

# **Suicide Facts**

Provisional 2001 Statistics  
(all ages)

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MANATŪ HAUORA

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## Key Points

- The total age-standardised suicide rate in 2001 was 11.7 deaths per 100,000 population (compared to 11.2 in 2000). Males continued to have a higher suicide death rate than females in 2001 (18.3 compared to 5.5 deaths per 100,000 population).
- In 2001, people aged 20–24 years had the highest suicide rate (25.3 deaths per 100,000 population), followed by people aged 25–29 years and 30–34 years (21.7 and 21.2 per 100,000 population respectively).
- In 2001, the total number of suicides was 499, up from 458 in 2000 but down from 516 in 1999. The 2000 number was the lowest total number since 1990 (455).
- Between 2000 and 2001 the total number of suicides increased among both males (375 to 382 deaths) and females (83 to 117 deaths). The all-ages sex ratio for suicide was 3.3 male suicides to every female suicide.
- The total rate of youth suicide (15–24 years) increased with 20.0 deaths per 100,000 population in 2001 compared with 18.1 per 100,000 population in 2000.
- New Zealand has the highest male youth suicide rate (15–24 years), and the second highest female youth suicide rate compared to other OECD countries.
- Māori continue to have higher suicide rates than non-Māori in 2001. In 2001, the rate of suicide among Māori was 13.4 deaths per 100,000 population compared with 11.2 for non-Māori.
- The 2001 suicide rates for Māori males and females were 20.7 and 6.8 per 100,000 population respectively and for non-Māori males and females were 17.7 and 4.9 per 100,000 population respectively.
- The hospitalisation rate for intentional self-harm in 2002 was 85.5 cases per 100,000 population. The female to male ratio for intentional self-harm was 2.1 female hospitalisations to every male hospitalisation.
- The youth hospitalisation rate for intentional self-harm in 2002 was 186.5 cases per 100,000 population.

# Technical Notes

## Data

### Suicide

The suicide mortality data contained in this report is provisional 2001 data for all ages.<sup>1</sup> 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. Data become official when published by the New Zealand Health Information Service (NZHIS) in the annual publication series *Mortality and Demographic Data*.

### Hospitalisation for intentional self-harm

The hospitalisation data in this report is 2002 data. To accurately track changes in hospital discharges over time, the Ministry of Health applies a filtering process to keep only medical and surgical records, which are inpatient events, and excludes all other records. In particular this filtering process joins discharge events for transfers between or within hospitals, for the same self-harm event allowing the calculation of rates of hospitalisation for intentional self-harm events.

Hospitalisation for intentional self-harm is a measure of the number of people who were admitted to hospital for intentional self-harm, whether they survived or not. Therefore people, who intentionally harm themselves and eventually die in hospital, are included. On the other hand, people who intentionally harm themselves but are not admitted to hospital are not included. The figures are for intentional self-inflicted injury and may include cases of deliberate self-harm where the intent was not death. However, it is still generally accepted as a proxy measure for attempted suicide.

It is important to be cautious about the interpretation of data for hospitalisation for intentional self-harm. Accurate data is not available on all hospitalisation for intentional self-harm because statistics are only collated 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.

<sup>1</sup> Provisional 2001 statistics for all ages are available on the New Zealand Health Information Service website: [www.nzhis.govt.nz](http://www.nzhis.govt.nz).

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 these cases will not appear in hospitalisation intentional self-harm figures. In addition, in 1999 and then in 2000 New Zealand introduced the ICD-10-AM international classification of disease system for morbidity and mortality statistics, respectively. This classification system 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.

Hospitalisation figures include people who are admitted more than once during that year, and also include those who died while in hospital.

## **Definitions**

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

### **Suicide numbers and rates**

The number of suicide deaths refers to the actual number of people who have died by suicide.

The rate of suicide refers to the frequency with which suicide occurs relative to the number of people in a defined population.

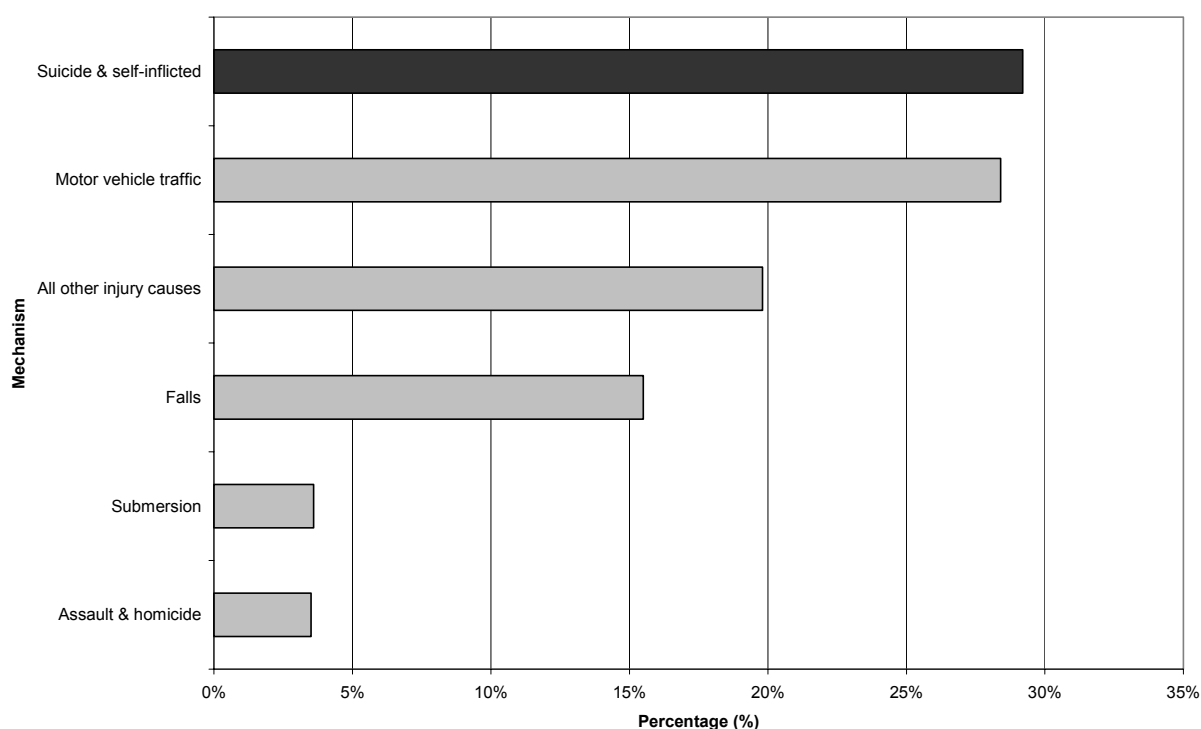
Age-standardised rates are rates that have been adjusted to take account of differences in the age distribution of the population over time or between different groups (for example, different ethnic groups). The standard population used was Segi's.

