

Youth Suicide Facts

Provisional 2000 Statistics
(15–24 year olds)

This fact sheet comments only on youth suicides. As there are still a large number of deaths awaiting coroner's findings, all age suicide statistics will not be available for 2000 until April 2003.

For 1999 all age suicide statistics see:

<http://www.moh.govt.nz/moh.nsf/238fd5fb4fd051844c256669006aed57/fca8632bafc3ab00cc256ba4007b9c06?OpenDocument>

Published in October 2002 by the
Ministry of Health
PO Box 5013, Wellington, New Zealand
ISSN: 1176-046X (Internet)

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 – Youth (15–24 years)	2
How many young people (15–24 years) died by suicide in 1999?	2
What is the rate of youth suicide (15–24 years) in New Zealand?	2
How many Māori youth (15–24 years) died by suicide in 2000?	3
Other information	3
Is the overall rate of youth suicide still increasing?	4
Suicide Attempts	5
How many young people (15–24 years) attempted suicide in 1999/2000 (July 1999 to June 2000)?	5
Are there problems with the accuracy of suicide attempt data?	5
What is the relationship between suicide and attempted suicide?	6
International Comparisons	7
How does New Zealand's youth suicide rate compare internationally?	7
Background Information on Suicide	9
What causes people to want to take their own lives?	9
Are there protective factors for suicide?	9
Where can people go for help?	10
How can suicide be prevented?	10
Key components of suicide prevention	10
Intervention themes	11
Examples of suicide prevention initiatives	11
What is the New Zealand Youth Suicide Prevention Strategy?	12
Help lines and services	12

Key Points

- The total number of youth (15–24 years) suicides in the year 2000 was 96 (18.1 per 100,000), down from 120 in 1999 and 140 in 1998. Those figures were the lowest total number and rate since 1986 when there were 91 suicides (15.6 per 100,000). The year 2000 suicide rate equates to approximately one suicide per 5500 young people.
- There was a large drop in the number of female suicide deaths from 37 (14.2 per 100,000) in 1999 to 15 (5.8 per 100,000) in 2000. Male suicide deaths and rates have changed little between 1999 and 2000; there were 83 (30.6 per 100 000) in 1999 and 81 (29.9 per 100,000) in 2000.
- Youth suicide deaths have decreased for both Māori and non-Māori females. In 2000, the Māori female rate was 7.4 (down from 18.7 in 1999) while the non-Māori female rate was 5.4 (down from 13.1 in 1999).
- In 2000, the rate of suicide for Māori was 25.7 per 100,000, and 16.2 per 100,000 in non-Māori. Young males continue to experience a high rate of suicide with a Māori rate of 43.5 in 2000 (42.4 in 1999), and a non-Māori rate of 26.4 in 2000 (27.7 in 1999).
- The hospitalisation rate for youth suicide attempts and self-inflicted injuries in 1999/2000 has increased slightly on the 1998/1999 rate.
- 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?

Provisional 2000 data is available on youth suicides.¹ These figures are still considered provisional because there are a small number of deaths that are subject to coroners' findings, and for which a cause of death has therefore not yet been assigned. Data becomes official once it is published by the New Zealand Health Information Service (NZHIS) in the Annual Mortality Publication series.

How is a death deemed to be a suicide?

Only a coroner can classify a death to be a suicide. A coroner will inquire into all suspicious deaths and make the decision after they have all the facts. In some cases the inquest will be heard over a year after the death, particularly if there are other factors surrounding the death that need to be investigated first.

¹ Provisional 1999 statistics for all ages are available on the New Zealand Health Information website: www.nzhis.govt.nz.

