td>
<td>64 3 372 0400</td>
</tr>
<tr>
<td>Fax:</td>
<td>64 3 372 0407</td>
</tr>
<tr>
<td>Email:</td>
<td><a href="mailto:marie.crowe@otago.ac.nz">marie.crowe@otago.ac.nz</a></td>
</tr>
</tbody>
</table>
SCHEDULE 7

NCIS Privacy Protocols

Statement of Purpose

1. The NCIS is a national data storage and retrieval system for coronial information. The Coroners’ jurisdiction in Australia and New Zealand is to:

   - investigate ‘sudden and unexpected’, or ‘violent and unnatural’ deaths;
   - determine what caused such deaths; and
   - where appropriate, indicate ways in which similar deaths may be prevented in future.

2. The information collected during the course of coronial investigations and the findings of Coroners are also useful to organisations with an interest in public health and safety. Prior to the development of the NCIS, the lack of a systematic, national database of coronial information hampered the function of coroners in identifying similar problems around the country, and public sector health and safety organisations in developing informed and timely policy responses to identified risk factors. The NCIS has been designed to provide a high quality information system to coroners, and public sector agencies and researchers with an interest in public health and safety.

3. Coroners and the Department are sensitive to the need to protect the privacy of personal information stored on the NCIS. Although this information primarily relates to deceased persons, the information is still regarded as potentially sensitive to the deceased’s relatives and friends.

4. These protocols have been produced after reviewing the various privacy regimes in Australia, in particular:

   - the Commonwealth Privacy Act 1988;
   - the Victorian Information Privacy Act 2000;
   - the New South Wales Privacy and Personal Information Protection Act 1998;
   - the New Zealand Privacy Act 1993; and
   - the National Health and Medical Research Council’s “Guidelines for the Protection of Privacy in the Conduct of Medical Research”
Definitions

‘Access Agreement’ means an agreement executed in writing between the Department and a third party which entitles that third party to access Data, either via online access or such other means as agreed between the parties, subject to any specified terms and conditions.

‘Authorised Organisation’ means a third party with which the Department has entered into a written Access Agreement.

‘Authorised User’ means an employee, servant or agent of the Authorised Organisation nominated in Schedule 6 and approved by the Department or such other employee, servant or agent subsequently nominated in writing by the Authorised Organisation and approved by the Department;

‘collect’ includes recording or downloading data.

‘Data’ means the coronial information provided by Participating Jurisdictions and compiled and collated and stored in the NCIS, and includes personal information.

'Department' means the Department of Justice for and on behalf of the State of Victoria.

‘Ethics Committee’ means a Health and Disability Ethics Committee (HDEC), which is a Ministerial Committee established under section 11 of the New Zealand Public Health and Disability Act (2000), whose function is to ensure that research meets or exceeds established ethical standards.

‘NCIS’ means the National Coronial Information System, being a remote data entry and retrieval system, managed by the Department.

‘Personal Information’ means information or an opinion, whether true or not, about an individual whose identity is apparent, or can reasonably by ascertained, from the information or opinion.
1. Access to and Collection of Data
   1.1 An Authorised User may only access and collect Data from the NCIS that is necessary for the purpose for which access to the NCIS was approved.

2. Security of Data
   2.1 An Authorised Organisation that has obtained access to or is in possession of Data must ensure that any such Data, for so long as it is in the possession or control of the Authorised Organisation, is protected by all reasonable safeguards.
   2.2 Whenever Data is left unattended by an Authorised User, it must be stored in a secure environment such as a secure network file system, locked drawer or locked filing cabinet.
   2.3 An Authorised User must not under any circumstances disclose their user name or password to any person for any reason. An Authorised User who becomes aware that any person has obtained unauthorised access to the NCIS or has obtained information regarding a user’s login name or password must immediately notify the Department.
   2.4 Authorised Organisations and Authorised Users must ensure that the original Data is not altered or modified in any way.

3. Use of Data
   3.1 An Authorised Organisation may only use Data for the purpose for which access to the NCIS was approved and in a manner that is consistent with any restrictions imposed on access pursuant to the Access Agreement.

4. Disclosure of Data
   4.1 An Authorised User who has obtained Data must not disclose Data to any other person unless such disclosure is specifically authorised by the Access Agreement or unless the disclosure is required or authorised by or under law.
   4.2 An Authorised Organisation must ensure that any report of publication based on or containing Data is presented accurately.
   4.3 Any report of publication published by an Authorised Organisation that contains or refers to Data must not contain any Personal Information.

