

# **Suicide Facts**

Provisional 1999 Statistics (all ages)

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<http://www.nzhis.govt.nz/stats/suicidestats99.html>



MANATŪ HAUORA

## Key Points

- The total number of suicides has reduced to 514 from 577 in 1998 and 561 in 1997. This is the lowest total number since 1994 (512) and the lowest rate since 1993.
- Total suicide deaths and rates have reduced among males in recent years, but there has been a slight increase in numbers and rates among females.
- In 1999 a total of 120 young people aged 15–24 years died by suicide, compared with 140 in 1998, and 142 in 1997. Young people still have higher rates of suicide than other age groups.
- Suicide deaths have reduced among both Māori and non-Māori. In 1999 the rate of suicide among both Māori and non-Māori was almost identical (12.0 to 12.2 per 100,000). However, Māori continue to have higher rates of youth suicide.
- The hospitalisation rate for suicide attempt and self-inflicted injury in 1999/2000 has increased slightly for the total population compared to 1998/1999 and 1997/1998 (but is identical to the 1995/1996 rate). Hospitalisation rates for youth (15–24 years) in 1999/2000 have also increased slightly on 1998/1999 but are lower than 1995/1996 rate.
- There is some variation in regional suicide rates for the total population but no apparent trend. There is more variation among youth rates but still no emergent regional trends.
- 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 the Government, service providers, communities and families.

## What is the most recent data available on suicide?

- We have *provisional* 1999 data for all ages. 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 becomes official once it is published by the New Zealand Health Information Service (NZHIS) in the annual publication series *Mortality and Demographic Data*.

## 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 which need to be investigated first.

# Suicide – All Ages

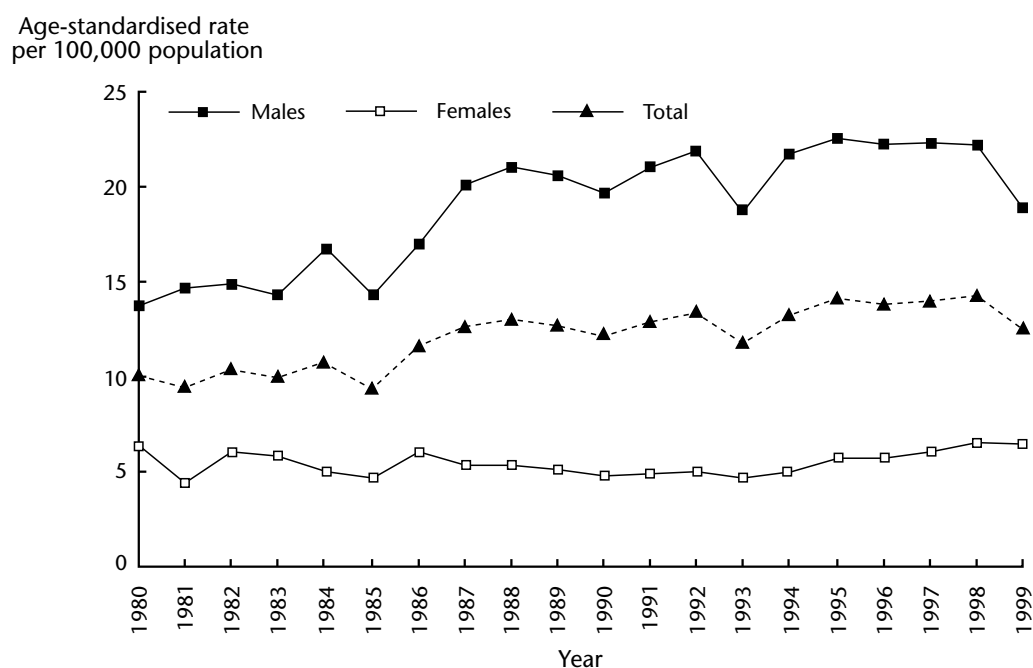
## How many people died by suicide in 1999?

- A total of 514 people died by suicide, compared with 577 in 1998, and 561 in 1997.
- In 1999, 383 males died by suicide, compared with 445 in 1998, and 440 in 1997.
- In 1999, 131 females died by suicide, compared with 132 in 1998, and 121 in 1997.

## What is the rate<sup>1</sup> of suicide in New Zealand?

- The suicide rate<sup>2</sup> for the total population was 12.5 per 100,000 in 1999, compared to 12.1 per 100,000 in 1990. This was the lowest rate since 1993.
- The rate of suicide for males was 18.9 per 100,000 in 1999, compared with 19.7 per 100,000 in 1990.
- The rate of suicide for females was 6.4 per 100,000 in 1999, compared to 4.7 per 100,000 in 1990.

Figure 1: Suicide death rate 1980–1999. Source: NZHIS.



<sup>1</sup> What is the difference between the number and rate?

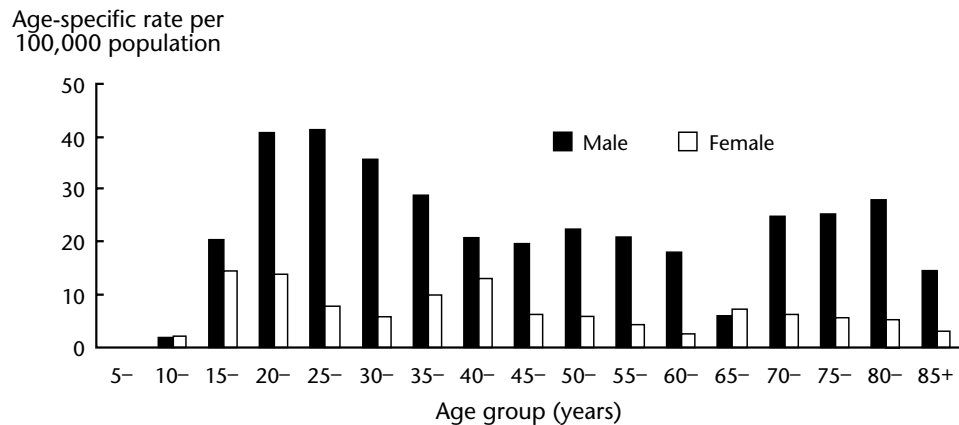
- The number of suicide deaths is exactly that: the actual number of people who have died by suicide.
- The age-specific rate of suicide is the frequency with which it occurs relative to the number of people in a defined population.

