

Suicide Facts

Provisional 2000 Statistics (all ages)

Published in May 2003 by the
Ministry of Health
PO Box 5013, Wellington, New Zealand

ISBN 0-478-25651-5 (Book)
ISBN 0-478-25652-3 (Website)
HP 3634

This document is available on the Ministry of Health's website:
<http://www.moh.govt.nz>



MANATŪ HAUORA

Contents

Key Points	1
What is the most recent data available on suicide?	1
How is a death deemed to be a suicide?	1
Suicide – All Ages	3
How many people died by suicide in 2000?	3
What is the rate of suicide in New Zealand?	3
Suicides by age group	4
How many Māori died by suicide in 2000?	5
How many Pacific people died by suicide in 2000?	6
What is the male–female suicide ratio?	6
Suicide – Youth (15–24 years)	7
How many young people (15–24 years) died by suicide in 2000?	7
What is the rate of youth suicide (15–24 years) in New Zealand?	7
How many Māori youth (15–24 years) died by suicide in 2000?	8
Other information	8
Is the overall rate of youth suicide still increasing?	9
Suicide Attempt	10
How many people attempted suicide in 2000/2001 (collected from mid-year to mid-year)?	10
Regional Comparisons	12
Key points (total population)	12
What are SMRs (Standard Mortality Ratios)?	13
International Comparisons	14
How does New Zealand’s suicide rate compare internationally?	14
How accurate are international comparisons?	16
Background Information on Suicide	17
What causes people to want to take their own lives?	17
Are there protective factors for suicide?	17
How can suicide be prevented?	17
Key components of suicide prevention	18
Intervention themes	18
Examples of suicide prevention approaches	18
What is the New Zealand Youth Suicide Prevention Strategy?	19
Where can people go for help?	19

Key Points

- In 2000, the total number of suicides was 458, down from 516 in 1999 and 577 in 1998. This is the lowest total number since 1986 (414) and the lowest rate since 1985.
- Total suicide deaths have reduced among both males and females in the last two years. In 2000, the female rate was the lowest since 1961.
- In 2000, both the 45–64 year age group and the 65 and over age group recorded the lowest rates since 1948.
- In 2000, a total of 96 young people aged 15–24 years died by suicide, compared with 120 in 1999 and 140 in 1998. Young people still have high rates of suicide but the highest rate is now in the 25–29 year age group.
- Suicide deaths have reduced in non-Māori, but have remained almost the same in Māori. In 2000, the rate of suicide in Māori was 13.1 per 100,000 compared with 10.7 per 100,000 in non-Māori.
- The hospitalisation rate for intentional self-harm in 2000/2001 was 129.2 per 100,000. The definition of intentional self-harm has been extended to include cases not previously included so should not be directly compared with previous years. Youth (15–24 years) had the highest hospitalisation rates in 2000/2001 (282.4 per 100,000).
- There is some variation in regional suicide rates for the total population but no pattern.
- The New Zealand Health Strategy has identified reducing suicide and suicide attempt across all ages as a priority health objective.
- Suicide prevention requires a range of interventions across a number of settings and the co-operation of Government, service providers, communities and families.

What is the most recent data available on suicide?

We have provisional 2000 data for all ages.¹ These figures are still considered provisional because there are a small number of deaths that are subject to coroners' findings, for which a cause of death has not yet been assigned. For this reason we are unable to say they are final. Data become official when published by the New Zealand Health Information Service (NZHIS) in the annual publication series *Mortality and Demographic Data* publication series.

How is a death deemed to be a suicide?

Deaths by suicide are subject to a coroner's inquiry and can only be officially deemed suicide once an inquest is complete. In some cases the inquest will be heard over a year

¹ Provisional 2000 all ages statistics are available on the New Zealand Health Information website: www.nzhis.govt.nz.

after the death, particularly if there are other factors surrounding the death that need to be investigated first.

Suicide – All Ages

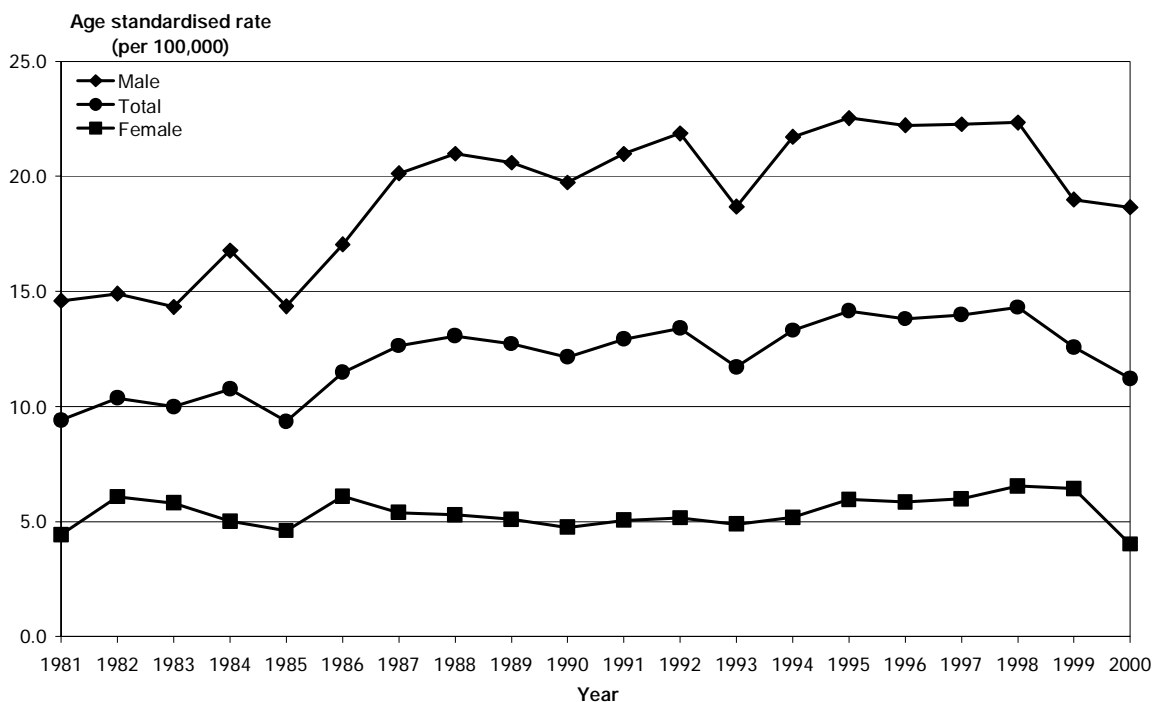
How many people died by suicide in 2000?

- A total of 458 people died by suicide, compared with 516 in 1999 and 577 in 1998.
- In 2000, 375 males died by suicide, compared with 385 in 1999 and 445 in 1998.
- In 2000, 83 females died by suicide, compared with 131 in 1999 and 132 in 1998.

What is the rate² of suicide in New Zealand?

- The age standardised suicide rate³ for the total population was 11.2 per 100,000 in 2000, compared to 12.1 per 100,000 in 1990. This was the lowest rate since 1985 (9.3 per 100,000).
- The rate of suicide for males was 18.7 per 100,000 in 2000, compared with 19.7 per 100,000 in 1990. This is the lowest rate since 1993 (18.7 per 100,000).
- The rate of suicide for females was 4.0 per 100,000 in 2000, compared to 4.7 per 100,000 in 1990. This is the lowest rate since 1961 (3.9 per 100,000).