5. Return or Destruction of Data
   5.1 Once an Authorised Organisation no longer requires the Data for the purpose for which it was collected, the organisation must ensure that it is destroyed or must otherwise ensure that the appropriate and secure archive arrangements are in place. Where an organisation intends to archive the Data, the organisation must ensure that any identifying Data is permanently de-identified prior to being archived. Where an organisation intends to destroy the Data, it must ensure that the Data is destroyed using a secure method such as shredding.
Appendix 3:
Participant Information Sheet
You are invited to take part in a study on Coroner recommendations to Mental Health Services regarding suicide. Whether or not you take part is your choice. If you don’t want to take part, you don’t have to give a reason. If you do want to take part now, but change your mind later, you can pull out of the study at any time.

This Participant Information Sheet will help you decide if you’d like to take part. It sets out why we are doing the study, what your participation would involve, what the benefits and risks to you might be, and what would happen after the study ends. We will go through this information with you and answer any questions you may have. We expect this will take about ten minutes. You may also want to talk about the study with other people, feel free to do this.

If you agree to take part in this study, you will be asked to sign the Consent Form on the last page of this document. You will be given a copy of both the Participant Information Sheet and the Consent Form to keep. This document is three pages long, including the Consent Form. Please make sure you have all the pages.

1. **Why are we doing the study?**

   The purpose of this study is to investigate the impact of coronial recommendations on mental health service delivery within New Zealand regarding death by suicide. The study also seeks to explore what factors influence the implementation of coroner recommendations in Mental Health Services. The first phase of the study involved accessing the New Zealand coronial database for information regarding recommendations made to Mental Health Services since 2007. The second phase of the study involves interviewing New Zealand Coroners and District Health Board Staff about the topic. The research is being undertaken as part of an academic qualification with the University of Otago, and the principle investigator is employed within the Canterbury District Health Board. There is no additional funding source. Questions regarding the study can be made to the lead investigator who can be contacted on the details given at the bottom of this form.

2. **What would your participation involve?**

   If you decide to take part the researcher will then arrange via phone or email a convenient time and place to meet with you. The interview can be done at your place of work, another place that is convenient or over the phone. The researcher/interviewer will go through this information sheet and if you are happy to consent to take part in the study you will be asked to sign two copies of the consent form. You will keep one copy and the other copy is for the researcher. The interview is likely to last around one hour and will be recorded.
You will be asked questions about the topic; this is likely to involve discussing relevant experience from your work. A set of pre-determined questions will be used however the interview will also have flexibility to follow and expand on your answers. You do not have to answer all the questions, and you may stop the interview at any time. Following this interview no further time will be required of you.

3. What are the possible benefits and risks to you of participating?
There is no intended direct benefit to you from taking part in this study. The information gathered could be used to further develop the knowledge and understanding of the topic. There are very few disadvantages to taking part. As already described it will take around an hour of your time. You will be asked questions on the topic including relevant information or experience from your work.

4. What are the rights of participants in the study?
Your participation is completely voluntary; you do not have to part in this study. If you do agree to take part in the study, you are free to withdraw from the study at any time, without having to give a reason. No material that could personally identify you or your area of employment will be used in any reports. The recordings from the interviews will be stored in a safe place and your specific details will be removed when they are transcribed into a written form.

5. What will happen after the study ends, or if you pull out?
When all the data has been gathered it will be transcribed into a written form and this will be analysed for themes and written up in a report. The expected completion date for the study is the end of 2016. A final report will be submitted to and available at the University of Otago. It is probable that the results will also be used in publications such as professional journals. As already stated you will not be identifiable in these reports. The data will be stored electronically with the university for a 5 year period. If you pull out of the study prior to the analysis of the data the transcription of your interview will be destroyed.

6. Where can you go for more information about the study, or to raise concerns or complaints?
To contact the principle investigator, contact:

Jenni Manuel
64 027 3303 3133
64 03 3720 400
jenni.manuel@cdhb.health.nz

If you have any questions, concerns or complaints about the study at any stage, please contact:

Professor Marie Crowe, research supervisor
64 03 3720 400
marie.crowe@otago.ac.nz
This study has been approved by the University of Otago Ethics Committee (Health). If you have any concerns about the ethical conduct of the research you may contact the committee through the Human Ethics Committee Administrator (ph 03 479 8256). Any issues you raise will be treated in confidence and investigated and you will be informed of the outcome.
Appendix 4:
Participant Consent Form
THE MENTAL HEALTH SERVICE RESPONSE TO CORONER RECOMMENDATIONS
CONSENT FORM FOR PARTICIPANTS

I have read the Information Sheet concerning this project and understand what it is about. All my questions have been answered to my satisfaction. I understand that I am free to request further information at any stage.