<sup>2</sup> These rates have been adjusted to take account of differences between the age distribution of the population.

## Suicides by age group

- In 1999 the highest rates of suicide are among males 20–39 years old (20–24: 41.2 per 100,000; 25–29: 41.5 per 100,000; 30–34: 36.0 per 100,000; 35–39: 29.1 per 100,000). Among females 15–19 years old (14.5 per 100,000) and 20–24 years old (14.0 per 100,000) have the highest rates.

**Figure 2: Suicide rates by age group and sex, 1999.** Source: NZHIS.



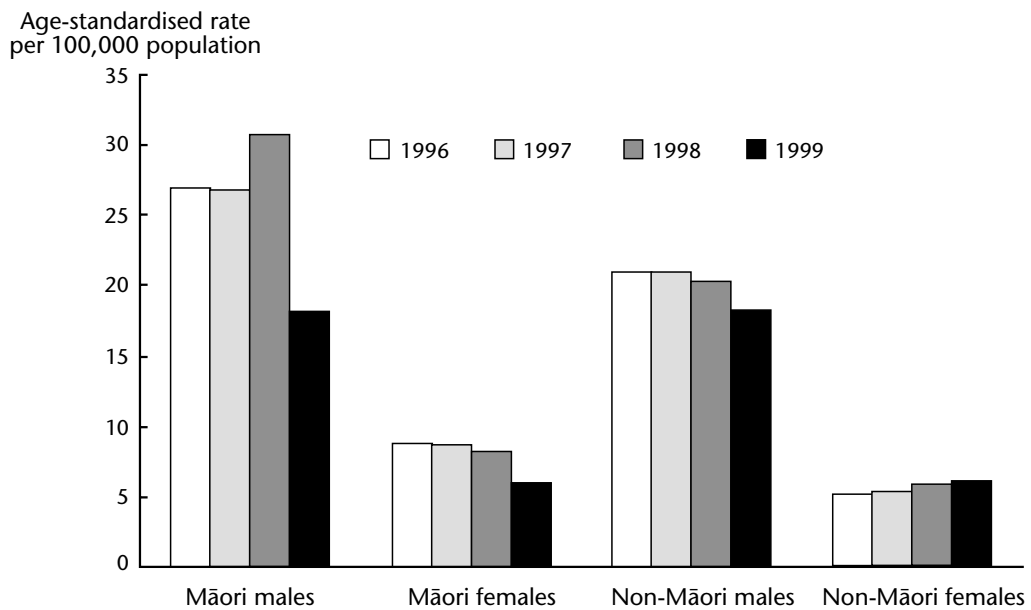
## How many Māori died by suicide in 1999?

- In 1999, 77 Māori died by suicide, compared to 112 in 1998 and 103 in 1997.
- In 1999, 57 Māori males died by suicide compared to 87 in 1998, 77 in 1997.
- In 1999, 20 Māori females died by suicide compared to 25 in 1998, 26 in 1997.
- The rate of suicide for Māori was 12.0 per 100,000, compared to the non-Māori rate of 12.2 per 100,000.
- In 1999, the rate of suicide for Māori males was 18.2 per 100,000, compared to the non-Māori rate of 18.4 per 100,000.
- In 1999, the rate of suicide for Māori females was 6.1 per 100,000, compared to the non-Māori rate of 6.2 per 100,000.

## How many Pacific people died by suicide in 1999?

- In 1999, 14 Pacific people died by suicide (eight males and six females), compared to 24 deaths in 1998.

Figure 3 : Suicide death rates by ethnicity, 1996–1999. Source: NZHIS.



## How has the classification of ethnicity changed? And can we still compare ethnicity data across years?

- In September 1995, the method used for recording ethnicity for all mortality changed from a system of biological concept (50 percent or more ancestry) to one of self-identification. This was to match with census changes to what is considered to be a more reliable method.
- The changes have had a major impact on the relative rates of all mortality for Māori and non-Māori.
- Ethnicity data can now only be compared as far as 1996. This is the case for all ethnic specific mortality data.