Figure 1: Suicide death rate 1981–2000 (Source: NZHIS)



² What is the difference between the number and rate?

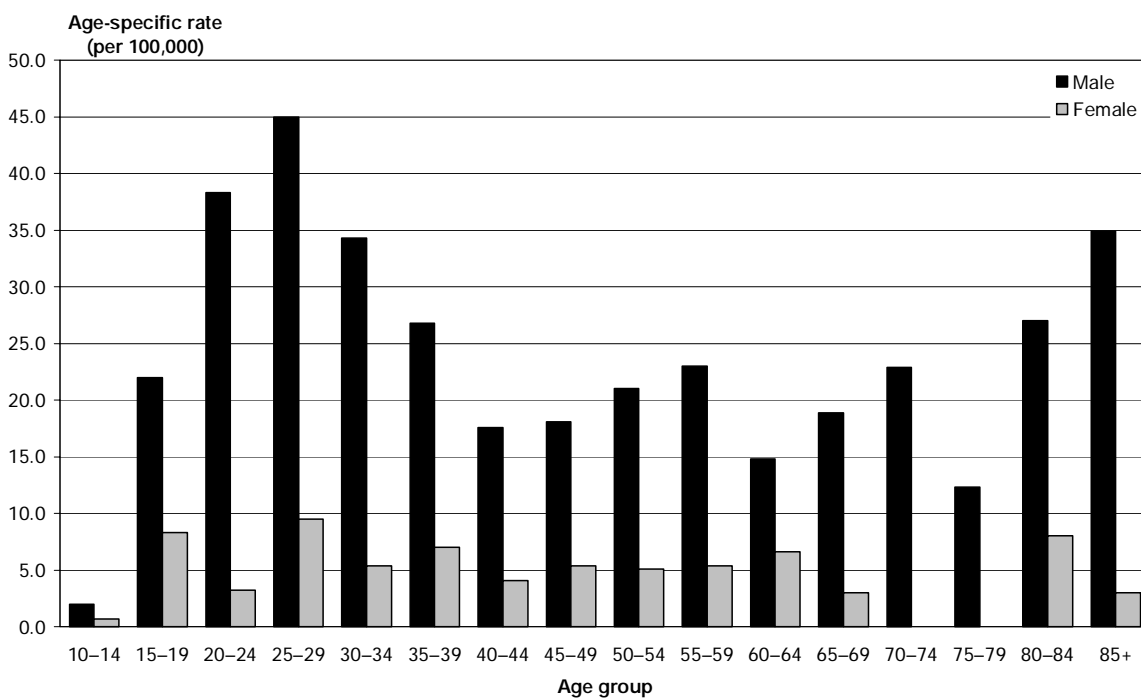
- The *number* of suicide deaths is exactly that; the actual number of people who have died by suicide.
- The age-specific rate of suicide is the *frequency* with which it occurs relative to the number of people in a defined population.

³ Age-standardised rates are rates that have been adjusted to take account of differences in the age distribution of the population over time.

Suicides by age group

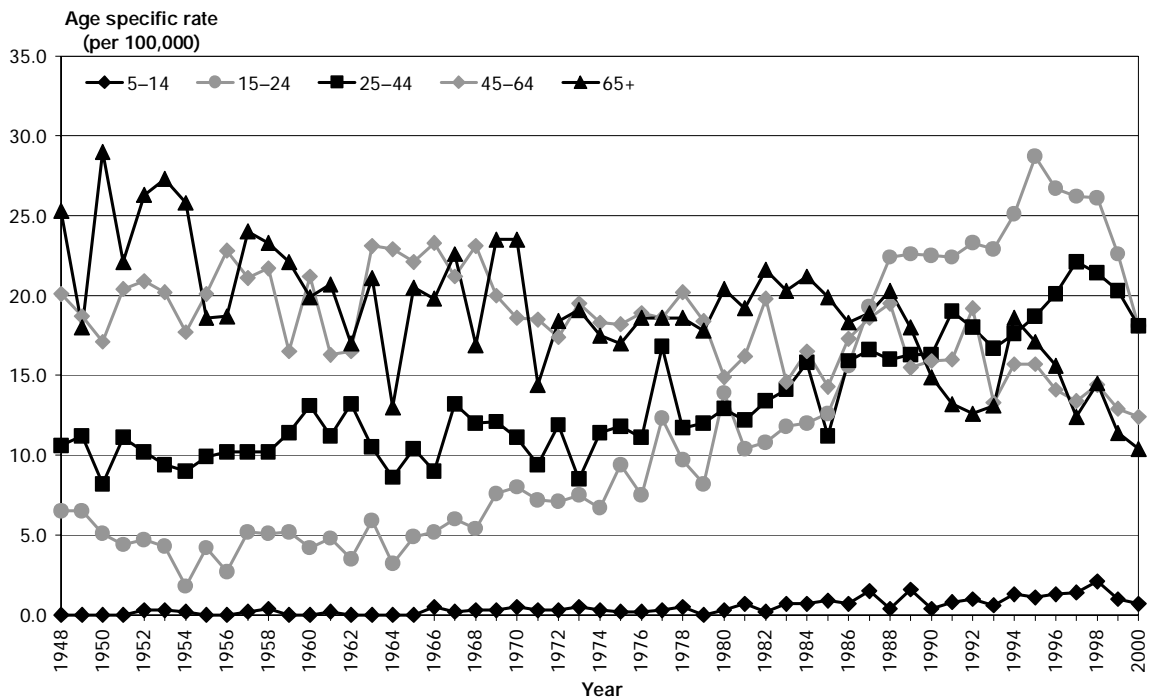
- In 2000, the highest rates of suicide were among males 25–29 years (45.0 per 100,000), followed by males aged 20–24 years (38.3 per 100,000). Among females, 25–29 year olds (9.5 per 100,000) and 15–19 year olds (8.3 per 100,000) had the highest rates (Figure 2).
- Over the last five years, suicide death rates across the broad age groups depicted in Figure 3 have been trending downward. In 2000, both the 15–24 year age group and the 25–44 year age group had a rate of 18.1 deaths per 100,000. In 2000, both the 45–64 year age group and the 65+ age group recorded the lowest rates since 1948.