I know that:-

1. My participation in the project is entirely voluntary;

2. I am free to withdraw from the project at any time without any disadvantage;

3. Personal identifying information will not be intentionally collected. Any identifying information disclosed in the recorded interviews will be removed from the transcripts as soon as possible. At the conclusion of the study the de-identified transcripts will kept and retained in secure storage for at least five years;

4. This project involves an open-questioning technique. The general line of questioning will be about coroner recommendations made to mental health services. The precise nature of some of the questions which will be asked have not been determined in advance, but will depend on the way in which the interview develops and that in the event that the line of questioning develops in such a way that I feel hesitant or uncomfortable I may decline to answer any particular question(s) and/or may withdraw from the project without any disadvantage of any kind.

5. The results of the project may be published and will be available in the University of Otago Library (Dunedin, New Zealand) but every attempt will be made to preserve my anonymity.

I agree to take part in this project.

...........................................................................................................  .................................................

(Signature of participant)       Date
Appendix 5:
Transcriber Confidentiality Agreement
THE MENTAL HEALTH SERVICE RESPONSE TO CORONER RECOMMENDATIONS

Transcribers Statement of Confidentiality

I consent to transcribe the audio-recordings for this research by being bound to the ethical principle of confidentiality. I agree to ensure all materials in my possession, related to this project are securely stored until such items have been handed over the researcher.

I will not discuss any aspects of contents, or make any references to these audio-recordings now or in the future.

Any queries of concerns I have will be discussed with the researcher only.

Name:

Signed:

Date:

If you require any further information please contact:

Jenni Manuel
0273303133
smije599@student.otago.ac.nz
Appendix 6:

Specialist Mental Health Services Perspective of Coronial Recommendations Questionnaire (SPCRQ)
Specialist Mental Health Services Perspective of Coronial Recommendations Questionnaire (SPCRQ)

Can you tell me about your experience with coronial inquiries?
Can you tell me about how coroner recommendations are handled within your DHB?

The first set of questions are general questions related to coroner recommendations and inquiry processes.

1) Rate the extent that coroners consult with your DHB prior to making recommendations

<table>
<thead>
<tr>
<th>Almost Always</th>
<th>Often</th>
<th>Sometimes</th>
<th>Rarely</th>
<th>Never</th>
</tr>
</thead>
</table>

Can you comment on why you have made this rating?

2) Rate to what extent you agree that coroners’ recommendations to SMHS are evidence based.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

Can you comment on why you have made this rating?

3) Rate to what extent you agree that coroners have the right knowledge to make recommendations to SMHS regarding suicide.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

Can you comment on why you have made this rating?

4) Please rate to what extent you agree that coroners’ recommendations to SMHS contribute to suicide prevention.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
</table>

Can you comment on why you have made this rating?
The following set of questions relate to the implementation of coroner recommendations

5) Please rate how often coroners recommendations are implemented within your DHB

| Almost always | Often | Sometimes | Rarely | Never |

Can you comment on why you have made this rating?

6) Please rate the adequacy of resourcing available to your DHB to enable the implementation of coroner recommendations

| Very adequate | Adequate | Neutral | Not Very Adequate | Not Adequate |

Can you comment on why you have made this rating?

7) Please rate to what extent you agree with written responses to coroners’ recommendations being made mandatory

| Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree |

Can you comment on why you have made this rating?

8) Please rate how often coroner findings are feedback to staff within SMHS

| Almost always | Often | Sometimes | Rarely | Never |

Can you comment on why you have made this rating?

The following set of questions relate to themes of coroner recommendations that have been made to SMHS regarding suicide. You are able to respond non-applicable.

9) In your experience please rate how appropriate coroners’ recommendations are regarding inter-agency communication.

| Very Appropriate | Appropriate | Neutral | Not very Appropriate | Not at all Appropriate |

Can you comment on why you have made this rating?
10) In your experience please rate how appropriate coroners’ recommendations are regarding restrictive management.

<table>
<thead>
<tr>
<th>Very Appropriate</th>
<th>Appropriate</th>
<th>Neutral</th>
<th>Not very Appropriate</th>
<th>Not at all Appropriate</th>
</tr>
</thead>
</table>

Can you comment on why you have made this rating?

11) In your experience please rate how appropriate coroners’ recommendations are regarding staff education.

<table>
<thead>
<tr>
<th>Very Appropriate</th>
<th>Appropriate</th>
<th>Neutral</th>
<th>Not very Appropriate</th>
<th>Not at all Appropriate</th>
</tr>
</thead>
</table>

Can you comment on why you have made this rating?

12) In your experience please rate how appropriate coroners’ recommendations are regarding working with families of consumers.