## Why do more males die by suicide than females?

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

# Suicide – Youth (15–24 years)

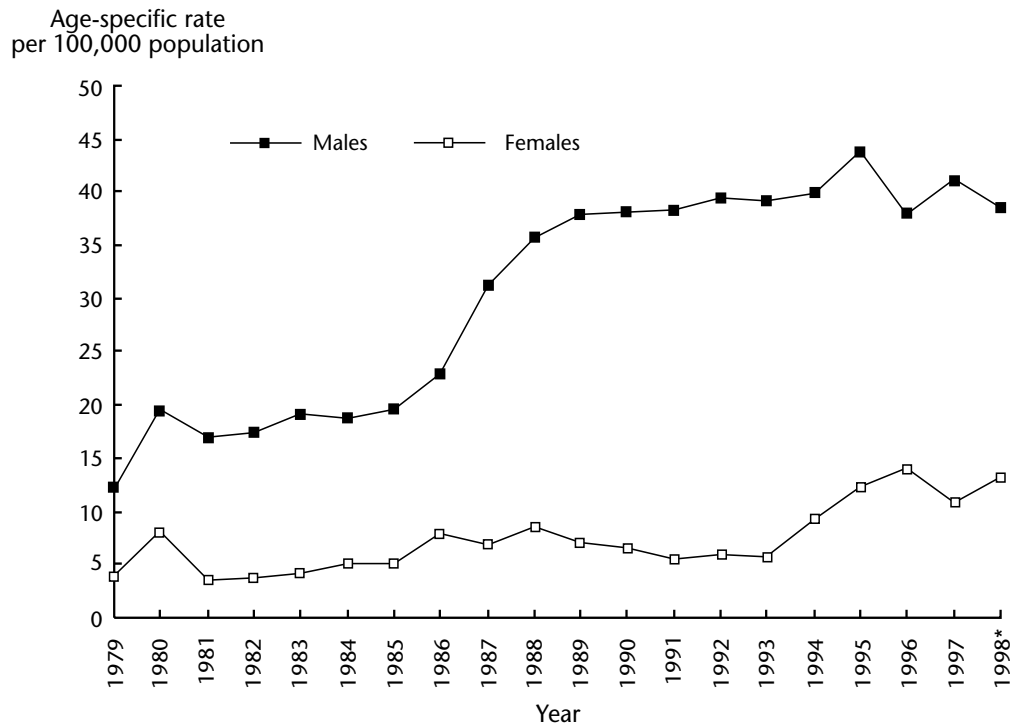
## How many young people (15–24 years) died by suicide in 1999?

- In 1999 a total of 120 young people aged 15–24 years died by suicide, compared with 140 in 1998, and 142 in 1997.
- Of these 120 young people, 83 were male and 37 were female.

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

- The total rate of youth suicide in 1999 was 22.6 per 100,000 compared to 22.5 per 100,000 in 1990.
- The rate of youth suicide for males (aged 15–24) in 1999 was 30.6 per 100,000, compared with 38.0 per 100,000 in 1990.
- The rate of youth suicide for females (aged 15–24) in 1999 was 14.2 per 100,000, compared with 6.7 per 100,000 in 1990.

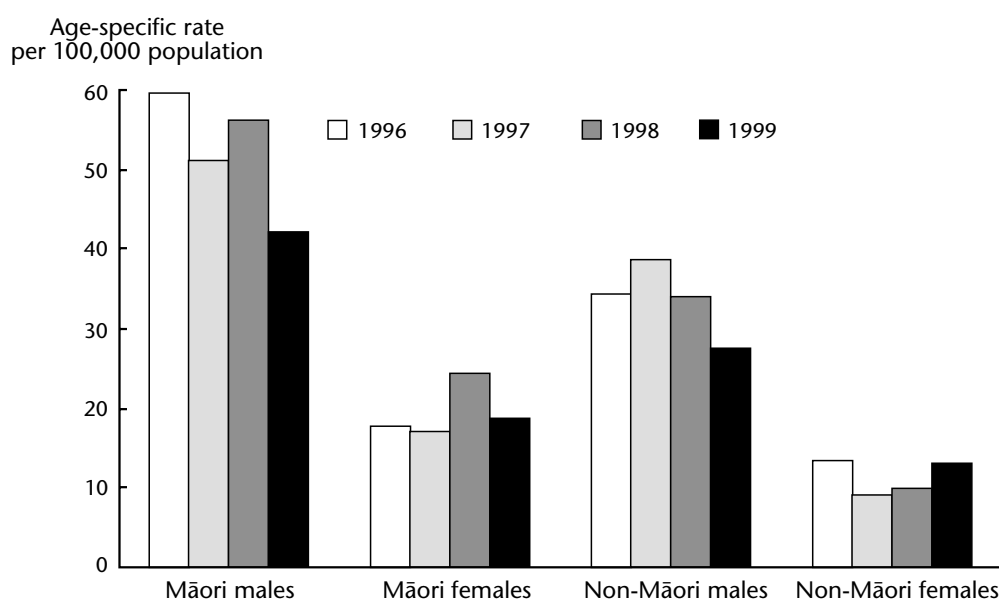
Figure 4: Youth suicide rates (aged 15–24), 1980–1999. Source: NZHIS.



## How many Māori youth (15–24 years) died by suicide in 1999?

- In 1999, 33 Māori young people (15–24 years) died by suicide (23 males, 10 females), compared to 43 in 1998, and 36 in 1997.
- In 1999, the rate of suicide for Māori youth was 30.6 per 100,000, compared to the non-Māori rate of 20.5 per 100,000.
- In 1999, the rate of suicide for young Māori males was 42.4 per 100,000, compared to the non-Māori rate of 27.7 per 100,000.
- In 1999, the rate of suicide for young Māori females was 18.7 per 100,000, compared to the non-Māori rate of 13.1 per 100,000.

*Figure 5: Youth suicide rates (aged 15–24) by ethnicity, 1996–1999. Source: NZHIS.*



## Is the overall rate of youth suicide still increasing?

- No. The youth suicide rate has now decreased for four consecutive years. The 1999 numbers and rates are the lowest for many years. Total youth suicide deaths are the lowest since 1987 and the total rate is the lowest since 1991. Youth suicide numbers and rates have dropped for both Māori and non-Māori. There was a slight increase for females from 1998 (due to an increase among non-Māori females).
- 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 1999/2000 (collected from mid-year to mid-year)?