Figure 2: Suicide rates by age group and gender, 2000



Source: NZHIS

Figure 3: Suicide deaths by age group, 1948–2000

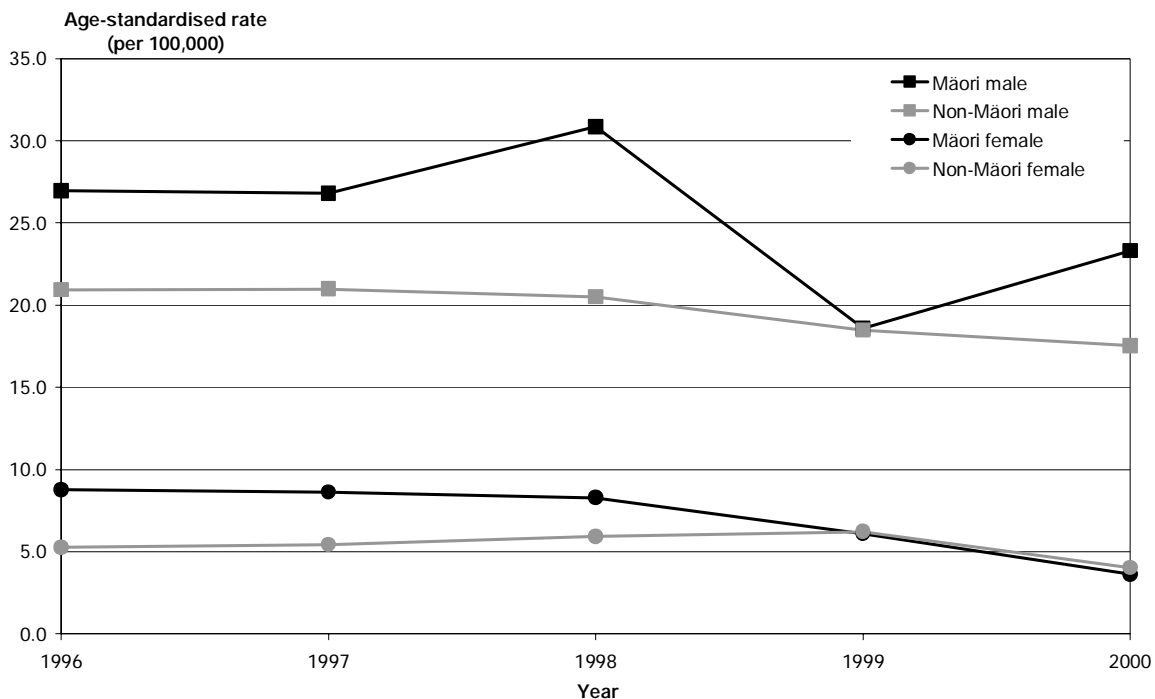


Source: NZHIS

How many Māori died by suicide in 2000?

- Eighty Māori died by suicide in 2000, compared to 78 in 1999 and 112 in 1998.
- Sixty-nine were male compared to 58 in 1999 and 87 in 1998.
- Eleven were female compared to 20 in 1999 and 25 in 1998.
- In 2000, the rate of suicide for Māori was 13.1 per 100,000, compared with 12.1 per 100,000 in 1999 and 19.2 per 100,000 in 1998.
- The rate of suicide for Māori males was 23.3 per 100,000, compared to the non-Māori rate of 17.5 per 100,000.
- The rate of suicide for Māori females was 3.6 per 100,000, compared to the non-Māori rate of 4.0 per 100,000.

Figure 4: Māori and non-Māori suicide death rates, 1996–2000



Source: NZHIS

How many Asian and Pacific people died by suicide in 2000?

- In 2000, 12 Pacific people died by suicide (10 males and two females), compared to 14 deaths in 1999 and 24 deaths in 1998.
- Twenty-one Asian people died by suicide in 2000 (16 males and 5 females).

What is the male–female suicide ratio?

- In 2000, the all-ages sex ratio for suicide in New Zealand was 4.5 male suicides to every female suicide. The youth suicide (15–24 years) ratio was 5.4 male suicides to every female suicide.
- Research⁴ suggests that the difference in male and female suicide is associated with choice of methods. Females, however, make more non-fatal suicide attempts.

⁴ A Beautrais. 2000. *Restricting access to means of suicide in New Zealand: a report prepared for the Ministry of Health on methods of suicide in New Zealand*. Wellington: Ministry of Health.

Suicide – Youth (15–24 years)⁵

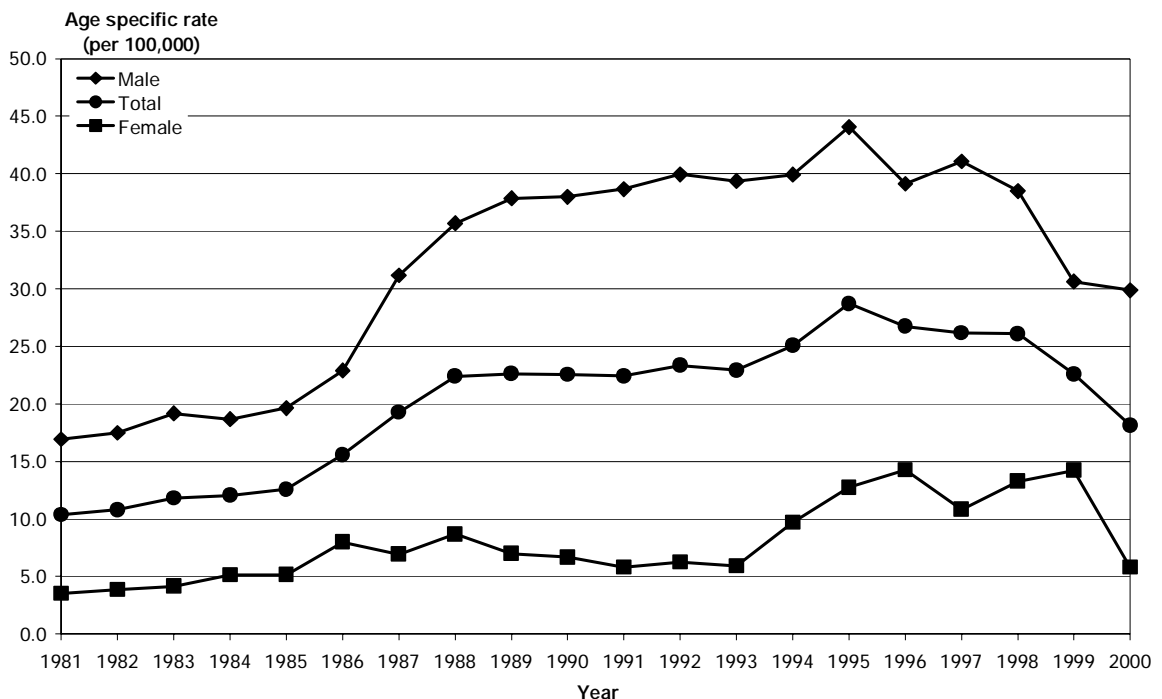
How many young people (15–24 years) died by suicide in 2000?

In 2000, a total of 96 young people aged 15–24 years died by suicide, compared with 120 in 1999 and 140 in 1998. Of these 96 young people, 81 were male and 15 were female.

What is the rate of youth suicide (15–24 years) in New Zealand?

- The total rate of youth suicide in 2000 was 18.1 per 100,000 compared with 22.5 per 100,000 in 1990.
- The rate of youth suicide for males (aged 15–24) in 2000 was 29.9 per 100,000 compared with 38.0 per 100,000 in 1990.
- The rate of youth suicide for females (aged 15–24) in 2000 was 5.8 per 100,000 compared with 6.7 per 100,000 in 1990.