Suicide – Youth (15–24 years)

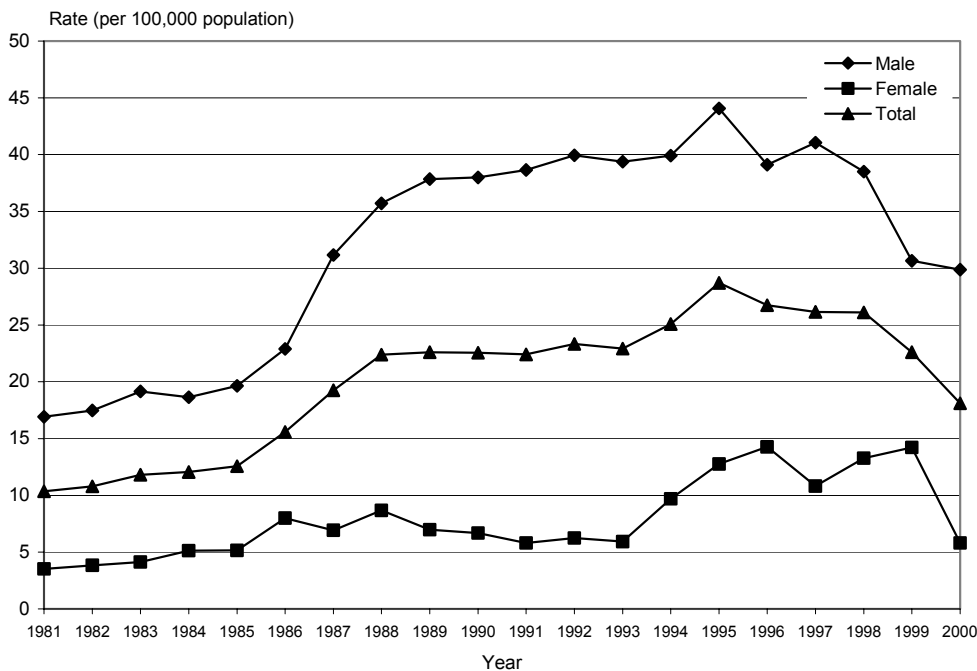
How many young people (15–24 years) died by suicide in 1999?

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 rate² 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 1: Youth suicide rates (aged 15–24), 1981–2000



Source: NZHIS

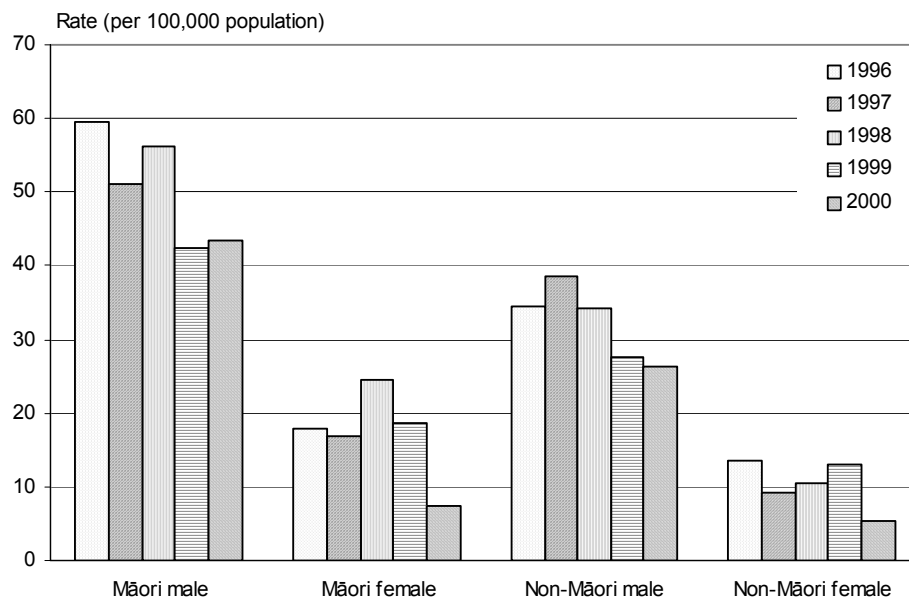
² What is the difference between a number and a rate?

- The number of suicide deaths is 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.

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.
- In 2000, the rate of suicide for Māori youth 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 2: Youth suicide rates (aged 15–24) by ethnicity, 1996–2000



Source: NZHIS

Other information

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

Is the overall rate of youth suicide still increasing?