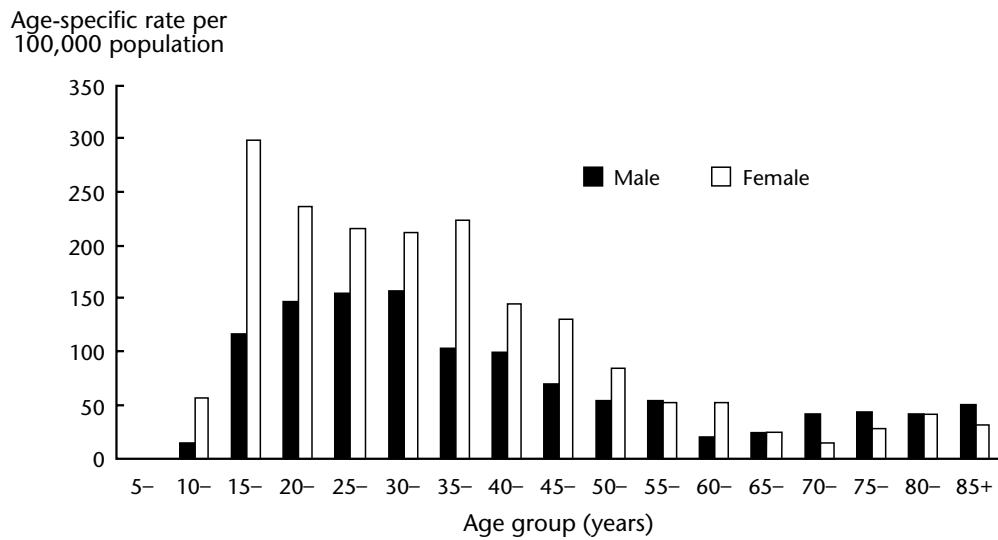
### All ages:

- The rate of hospitalisation for 1999/2000 was 95.7 per 100,00, compared to 92.9 per 100,000 in 1998/1999, and 94.8 per 100,000 in 1997. In 1999/2000, there were 3767 hospitalisations for self-inflicted injury compared to 3631 in 1998/1999. The rate of hospitalisation in 1999/2000 was the same as 1995/1996 (five years ago).
- In 1999/2000 there were 1389 male hospitalisations (a rate of 70.4 per 100,000) compared to 1427 hospitalisations in 1998/1999 (a rate of 73.1 per 100,000).
- In 1999/2000 there were 2378 female hospitalisations (a rate of 121.2 per 100,000), up from 2204 in 1998/1999 (a rate of 112.9 per 100,000).
- Among Māori in 1999/2000 there were of 556 hospitalisations, at a rate of 89.5 per 100,000 (213 male hospitalisations at a rate of 70.4 per 100,000, and 343 female hospitalisations at a rate of 108.0 per 100,000).
- More females are hospitalised for attempting suicide than males. This is mainly due to females more often choosing methods such as self-poisoning, which generally are less fatal, but still serious enough to require hospitalisation.

### Youth (15–24 years):

- Youth have the highest hospitalisation rates.
- The hospitalisation rate for young people (15–24 years) in 1999/2000 is 198.5 per 100,000 (1054 hospitalisations) compared to 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 male hospitalisations (rate of 131.4 per 100,000) compared to 402 hospitalisations (rate of 147.4 per 100,000) in 1998/1999.
- In 1999/2000 there were 698 female hospitalisations (rate of 268.3 per 100,000) compared to 645 hospitalisations (rate of 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).

Figure 6: Rates of suicide and self-inflicted injury by age, 1999–2000. 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 don't 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 & Emergency (A&E) as outpatients, 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.
- 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?

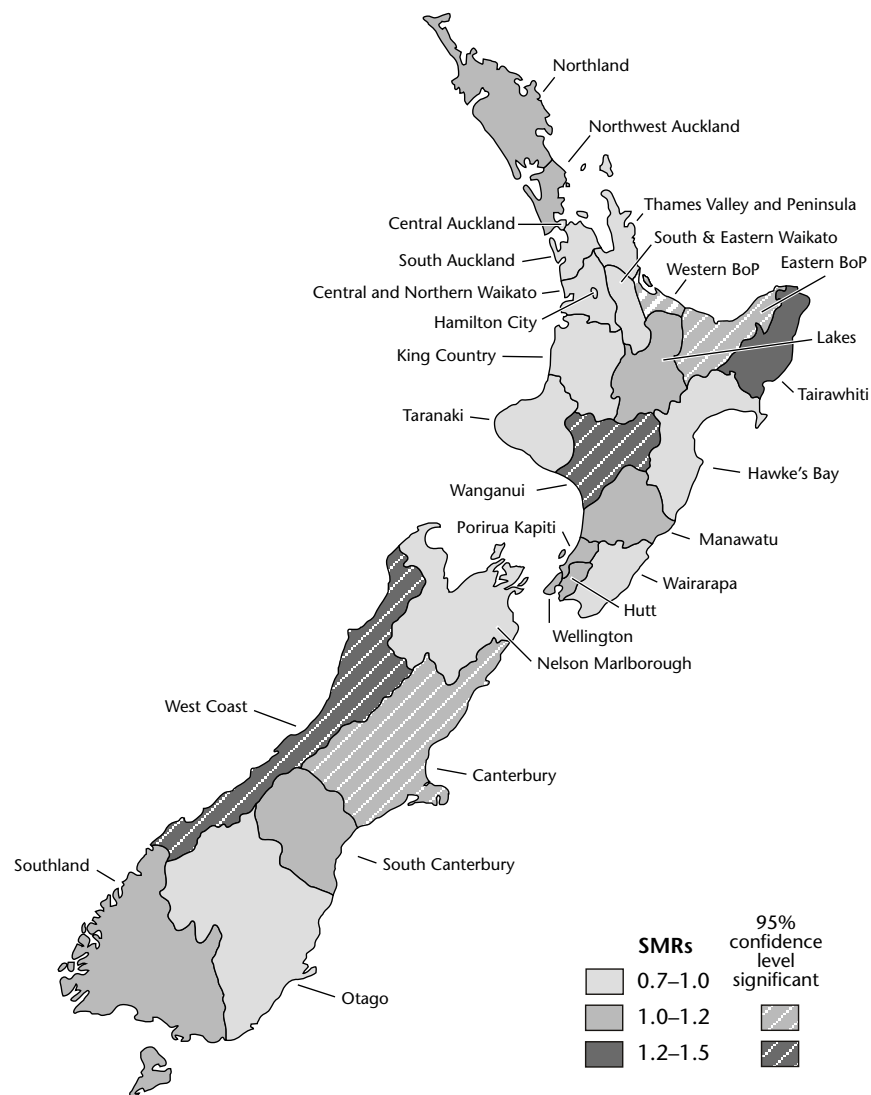
- People who have already made one suicide attempt are at greater risk of dying by suicide so it is important that such people get effective follow-up support and treatment.