Figure 5: Youth suicide rates (aged 15–24), 1981–2000



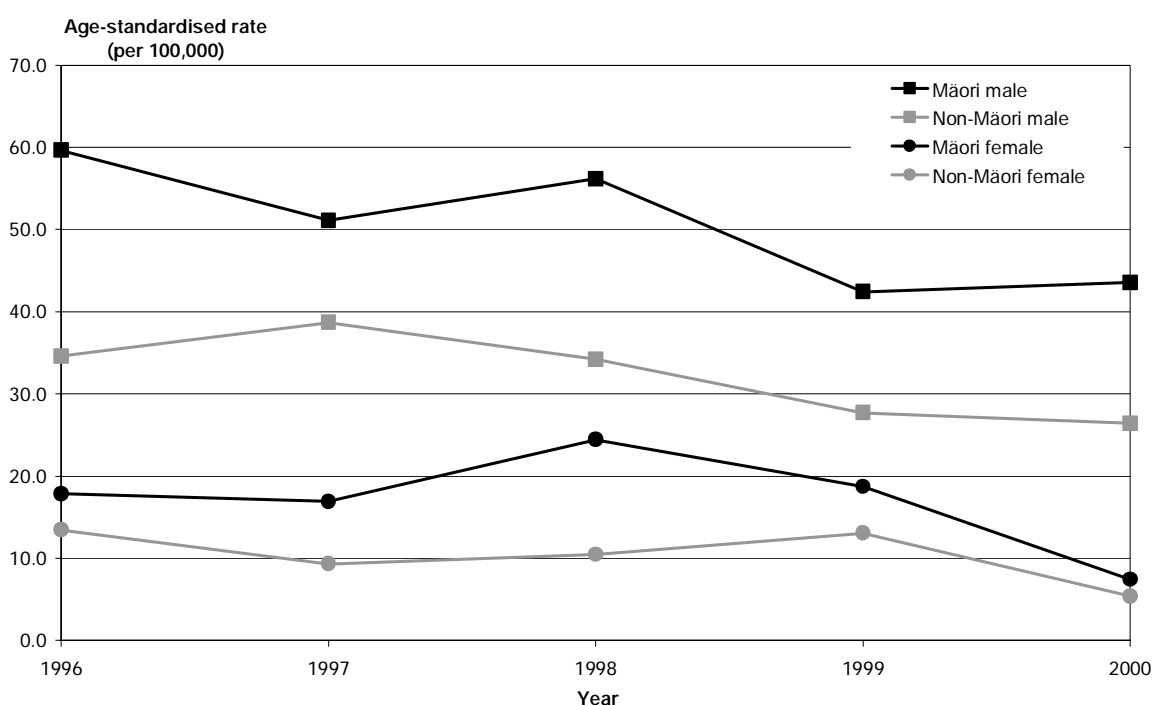
Source: NZHIS

⁵ Youth suicide data for the year 2000 was released in October 2002.

How many Māori youth (15–24 years) died by suicide in 2000?

- In 2000, 28 Māori young people (15–24 years) died by suicide (24 males, four females), compared to 33 in 1999 and 43 in 1998.
- The suicide rate for Māori youth in 2000 was 25.7 per 100,000, compared with the non-Māori rate of 16.2 per 100,000.
- In 2000, the rate of suicide for young Māori males was 43.5 per 100,000, compared with the non-Māori rate of 26.4 per 100,000.
- In 2000, the rate of suicide for young Māori females was 7.4 per 100,000, compared with the non-Māori rate of 5.4 per 100,000.

Figure 6: Māori and non-Māori youth suicide rates (aged 15–24), 1996–2000



Source: NZHIS

Other information

- In 2000, amongst the total population, there were 31 suicide deaths in males aged 15–19, and 50 in males aged 20–24; there were 11 suicide deaths in females aged 15–19, and four in females aged 20–24. There were four suicide deaths in people under 15 years of age.
- In 2000, there were six youth (15–24 years) suicide deaths among Pacific people and five among Asian people.

Is the overall rate of youth suicide decreasing?

- Yes. The youth suicide rate has now decreased for five consecutive years. The number and rate for 2000 are the lowest since 1986. The number and rate of youth suicides have dropped for both Māori and non-Māori, reflecting the reduction in the number of female suicide deaths. There has been a slight increase in the Māori male rate, and a slight decrease in the non-Māori male rate compared with 1999.
- Because suicide is, in statistical terms, an uncommon event and rates vary from year to year, it is better to look at the total pattern of suicide rates over several years.

Suicide Attempt

How many people attempted suicide in 2000/2001 (collected from mid-year to mid-year)?

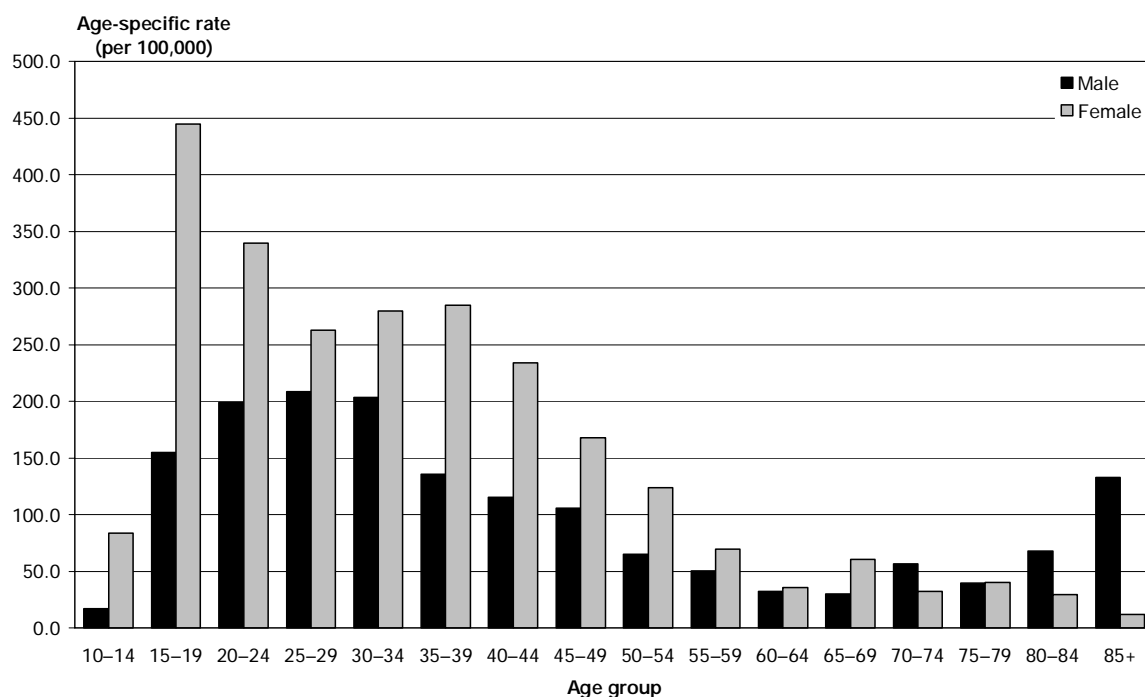
All ages

- The rate of hospitalisation for intentional self-harm in 2000/2001 was 129.2 per 100,000. It is not possible to compare this rate with previous years as the definition of intentional self-harm has been extended to include cases not previously included.
- In 2000/2001, there were 1800 male hospitalisations (a rate of 91.7 per 100,000) and 3260 female hospitalisations (a rate of 167.4 per 100,000).
- Among Māori in 2000/2001 there were 743 hospitalisations, at a rate of 119.0 per 100,000 (284 male hospitalisations at a rate of 93.5 per 100,000 and 459 female hospitalisations at a rate of 144.0 per 100,000).
- Among non-Māori in 2000/2001 there were 4317 hospitalisations, at a rate of 131.2 per 100,000 (1516 male hospitalisations at a rate of 90.6 per 100,000 and 2801 female hospitalisations at a rate of 172.9 per 100,000).
- More females are hospitalised for intentional self-harm than males. Females more commonly choose methods such as self-poisoning that generally are not fatal, but still serious enough to require hospitalisation.
- The female to male ratio for intentional self-harm in New Zealand in 2000/2001 was 1.8 female hospitalisations to every male hospitalisation.

