Waitematā
District Health Board

Best Care for Everyone

Specialist Mental Health & Addiction Services
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[redacted]

Dear [redacted]

Re: OIA request – Mental health patients

Thank you for your Official Information Act request received on the 7 February 2020 seeking information about people who have left Waitematā District Health Board (DHB)-operated facilities since 2013.

Before responding to your specific questions, it may be useful to provide some context about our services.

Waitematā DHB serves a population of more than 630,000 across the North Shore, Waitakere and Rodney areas, the largest and one of the most rapidly growing DHBs in the country.

Our Specialist Mental Health and Addiction Service is the largest of its kind in the country, by volume of service-users seen. It comprises Adult Mental Health Services, Child Youth and Family Mental Health Services, Takanga a Fohe (Pacific mental health and addictions), Whitiki Maurea (Kāupapa Māori mental health and addictions), the Regional Forensic Psychiatry Service (covering Northland and greater Auckland regions) and Community Alcohol and Drug Services (CADS).

All of our addictions services cover the greater Auckland region (from Mercer to Wellsford). Mental Health Services for Older Adults sits within Waitematā DHB's Speciality Medicine and Health of Older People Division.

While we acknowledge that public discussion about suicide can be useful, we respectfully ask that all information treated in any responses regarding suicide or suspected suicide is treated with sensitivity for the impact that public discussion about suicide can have, particularly any impact on individuals contemplating suicide.

Guidelines for responsible media management of suicide reporting are published on the Mental Health Foundation website and can be found here: https://www.mentalhealth.org.nz/home/our-work/category/39/suicide-media-response-service?gclid=EAIaIQobChMIk_Tls4OP1wIVQiRoCh3D6g-2EAAYASAAEgIlL_D_BwE.

In response to your request, we are able to provide the following information:

Please state how many patients detained under the Mental Health Act have:

1) Left a DHB-operated open or secure facility/ward in the past seven years, 2013 to present, when they were not supposed to or were supposed to return through:
a) Escorted leave
b) unescorted leave
c) escape
4) transfer
5) weekend or day leave
6) any other way.
Please break down by year and type of facility.

Waitematā DHB is not able to provide all of the information requested, as our reporting systems only collect data about people leaving facilities or those who are late back from leave. These systems do not include the categories above. Instead, the full details of each absence are recorded with the individual clinical notes of each person.

Due to the sensitivity of the information, frontline clinical staff would need to review individual patient files and it would not be appropriate to use a contractor to review the records. This would take the frontline staff away from their clinical work and prejudice our ability to provide core clinical services.

We have considered whether charging or extending the timeframe for responding would assist us in managing this work and have concluded it would not. Therefore, we have determined to refuse this element of your request under Section 18(f) of the Official Information Act due to substantial collation or research.

However, we have provided the information we are able to in the table below. We have interpreted "escape" as people under the Mental Health Act who have left inpatient units without authorised leave.

In interpreting the following figures it should be taken into account that a substantial proportion of people recorded as "absent" are late back from approved leave rather than having left from a facility without approved leave.

This includes:

- People who may return minutes late from approved leave
- People who are repeatedly late (i.e., the same person multiple times)
- People who provide a valid reason for lateness.

Calendar years	Total number of people treated under the Mental Health Act who did not adhere to the agreed conditions of their escorted leave, transfer, weekend or day leave			Absent without authorised leave	
	Acute Mental Health Units	Acute Older Persons Mental Health Unit	Forensic Psychiatry Units [2]	Acute Mental Health Units[1]	Forensic Psychiatry Units [2]
2013	287	1	1		
2014	262				
2015	197				
2016	99		1	1	
2017	110			1	
2018	131			7*	

2019	116		4	9*	1

[1] Data only collected since 2016. Data is not collected from Mental Health of Older Persons Services
[2] Waitematā DHB operates the Forensic Psychiatry Services for the Northern Region
* Increase may reflect improved reporting system.

2) Please state how many of those patients who left while under DHB mental health care died by suicide or suspected suicide. Please break down by year, ethnicity and gender.

Two patients who were being treated under the Mental Health Act absented themselves from DHB mental health inpatient units and died by suspected suicide in 2017. Both were New Zealand European males.

3) Please state how many of those patients disappeared and were never found again.

No patients have been absent and never located again.

4) Please state how many of those patients suffered an adverse event/trauma through the unapproved departure; i.e. raped, robbed, assaulted, accidental death or homicide etc.

We are unable to provide this information as our reporting systems do not contain this level of detail. As per our response above, to provide the information requested would require a review of the individual clinical notes of each person. Therefore, we have determined to refuse this element of your request under Section 18(f) of the Official Information Act due to substantial collation or research.

5) Please state for the same timeframe the number of patients who died INSIDE the DHB-run mental health facility and type of death, e.g. suicide, suspected suicide, accidental death, illness etc.

Calendar years	Total number of people treated under the Mental Health Act who have died inside DHB-run mental health facility			
	Suicide*	Suspected suicide	Accidental death	Illness
2013				
2014				
2015				1
2016				
2017		2		
2018	1			
2019		2		1

*Only the coroner can make a finding of suicide

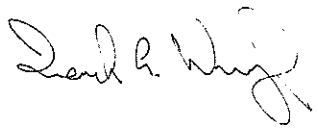
While acknowledging we are unable to provide information in response to all elements of your request because this information is not readily available, we trust this information is helpful.

You have the right to seek an independent review of any of the decisions taken in providing this response by contacting the Office of the Ombudsman via www.ombudsman.parliament.nz.

Waitematā DHB supports the open disclosure of information to assist community understanding of how we are delivering publicly funded healthcare. This includes the proactive publication of anonymised Official Information Act responses on our website from 10 working days after they have been released.

If you consider there are good reasons why this response should not be made publicly available, we will be happy to consider your views.

Yours sincerely



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Waitematā District Health Board