# Regional Comparisons

## Key points (total population)

- Although there is variation at the District Health Board level, no overall trend in suicide rates is apparent.
- The Bay of Plenty, Whanganui, West Coast and Canterbury District Health Boards have suicide rates significantly higher than the national rate.<sup>3</sup> No District Health Board has suicide rates significantly lower than the national rate.

**Figure 7: Total population suicide rates by DHB subregion, 1995–1999 (Standardised Mortality Ratio).** Note: The Hawke’s Bay DHB region incorporates the Chatham Islands.



<sup>3</sup> These regions have been highlighted because the confidence interval is high (ie, above 95 percent as highlighted in the maps). Other areas above the national average like Tairāwhiti are excluded because the confidence interval is below 95 percent.

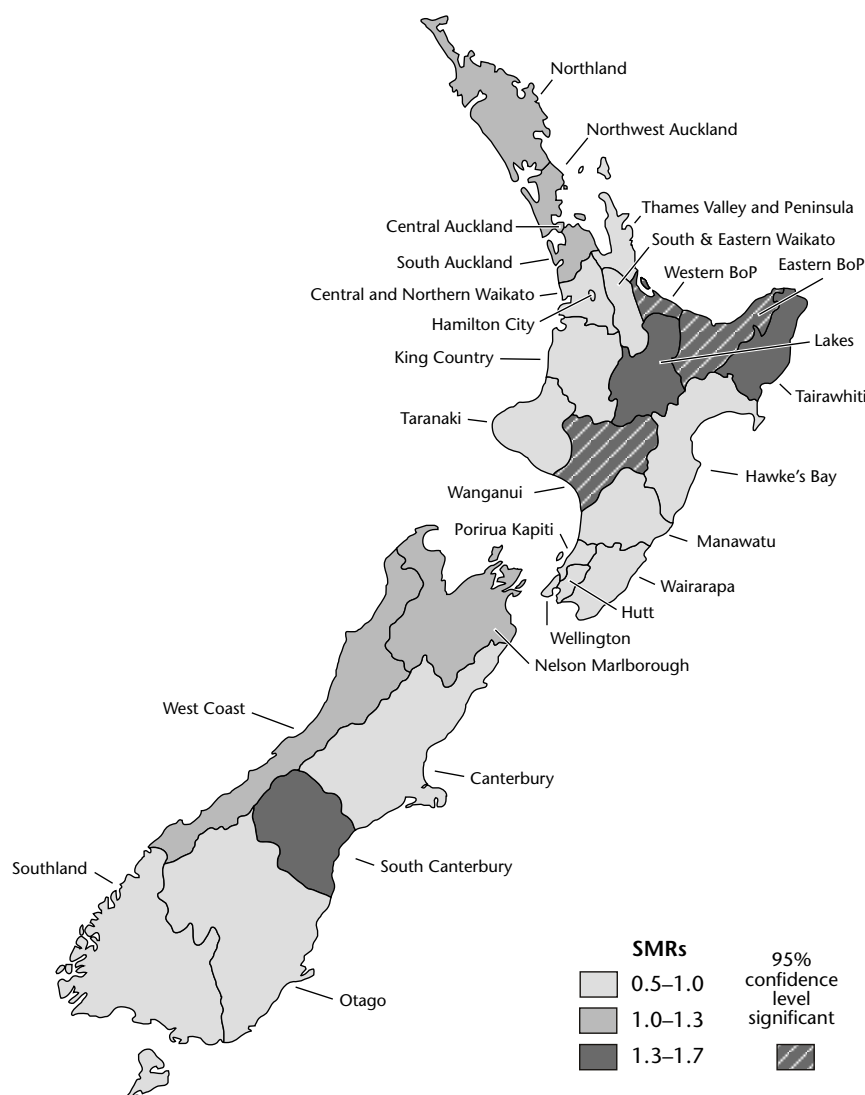
## Key points (youth)

- While the magnitude of regional variation amongst youth suicide rates is greater, the number of District Health Boards reaching levels of significance is less than for the total population. The lower levels of significance are due to the smaller populations involved in calculating youth suicide rates.
- The Bay of Plenty and Whanganui District Health Boards have significantly higher youth suicide rates, while only the Auckland District Health Board has a significantly lower youth suicide rate than the national rate.<sup>4</sup>

## General points

- Whanganui and Bay of Plenty have significantly higher suicide rates for both youth and the general population.

**Figure 8: Total youth (15–24 years) suicide rates by DHB subregion, 1995–1999 (Standardised Mortality Ratio).** Note: The Hawke's Bay DHB region incorporates the Chatham Islands.