Youth (15–24 years)

- Youth have the highest hospitalisation rates for intentional self-harm.
- The hospitalisation rate for young people (15–24 years) in 2000/2001 was 282.4 per 100,000 (1496 hospitalisations). The Māori rate was 244.8 per 100,000, which was lower than the non-Māori rate of 292.1 per 100,000.
- In 2000/2001, there were 478 male hospitalisations (rate of 176.3 per 100,000) and 1018 female hospitalisations (rate of 393.5 per 100,000).
- In 2000/2001, the hospitalisation rate for Māori females was 307.7 per 100,000, lower than the non-Māori female rate of 416.0 per 100,000. For Māori males, the hospitalisation rate was 183.2 per 100,000, higher than the non-Māori male rate of 174.6 per 100,000).

Figure 7: Rates of suicide and self-inflicted injury hospitalisation by age, 2000/2001



Source: NZHIS

Are there problems with the accuracy of suicide attempt data?

- Yes. It is important to be cautious about interpretation of suicide attempt data.
- We do not have accurate data on all suicide attempts because records are only kept on those who are admitted to hospital as inpatients or day patients. Data is not collected nationally on people treated in Accident and Emergency (A&E) as outpatients (although some hospitals are now reporting people admitted to A&E day or short stay units), nor people treated by GPs, nor those who do not seek medical treatment.
- Also, changing treatment practices make comparisons across years difficult. For example, improving treatments for overdose has meant that more people can be treated on an outpatient basis, and will not appear in hospitalisation suicide attempt figures. In addition, in 2000 a new international classification of disease (ICD-10) system was introduced that slightly altered the inclusion criteria for the diagnosis of intentional self-harm. The definition of an admission also changed resulting in the inclusion of cases that had not previously been included.
- The suicide attempt figures (above) are for self-inflicted injury and may include cases of deliberate self-harm where the intent was not death.
- Hospitalisation figures include people who are admitted more than once during that year, and also include those who died while in hospital.

What is the relationship between suicide and attempted suicide?

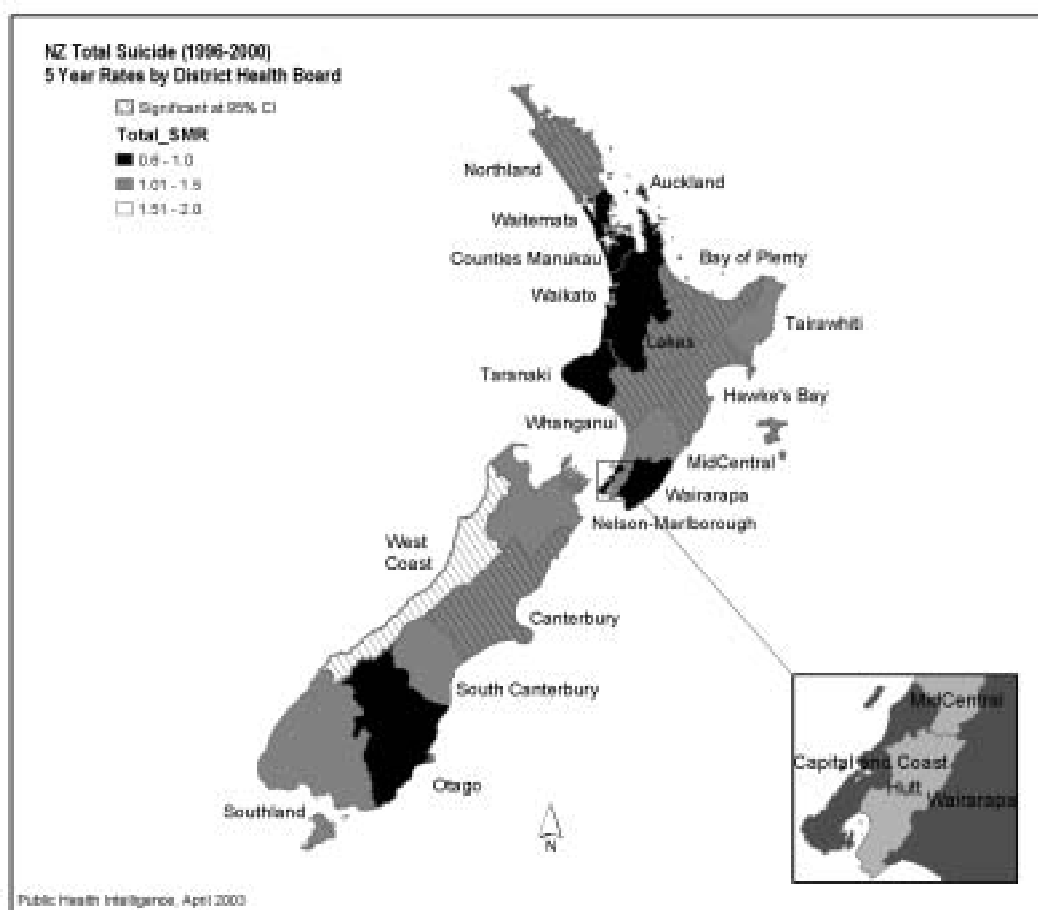
People who have already made one suicide attempt are at greater risk of dying by suicide, so it is important that such people receive effective follow-up support and treatment.

Regional Comparisons

Key points (total population)

- Although there is variation at the District Health Board level, no pattern in suicide rates is apparent. Caution should be used in interpreting regional variations due to small numbers and large fluctuations from year to year.
- Standard Mortality Ratios (SMRs) for 1996–2000 show that Northland, Bay of Plenty, Lakes, Whanganui, Hawke's Bay, West Coast and Canterbury District Health Boards have suicide rates significantly higher than the national rate.⁶ Only the Auckland District Health Board suicide rate for males was significantly lower than the national rate.

Figure 8: Total population suicide rates by DHB sub-region, 1996–2000 Standardised Mortality Ratio (SMR)



Source: Public Health Intelligence

Note: The Hawke's Bay DHB region incorporates the Chatham Islands (shown as an insert to the right of Hawke's Bay).

⁶ These regions have been highlighted because the SMR is high and the 95 confidence interval does not include one. Other areas above the national average like Tairāwhiti are excluded because the confidence interval includes one.