- No. 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 a 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 Attempts³

How many young people (15–24 years) attempted suicide in 1999/2000 (July 1999 to June 2000)?

- The hospitalisation rate for young people (15–24 years) in 1999/2000 was 198.5 per 100,000 (1054 hospitalisations) compared with 195.2 per 100,000 in 1998/1999 (1047 hospitalisations) and 215.8 per 100,000 in 1997/1998 (1172 hospitalisations). The hospitalisation rate in 1995/1996 was 238.4 per 100,000 (five years ago).
- In 1999/2000, there were 356 young male hospitalisations (131.4 per 100,000) compared with 402 hospitalisations (147.4 per 100,000) in 1998/1999.
- In 1999/2000, there were 698 young female hospitalisations (268.3 per 100,000) compared with 645 hospitalisations (244.6 per 100,000) in 1998/1999.
- In 1999/2000, the hospitalisation rate for Māori females was 224.4 per 100,000, lower than the non-Māori female rate of 279.6 per 100,000. For Māori males the hospitalisation rate was 158.6 per 100,000, higher than the non-Māori male rate of 124.6 per 100,000).

Are there problems with the accuracy of suicide attempt data?

Yes. It is important to be cautious about interpretation of suicide attempt data for the following reasons:

- Accurate data on all suicide attempts is not available because records are kept only 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, on people treated by GPs, and on those who do not seek medical treatment.
- Changing treatment practices make comparisons across years difficult; for example, the improvement of treatments for overdose has meant more people can be treated as outpatients, and they will not appear in the figures.
- The suicide attempt data (above) relate to 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 as well as those who died while in hospital.

³ This data was released in April 2002.

What is the relationship between suicide and attempted suicide?

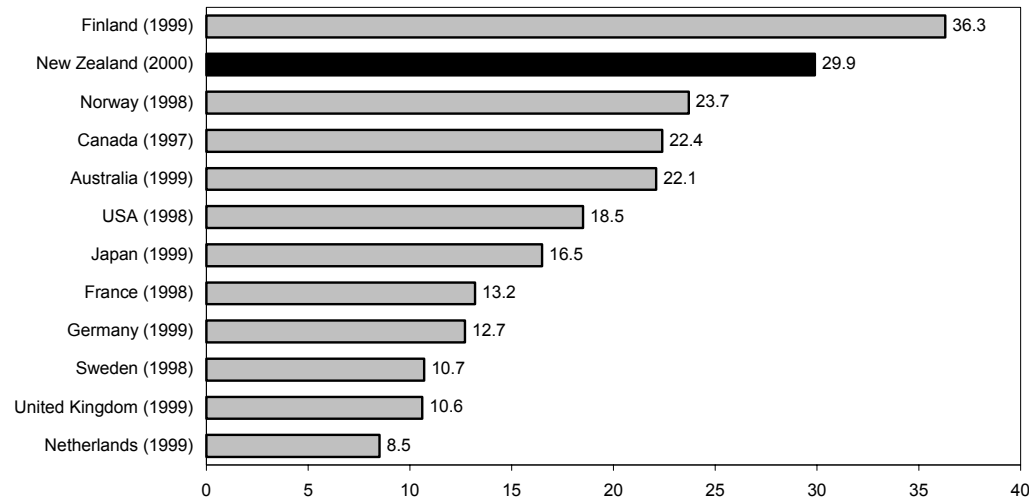
People who have already made one suicide attempt are at greater risk of dying by suicide so it is important that such people get effective follow-up support and treatment.

International Comparisons

How does New Zealand's youth suicide rate compare internationally?

- Data for 2000 is not yet available from other OECD countries, so comparison years vary.
- Comparing international rates of suicide is inherently problematic as countries use different methods to classify suicide.
- In 2000 New Zealand youth aged 15–24 years had the second highest rate of suicide for males (highest in 1999) and the fourth highest for females (highest in 1999) among selected OECD countries.