<sup>4</sup> These regions have been highlighted because the confidence interval is high (ie, above 95 percent as highlighted in the maps). Others are excluded where the confidence is lower.

**Table 1: Suicide deaths by DHB region and sex, 1995–1999.** Note: Shaded areas indicate regions with significantly higher or lower Standard Mortality Ratios (SMRs) with high confidence levels (96 percent or above).

	Male		Female		Total	
	SMR	95% CI	SMR	95% CI	SMR	95% CI
Northland	1.05	0.8–1.3	1.50	1.0–2.1	1.16	1.0–1.4
Waitemata	1.02	0.9–1.2	1.20	0.9–1.5	1.06	0.9–1.2
Auckland	1.02	0.9–1.2	1.09	0.8–1.4	1.03	0.9–1.2
Counties Manukau	0.96	0.8–1.1	0.93	0.7–1.2	0.95	0.8–1.1
Waikato	0.95	0.8–1.1	0.83	0.6–1.1	0.93	0.8–1.1
Lakes	1.16	0.9–1.5	1.07	0.6–1.7	1.15	0.9–1.4
Bay of Plenty	1.29	1.1–1.5	1.05	0.7–1.5	1.24	1.0–1.5
Tairāwhiti	1.42	1.0–2.0	0.70	0.2–1.6	1.27	0.9–1.7
Hawke’s Bay	1.05	0.8–1.3	0.97	0.6–1.5	1.03	0.8–1.2
Taranaki	1.01	0.8–1.3	0.84	0.5–1.4	0.98	0.8–1.2
MidCentral	0.99	0.8–1.2	1.54	1.1–2.1	1.12	0.9–1.3
Whanganui	1.23	0.9–1.6	1.50	0.9–2.4	1.31	1.0–1.7
Capital and Coast	1.04	0.9–1.2	1.10	0.8–1.5	1.05	0.9–1.2
Hutt	1.21	1.0–1.5	1.07	0.7–1.6	1.18	1.0–1.4
Wairarapa	0.63	0.3–1.1	0.82	0.3–1.9	0.68	0.4–1.1
Nelson-Marlborough	1.04	0.8–1.3	0.90	0.5–1.4	1.02	0.8–1.3
West Coast	1.57	1.1–2.2	1.12	0.4–2.4	1.51	1.1–2.1
Canterbury	1.20	1.1–1.4	1.14	0.9–1.4	1.19	1.1–1.3
South Canterbury	1.16	0.8–1.6	0.92	0.4–1.8	1.12	0.8–1.5
Otago	1.03	0.8–1.3	0.74	0.5–1.1	0.96	0.8–1.2
Southland	1.26	1.0–1.6	0.85	0.5–1.4	1.19	1.0–1.5

## What are Standardised Mortality Ratios?

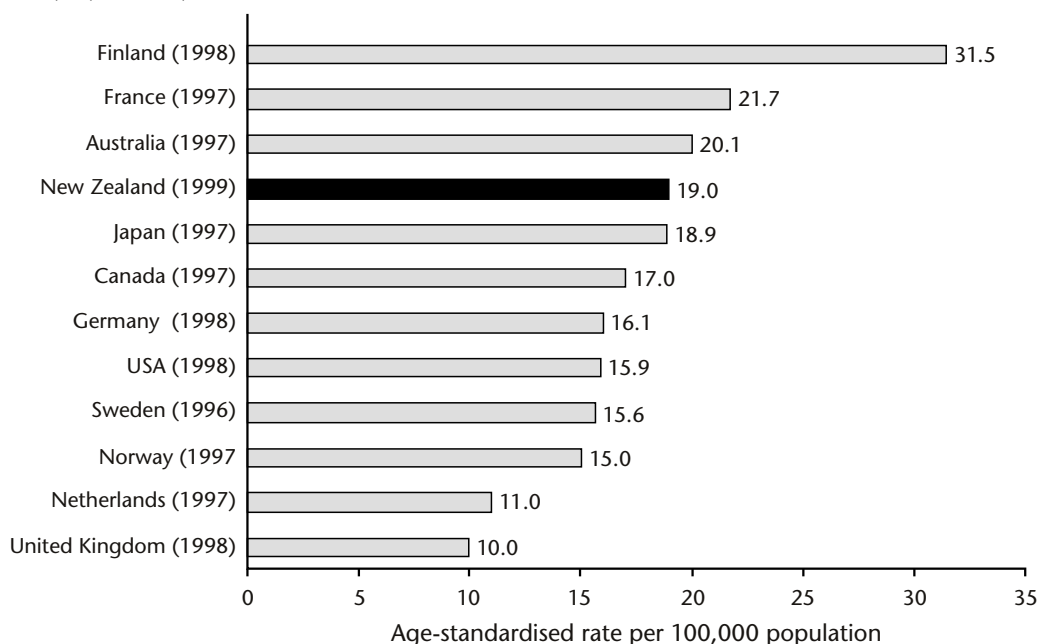
- SMRs (Standardised Mortality Ratios) are a means of comparing regional variations in rates of mortality (or morbidity). In a regional analysis, SMRs compare subnational rates, in this case District Health Boards, with that of the national rate. These ratios indicate whether a region is below or above 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).
- In addition to the SMRs, a 95 percent confidence interval indicates whether these differences (from national rate) are likely to occur by chance, ie, they give confidence in the variations observed. It should be noted that these confidence intervals are distinct from the magnitude of difference in the SMRs, that is, large differences may not be ‘real’.