Table 1: Suicide deaths by DHB region and sex, 1996–2000

	Male		Female		Total	
	SMR	95% CI	SMR	95% CI	SMR	95% CI
Northland	1.1	0.9–1.4	1.7	1.2–2.4	1.3	1.0–1.5
Waitemata	0.9	0.7–1.0	0.9	0.7–1.1	0.9	0.8–1.0
Auckland	0.8	0.7–0.9	1.1	0.8–1.4	0.8	0.7–1.0
Counties Manukau	0.8	0.7–1.0	0.9	0.7–1.2	0.9	0.7–1.0
Waikato	1.0	0.8–1.1	0.9	0.6–1.2	0.9	0.8–1.1
Lakes	1.3	1.0–1.6	1.1	0.6–1.8	1.2	1.0–1.5
Bay of Plenty	1.2	1.0–1.4	1.2	0.8–1.7	1.2	1.0–1.4
Tairāwhiti	1.4	0.9–1.9	0.6	0.2–1.4	1.2	0.8–1.7
Hawke's Bay	1.3	1.1–1.6	0.7	0.4–1.1	1.2	1.0–1.4
Taranaki	0.9	0.7–1.2	1.1	0.6–1.8	1.0	0.7–1.2
MidCentral	0.9	0.7–1.1	1.6	1.1–2.2	1.1	0.9–1.3
Whanganui	1.3	0.9–1.7	2.2	1.3–3.6	1.5	1.1–1.9
Capital & Coast	0.8	0.7–1.0	0.8	0.6–1.2	0.8	0.7–1.0
Hutt Valley	1.1	0.8–1.3	1.1	0.7–1.7	1.1	0.9–1.3
Wairarapa	0.6	0.3–1.0	0.7	0.1–2.0	0.6	0.4–1.0
Nelson Marlborough	1.1	0.9–1.4	1.1	0.7–1.7	1.1	0.9–1.4
West Coast	2.1	1.5–3.0	1.2	0.5–2.7	2.0	1.4–2.7
Canterbury	1.1	1.0–1.2	1.0	0.8–1.2	1.1	1.0–1.2
South Canterbury	1.3	0.9–1.8	0.6	0.2–1.4	1.2	0.8–1.6
Otago	1.0	0.8–1.2	0.8	0.5–1.2	0.9	0.8–1.1
Southland	1.2	0.9–1.5	0.7	0.4–1.3	1.1	0.9–1.4

Source: Public Health Intelligence

Note: Shaded areas indicate regions with significantly higher Standard Mortality Ratios (SMRs). Numbers in this table are rounded to one decimal place.

What are SMRs (Standard Mortality Ratios)?

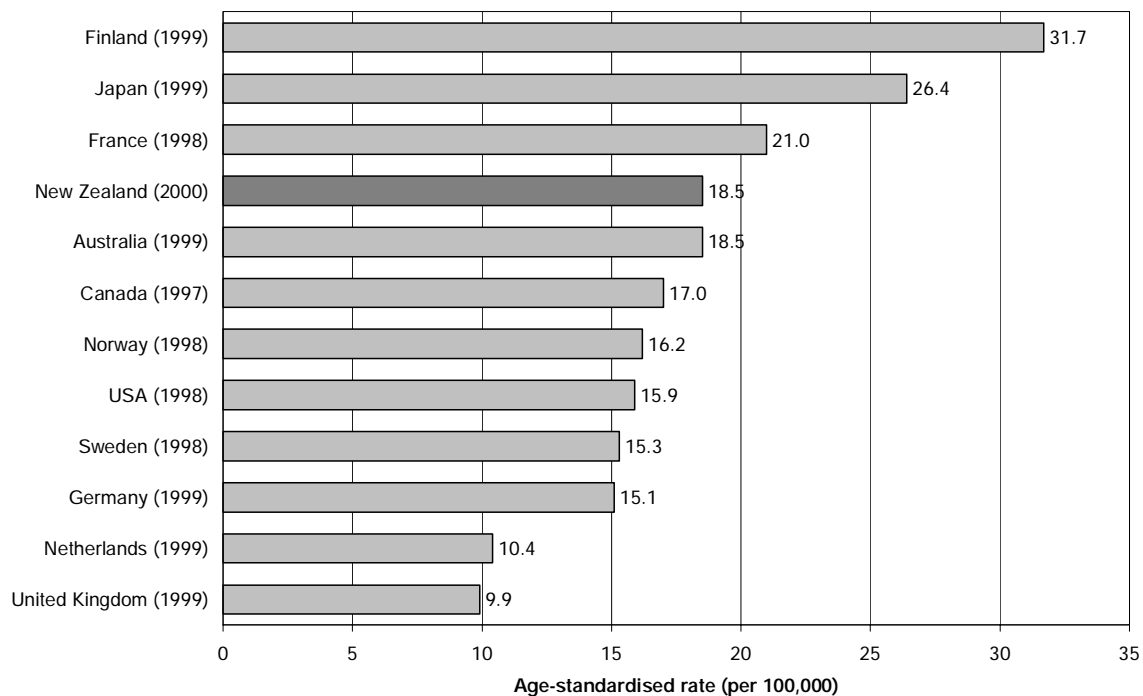
- **SMRs (Standardised Mortality Ratios) are a means of comparing regional variations in rates of mortality (or morbidity). In a regional analysis, SMRs compare subnational rates, in this case District Health Boards, with that of the national rate. These ratios indicate whether a region is below or above the national rate, ie, below or above 1. SMRs are used when age-specific rates cannot be calculated (ie, where data is missing or there are no cases), or where there are very small denominators (populations).**
- **The SMR is significant if the 95 percent confidence interval does not include one. If the confidence interval includes one, then the region's rate is not significantly different from the national rate.**

International Comparisons

How does New Zealand's suicide rate compare internationally?

- In comparison with selected OECD countries, New Zealand's 2000 suicide rates are high for males, particularly male youth.
- In 2000, New Zealand's all-age suicide rates for males were the fourth highest among selected OECD countries. However, New Zealand's female all-age suicide rates were 10th among the selected OECD countries (Figures 9 and 10).
- For youth aged 15–24 years, New Zealand has the second highest rates of suicide for males and fourth highest rates for females among selected OECD countries (Figures 11 and 12).

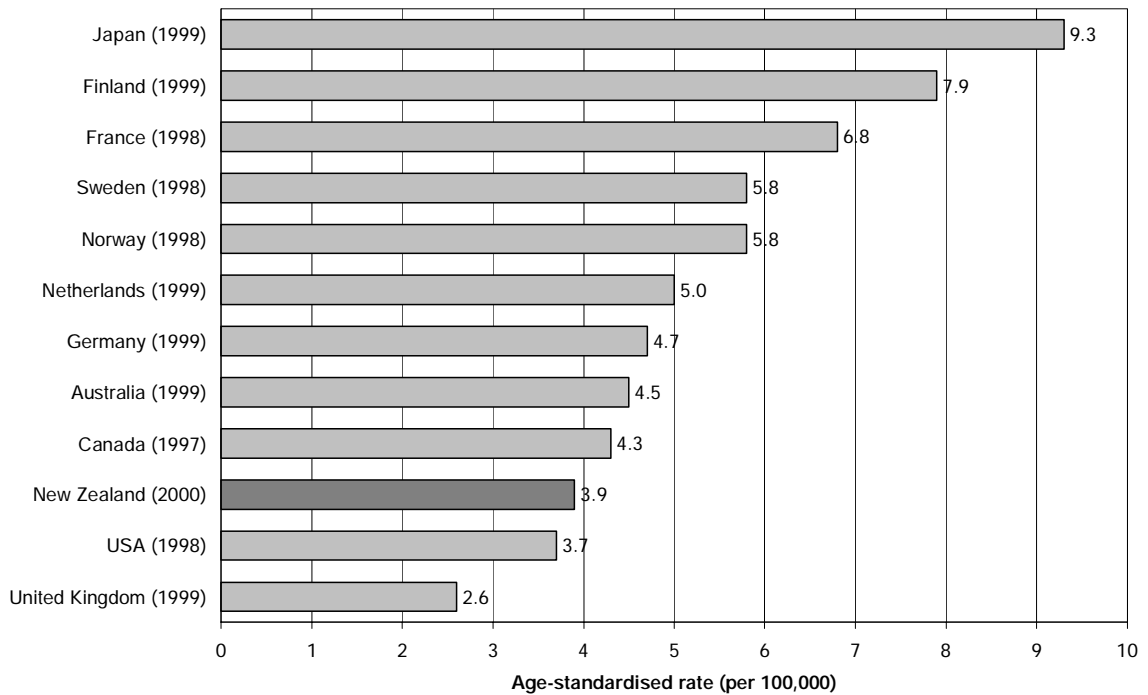
Figure 9: Total male suicide rates for selected OECD countries (2000 New Zealand)*