Figure 3: Male youth (15–24 years) suicide rates per 100,000 in selected OECD countries (2000 New Zealand)*

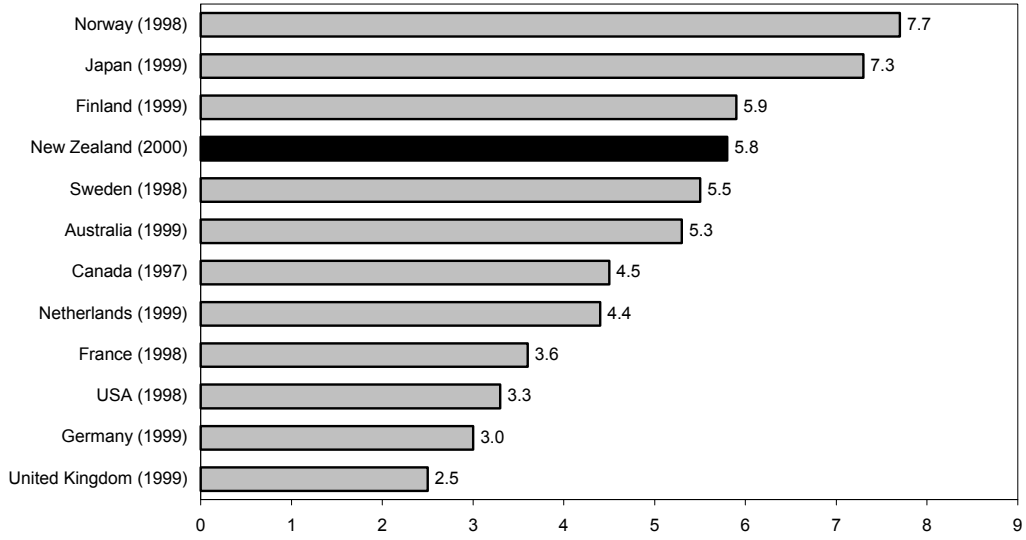


Source: NZHIS

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

Note: the x axis scale is different for figure 3 and figure 4.

Figure 4: Female youth (15–24 years) suicide rates per 100,000 in selected OECD countries (2000 New Zealand)*



Source: NZHIS

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

Note: the x axis scale is different for figure 3 and figure 4.

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.⁴
- 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.

⁴ Beautrais A (1998) *A Review of the Evidence: In Our Hands, The New Zealand Youth Suicide Prevention Strategy*. Wellington: Ministry of Health.

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:

- family doctor (GP) or practice nurse
- community mental health service
- marae-based health clinics
- Māori community health workers
- counsellor (including school guidance counsellor) or Māori health/counselling services
- phone counselling services such as Lifeline, Samaritans or Youthline.

If the situation is critical try to ensure the person is safe and contact your nearest hospital emergency department or psychiatric emergency team.

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.

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 and 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, etc)
- 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 initiatives

- 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 healthcare, emergency services, Corrections, Child, Youth and Family, school guidance counsellors, etc).
- 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.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 government-level implementation of the strategy.

Help lines and services

Help lines

Refer to front pages of the telephone book. Helplines include:

- Lifeline
- Samaritans
- Youthline.

Services for emergencies

- Psychiatric emergency services.
- Community mental health services.
- General practitioners.
- Emergency department of the local hospital.

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.

General support services

- Community mental health services.
- General practitioner.
- Lesbian and gay support counselling services.
- Iwi and other Māori health/counselling services.
- Sexual abuse counselling services.
- Family counselling services.
- Alcohol and drug services.
- Other specialist counselling services, such as bereavement services, family counsellors, whānau support services, refugee support services, etc).
- Victim support.
- Samaritans/Lifeline/Youthline.
- School counsellor.
- Group Special Support, Ministry of Education (formally Specialist Education 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
Ph (09) 638-7364
Fax (09) 630-7190
E-mail: 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) 630-8573, Website: www.mentalhealth.org.nz.

Statistics

New Zealand Health Information Service:

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

New Zealand Youth Suicide Prevention Strategy

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

Debbie Edwards

National Co-ordinator
Ministry of Youth Affairs
Ph (04) 914-4863
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 0800 226 440
E-mail pubs@moh.govt.nz