# International Comparisons

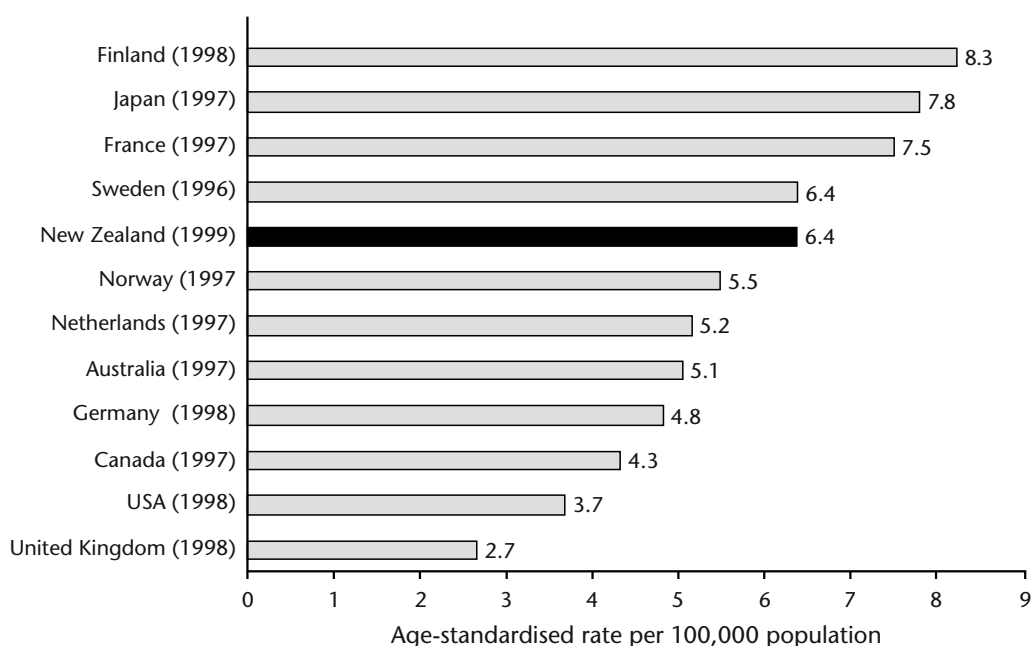
## How does New Zealand's suicide rate compare internationally?

- In comparison with selected OECD countries, New Zealand's 1999 suicide rates are high, particularly among youth.
- In 1999, New Zealand's all age suicide rates for males and females were the fourth highest among selected OECD countries.

**Figure 9: Total male suicide rates for selected OECD countries.** Note: Comparison years vary by country between 1997 and 1999. Source: NZHIS.



**Figure 10: Total female suicide rates for selected OECD countries.** Note: Comparison years vary by country between 1997 and 1999. Source: NZHIS.

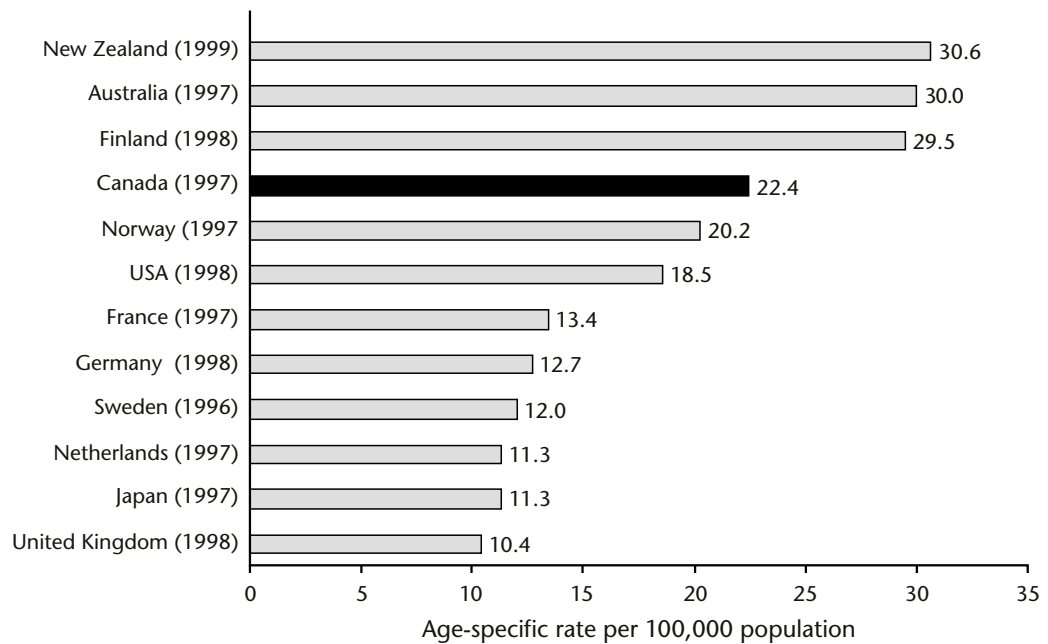


- For youth aged 15–24 years, New Zealand has the highest rates of suicide for both males and females among selected OECD countries.
- The increase in youth suicide over the last 20 years appears to be a global trend, particularly amongst developed countries.