Source: NZHIS

* Note: Comparison years vary by country between 1997 and 2000.

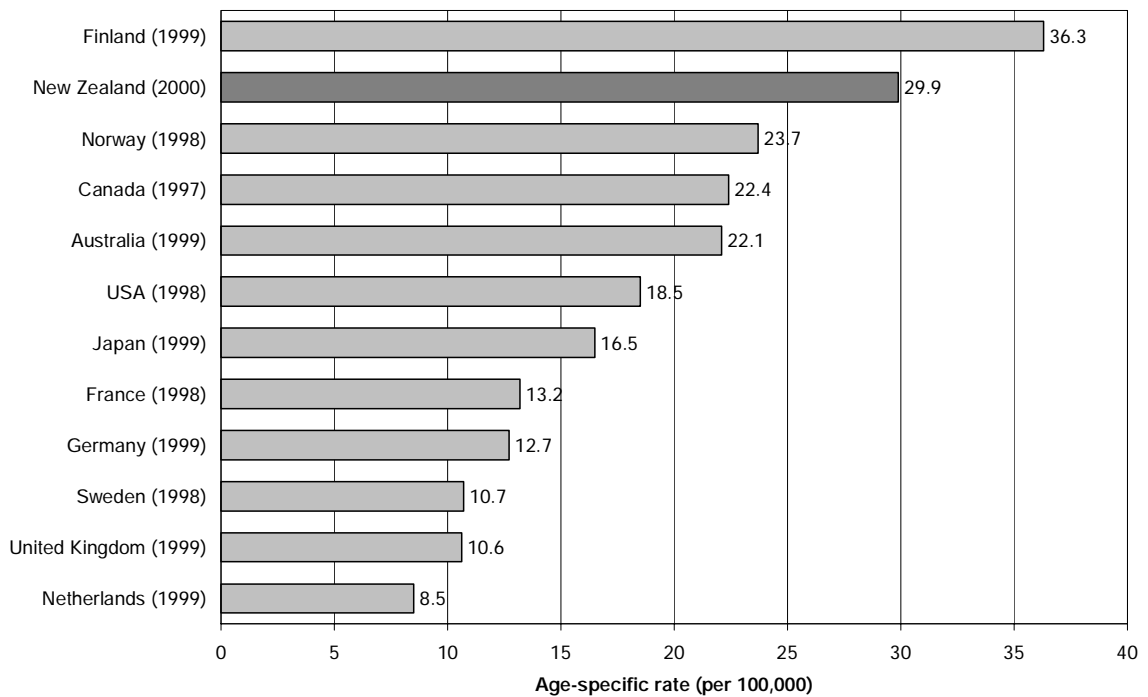
Figure 10: Total female suicide rates for selected OECD countries (2000 New Zealand)*



Source: NZHIS

* Note: Comparison years vary by country between 1997 and 2000.

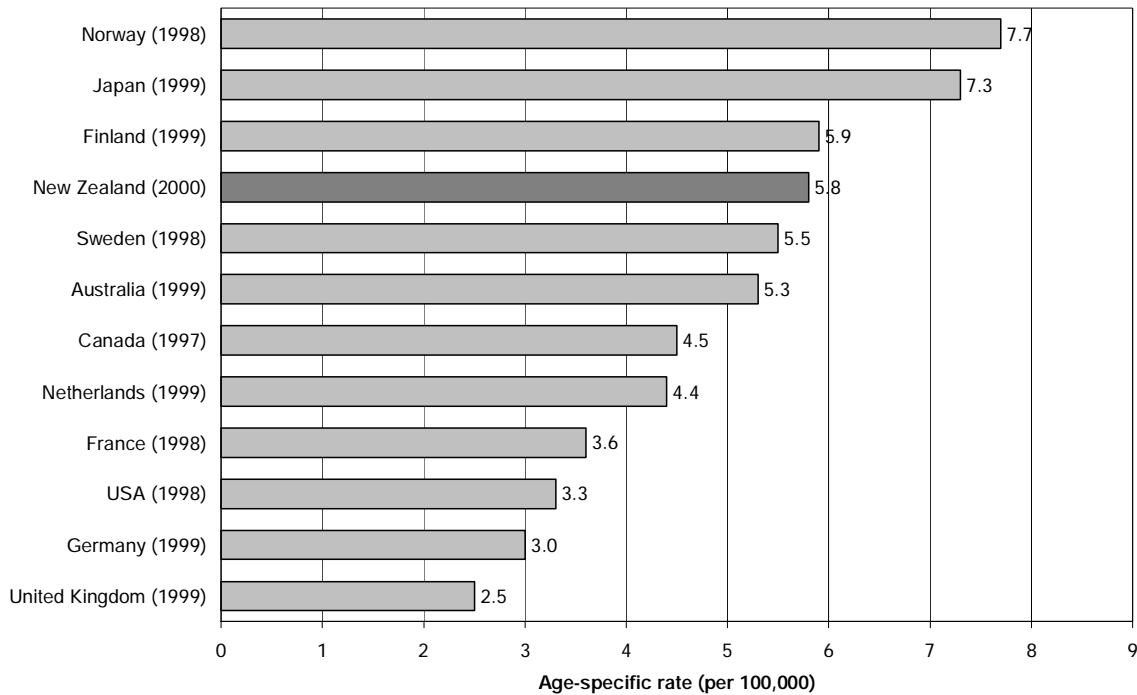
Figure 11: Male youth suicide rates (15–24 years) for selected OECD countries (2000 New Zealand)*



Source: NZHIS

* Note: Comparison years vary by country between 1997 and 2000.

Figure 12: Female youth suicide rates (15–24 years) for selected OECD countries (1999 New Zealand)*



Source: NZHIS

* Note: Comparison years vary by country between 1997 and 1999.

How accurate are international comparisons?

Comparing international rates of suicide is inherently problematic as countries may have different evidentiary standards when ascertaining whether a death was a suicide.

Background Information on Suicide

What causes people to want to take their own lives?