<table>
<thead>
<tr>
<th>Very Appropriate</th>
<th>Appropriate</th>
<th>Neutral</th>
<th>Not very Appropriate</th>
<th>Not at all Appropriate</th>
</tr>
</thead>
</table>

Can you comment on why you have made this rating?

13) In your experience please rate how appropriate coroners’ recommendations are regarding risk assessment.

<table>
<thead>
<tr>
<th>Very Appropriate</th>
<th>Appropriate</th>
<th>Neutral</th>
<th>Not very Appropriate</th>
<th>Not at all Appropriate</th>
</tr>
</thead>
</table>

Can you comment on why you have made this rating?

14) In your experience please rate how appropriate coroners’ recommendations are regarding service delivery.

<table>
<thead>
<tr>
<th>Very Appropriate</th>
<th>Appropriate</th>
<th>Neutral</th>
<th>Not very Appropriate</th>
<th>Not at all Appropriate</th>
</tr>
</thead>
</table>

Can you comment on why you have made this rating?

Is there anything that you would like to add to the discussion that we might not have covered?
Appendix 7:

Family and whānau worker focus group interview schedule
Family and whānau worker focus group interview schedule

1) Can you tell me about how families feel about the level of involvement they have in their family members SMHS treatment?

2) Can you tell me about the level of information that is provided to families by SMHS staff regarding the care of their family members?

3) Can you tell me about SMHS staff obtaining information from families?
Appendix 8:

Family and whānau worker focus group handout
Examples of Coroners’ Recommendations that Target Working with Families

The following are examples of coroners’ recommendations directed to SMHS that target how health services are working with families of mental health consumers.

Subtheme One: Involving Family in Treatment

1. I recommend that DHB communicate more frequently and more effectively with the family of its patients, both from the perspective of the family (and their need to be updated and involved) but, more importantly, from a therapeutic perspective. There will be times where family contact or involvement would be inappropriate for a patient, but I observe that, in the case of **, the involvement and support of family would have been immensely valuable as a part of his care.

2. Involvement of family and caregivers is a critical part of psychiatric care, mandated by the Mental Health Act. We recommend the service ensures the requirements of Section 7(A) of the Act are met and where decisions not to involve the family are made, that these are documented and reviewed. The Ministry of Health guidelines to the Mental Health Act of April 1, 2000 provide clear guidance in this area. This direction should also include involvement of family/caregivers and discharge planning with similar requirements for documentation where this is not deemed clinically appropriate.

3. The 'circumstances of the death' of * had identified issues relating to communication by DHB clinicians with the families of patients. Psychiatrists tasked with the care of patients presenting to them must be encouraged to take positive and active steps to engage with appropriate family members in order that such engagement enhances the clinical care given.
Subtheme Two: Provision of Information to Families

1. I recommend that DHB Mental Health Services reflects on the response to Mrs [wife] call and considers whether, in similar circumstances in future, the Intake and Assessment Team should routinely give more proactive, practical advice to ensure the person making the referral knows how or where to seek further help or support in the period before the mental health service responds.

2. I recommend the DHB develop a simple and brief notice to families for all mental health patients advising, in particular, the name(s) of the significant clinicians and case workers, their contact numbers, particularly their after-hours numbers, and that should also include a clear assurance that the DHB actually wants the family to engage the clinicians if there are concerns. I say again that, to be effective, it needs to be concise and easy to understand.

3. THAT the risk management plans developed by CAT Team members following serious acts of self-harm or attempted suicide by patients be reduced to writing and a copy thereof made available to those family members/friends into whose care the patient is to be placed, with clear and explicit advice as to the nature and extent of ongoing risk and the need for monitoring.

Sub-theme three: Obtaining Information from Families

1. I recommend that when assessing a patient who presents with suicidal indications that relevant health information be collected, including if appropriate from family, whanau and other relevant persons to provide the information necessary to make an informed risk assessment (and if there is risk of self-harm, there be a low threshold in applying the exemption available to override the wishes of the person being assessed objecting to the gathering of that health information).

2. I consider that in accordance with DHB policy all reasonable endeavours should be made to identify family and/or close associates of the person being assessed, and that supporting information from those persons be obtained to ensure a proper assessment is made, and if the patient is to remain in the community that family and close associates who are effectively that community be adequately informed to assist in providing a safe environment. In particular, caution is required where the patient is returning to an environment where the patient lives in isolation, without immediate support from family.

3. Further, as set out in paragraph [13] of this finding, the Court recommends that the Mental Health Services consult with a patient's caregiver to obtain a further overview provided it is done within the prescribed limits of the privacy law.