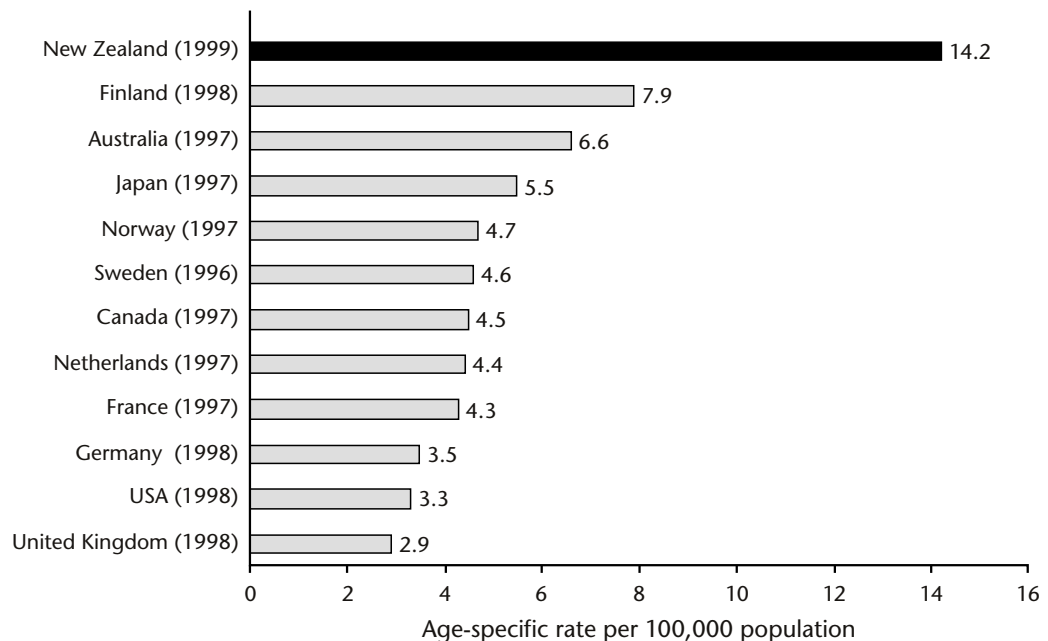
## How accurate are international comparisons?

- Comparing international rates of suicide is inherently problematic as countries use different methods to classify suicide.

**Figure 11: Male youth suicide rates (15–24 years) for selected OECD countries.** Note: Comparison years vary by country between 1997 and 1999. Source: NZHIS.



**Figure 12: Female youth suicide rates (15–24 years) for selected OECD countries.** Note: Comparison years vary by country between 1997 and 1999. Source: NZHIS.



# Background Information on Suicide

## What causes people to want to take their own life?

- Because each person is unique, there is no single reason why people choose to end their life. However, from research we know that there are several factors that 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 before the suicide attempt
  - immediately before 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.<sup>5</sup>
- 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 ones 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.

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<sup>5</sup> 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:

- a family doctor (GP) or practice nurse
- a community mental health service
- marae-based health clinics
- Māori community health workers
- a 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?

- Just as there is no one reason which brings someone to take their own life, there is no one answer. Rather, a range of initiatives needs to be in place across a number 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 of 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)
  - have a wide view of prevention as 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. postvention management and support for families and friends following suicide.

## What are some examples of where we can focus suicide prevention initiatives?

- The prevention, recognition and treatment of depression.
- Promote positive mental health in families, schools, workplaces and the community.
- Promote awareness of mental health issues at the community level.
- Improve services (both mental health, emergency and general health services).
- Support initiatives to reduce the stigma of mental illness (eg, Like Minds, Like Mine campaign).
- Increase public understanding of what to do if someone is suicidal.
- Improve the support and treatment of those who have already attempted suicide, and their families and friends.
- Implement measures to restrict access to the means of suicide.
- Provide guidance to the media about the reporting and publicity of suicide to minimise the potential of imitative suicides.
- Improve our knowledge and information systems so we can better target suicide prevention strategies for the best outcomes.
- Support communities, families and whānau to provide emotionally safe and nurturing environments for all people, particularly children and young people.
- Expand 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 – see [www.moh.govt.nz](http://www.moh.govt.nz).

## 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 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.
- From 2001 the Ministry of Youth Affairs has the leadership role for promoting, co-ordinating and communicating the implementation of the strategy.
- A Ministerial and Inter-Agency Committee have also been formed to oversee the government-level implementation of the Strategy.

The 2002 implementation plan will be available from May 2002 from the Ministry of Youth Affairs: phone (04) 471 2158, web site: [www.youthaffairs.govt.nz](http://www.youthaffairs.govt.nz).

## Help lines and services

### Help lines

Refer to page 32 of the telephone book.

Helplines include:

- Lifeline
- Samaritans
- Youthline.

### Services for emergencies

- Psychiatric emergency services
- Community mental health services
- General practitioner
- 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 service such as bereavement services, family counsellors, whānau support services, or refugee support services
- Victim Support
- Samaritans/Lifeline/Youthline
- School counsellor
- Specialist Education Service.

## General information for the public on mental health

- The Mental Health Foundation of New Zealand, phone (09) 630 8573, web site [www.mentalhealth.org.nz](http://www.mentalhealth.org.nz).

## Statistics

New Zealand Health Information Service, web site: [www.nzhis.govt.nz](http://www.nzhis.govt.nz), phone (04) 922 1800, fax (04) 922 1897, e-mail: [inquiries@nzhis.govt.nz](mailto: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, phone (04) 914 4863, fax (04) 471 2233.

A stocktake of initiatives that address youth suicide prevention will be available from May 2002 on the Ministry of Youth Affairs web site: [www.youthaffairs.govt.nz](http://www.youthaffairs.govt.nz).

## SPINZ (Suicide Prevention Information New Zealand)

For general information for the public about youth suicide and youth suicide prevention, contact SPINZ: web site: [www.spinz.org.nz](http://www.spinz.org.nz), contact: Leora Hirsh, phone (09) 638 7364, fax (09) 630 7190, e-mail: [info@spinz.org.nz](mailto:info@spinz.org.nz). For New Zealand Youth Suicide Prevention Strategy documents, contact **Wickliffe, phone 0800 226 440, e-mail [moh@wickliffe.co.nz](mailto:moh@wickliffe.co.nz)**.