- Because each person is unique, there is no single reason why people choose to end their lives. However, from research it is known that several factors may contribute to a person engaging in suicidal behaviour.
- Mental disorder, most commonly depression, appears to be the most important risk factor for suicide and suicide attempts.
- Research from the Canterbury Suicide Project in Christchurch has found that young people who have died by suicide, or who have made a serious suicide attempt, often have shared circumstances, such as:
 - they have some underlying psychological distress or mental illness
 - they display some recognisable mental health or adjustment difficulty prior to the suicide attempt
 - immediately prior to the suicide attempt they may face a severe stress or life crisis that often centres around the breakdown of an emotional or supportive relationship
 - they tend to come from disturbed or unhappy family and childhood backgrounds
 - they tend to come from socially and educationally disadvantaged backgrounds.⁷
- Research from this study also found that approximately 90 percent of people who die by suicide or make suicide attempts will have one or more recognisable psychiatric disorders at the time. The most common of these are: depression, substance-use disorders (alcohol, cannabis and other drug abuse) and significant behavioural problems.

Are there protective factors for suicide?

Research is continuing to investigate the range of factors that may have the capacity to protect people who might otherwise be at risk of suicide. Suggested protective factors include good coping skills and problem-solving behaviours, positive beliefs and values, feelings of self-esteem and belonging, connections to family or school, secure cultural identity, supportive family/whānau, hapū and iwi, responsibility for children, social support, and holding attitudes against suicide.

How can suicide be prevented?

As there is no one reason that brings someone to take their own life, initiatives need to be in place across a range of settings supported by government, service providers, communities and families. Such interventions are generally aimed at promoting protective factors and reducing risk factors for suicide.

⁷ Beautrais A. 1998. *A Review of the Evidence: In Our Hands, The New Zealand Youth Suicide Prevention Strategy*. Wellington: Ministry of Health.

Key components of suicide prevention

In the absence of conclusive scientific evidence on all aspects of suicide prevention, there is strong agreement internationally on the key components for suicide prevention. The main themes from reports and strategies on suicide prevention, both in New Zealand and internationally, state the need for a comprehensive and intersectoral approach. This approach should use multiple strategies that:

- address multiple risk factors and enhance protective factors
- involve sustained action over a long period
- involve local, regional and national action
- involve action across several sectors (eg, health, education, police, corrections, child, youth and family)
- have a wide view of prevention requiring interventions to occur at a range of levels including the environment, whole population, specific population groups (eg, Māori, youth, Pacific peoples, males) and individuals at risk (preferably in the context of the family/whānau)
- include a focus on improving data, research and evaluation.

Intervention themes

There is general agreement that a comprehensive approach to suicide prevention needs interventions to address the following six themes:

1. Mental health promotion including strengthening social cohesion and providing supportive environments.
2. Effective, accessible and responsive services for people with mental disorders or suicidal behaviours (including prevention, recognition and treatment of depression).
3. Training and skill development on suicide risk assessment and management.
4. A managed approach to media and publicity about suicide.
5. Reducing access to the means of suicide.
6. Management and support for families and friends following suicide.

Examples of suicide prevention approaches

- The prevention, recognition and treatment of depression.
- The promotion of positive mental health in families, schools, workplaces and the community.
- The promotion of awareness of mental health issues at the community level.
- Improvement of services that have contact with people at risk of suicide (eg, primary health care, emergency services, Corrections, Child, Youth and Family, school guidance counsellors).
- The support of initiatives to reduce the stigma of mental illness (eg, *Like Minds, Like Mine* campaign).

- The improvement of public understanding of what to do if someone is suicidal.
- The improvement of support and treatment of those who have already attempted suicide, and their families and friends.
- The implementation of measures to restrict access to the means of suicide.
- The provision of guidance to the media about the reporting and publicity of suicide to minimise the potential of imitative suicides.
- The improvement of knowledge and information systems so suicide prevention strategies can be targeted for the best outcomes.
- The support of communities, families and whānau to provide emotionally safe and nurturing environments for all people, particularly children and young people.
- The expansion of family support and early intervention services to help keep children and young people safe and healthy.

A toolkit has been developed to provide guidance to District Health Boards on the most effective ways in which they can work to reduce the rate of suicide and suicide attempts in their region. This is available on the Ministry of Health website:
<http://www.newhealth.govt.nz/toolkits/suicideprevention.htm>.

What is the New Zealand Youth Suicide Prevention Strategy?

- In March 1998, the Government released *The New Zealand Youth Suicide Prevention Strategy*. This strategy provides a framework for understanding what suicide prevention is, and signals the steps a range of government agencies, communities, service providers, Māori whānau, hapū and iwi must take to reduce the incidence of suicide.
- Through the strategy, all suicide prevention initiatives should become increasingly co-ordinated and any service gaps identified and addressed.
- The strategy has two components. *In Our Hands* is the general population strategy. *Kia Piki te Ora o te Taitamariki* takes an approach based on whānau, hapū, iwi and Māori community development and encourages mainstream services to be more responsive to Māori.
- Since 2001, the Ministry of Youth Affairs has had the leadership role for promoting, co-ordinating and communicating the implementation of the strategy.
- A Ministerial and Inter-agency Committee, and an External Reference Group have also been formed to oversee the implementation of the strategy.

Where can people go for help?

If you are concerned about someone who may be suicidal or is very distressed, you can approach the following people for advice:

- General practitioner (GP) or practice nurse.
- Community mental health service.

- Māori community health service.
- Counselling services such as school guidance counsellor, iwi and other Māori health/counselling services, lesbian and gay support counselling services, sexual abuse counselling services, alcohol and drug services or other specialist counselling services, such as bereavement services, family counsellors, whānau support services, refugee support services, etc.
- Help lines such as Lifeline, Samaritans or Youthline (refer to front pages of telephone book).
- Group Special Support, Ministry of Education (formally Specialist Education Service).

In an emergency

Anyone seriously concerned about an individual's immediate safety should:

- remain with them until appropriate support arrives
- remove any obvious means of suicide (guns, medication, cars, knives, rope, etc)
- contact the nearest hospital or psychiatric emergency service.

SPINZ (Suicide Prevention Information New Zealand)

For general information on youth suicide and youth suicide prevention, and for copies of New Zealand Youth Suicide Prevention Strategy documents, contact:

SPINZ
 PO Box 10318
 Dominion Road
 Auckland
 Ph (09) 300-7035
 Fax (09) 300-7020
 Email: info@spinz.org.nz
 Website: www.spinz.org.nz

General information for the public on mental health

The Mental Health Foundation of New Zealand, ph (09) 300-7010, website: www.mentalhealth.org.nz.

Statistics

For health data contact the New Zealand Health Information Service (NZHIS):

Website: www.nzhis.govt.nz
 Ph (04) 922-1800
 Fax (04) 922 1897
 Email: inquiries@nzhis.govt.nz

New Zealand Youth Suicide Prevention Strategy

To find out more about the New Zealand Youth Suicide Prevention Strategy contact:

National Co-ordinator, Youth Suicide Prevention
Ministry of Youth Affairs
Ph (04) 916-4948
Fax (04) 471-2233

A stocktake of all government activities that relate to youth suicide prevention is available on the Ministry of Youth Affairs website: www.youthaffairs.govt.nz.

For more copies of this Fact Sheet and Suicide Fact Sheets for previous years, contact:

Wickliffe
Ph (04) 496 2277
Email pubs@moh.govt.nz