# Suicide – All Ages

## Relevance

Suicide is an important and serious health issue. It is an indicator of mental health in the population. Reducing the rate of suicide and suicide attempts is a priority in the New Zealand Health Strategy and the New Zealand Injury Prevention Strategy. The Injury Prevention Research Unit (IPRU), University of Otago, has estimated that in 2000 suicide and intentional self-inflicted injury made up the greatest proportion of all injury related fatalities (Figure 1).

**Figure 1:** Percentage of total fatal injuries by injury category, 2000



Source: Injury Prevention Research Unit

## What is the rate of suicide in New Zealand?

- The age-standardised suicide rate for the total population was 11.7 per 100,000 population in 2001, compared to 11.2 per 100,000 population in 2000. The 2000 rate was the lowest rate since 1985 (9.3 per 100,000 population).
- The age-standardised suicide rate for males was 18.3 per 100,000 population in 2001, compared with 18.7 per 100,000 population in 2000. This is the lowest rate since 1986 (17.0 per 100,000 population).
- The age-standardised rate of suicide for females was 5.5 per 100,000 population in 2001, compared to 4.0 per 100,000 population in 2000.

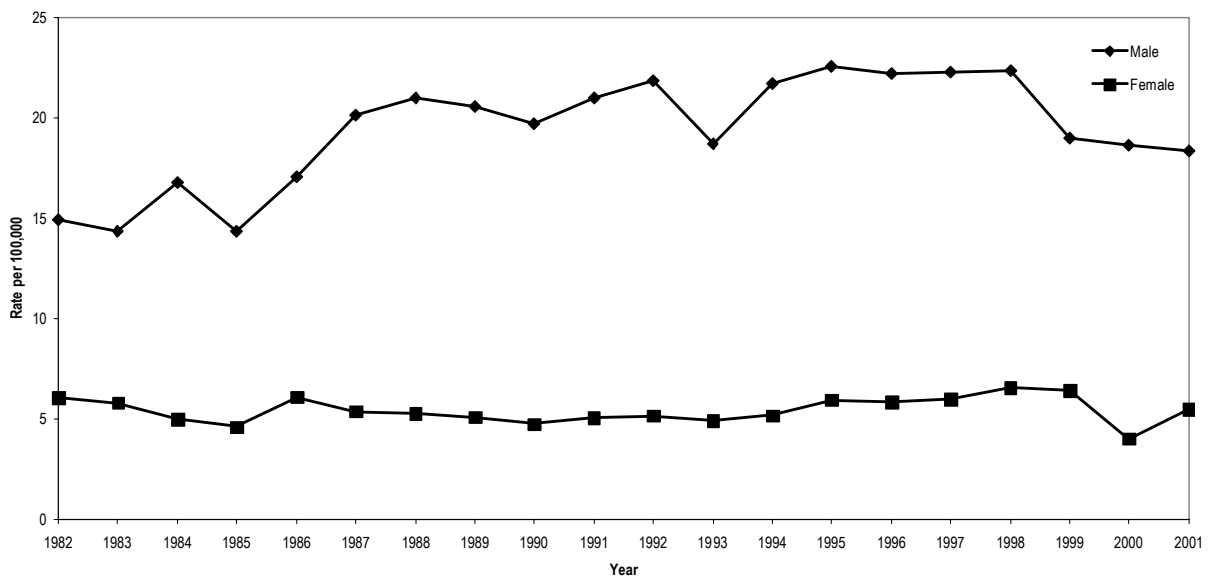
## Is the overall rate of suicide decreasing?

- The rate of suicide for females was stable between 1982 and 1999. The rate then decreased in 2000, and increased in 2001, but the rate was still lower than in 1999 (Figure 2).
- The rate of suicide for males increased to a peak of 22.5 deaths per 100,000 population in 1995. Since then the rate has decreased but is still higher than the rate in 1982.

## How many people died by suicide in 2001?

- A total of 499 people died by suicide, compared with 458 in 2000 and 516 in 1999.
- In 2001, 382 males died by suicide, compared with 375 in 2000 and 385 in 1999.
- In 2001, 117 females died by suicide, compared with 83 in 2000 and 131 in 1999.

**Figure 2:** Suicide death rate 1982–2001



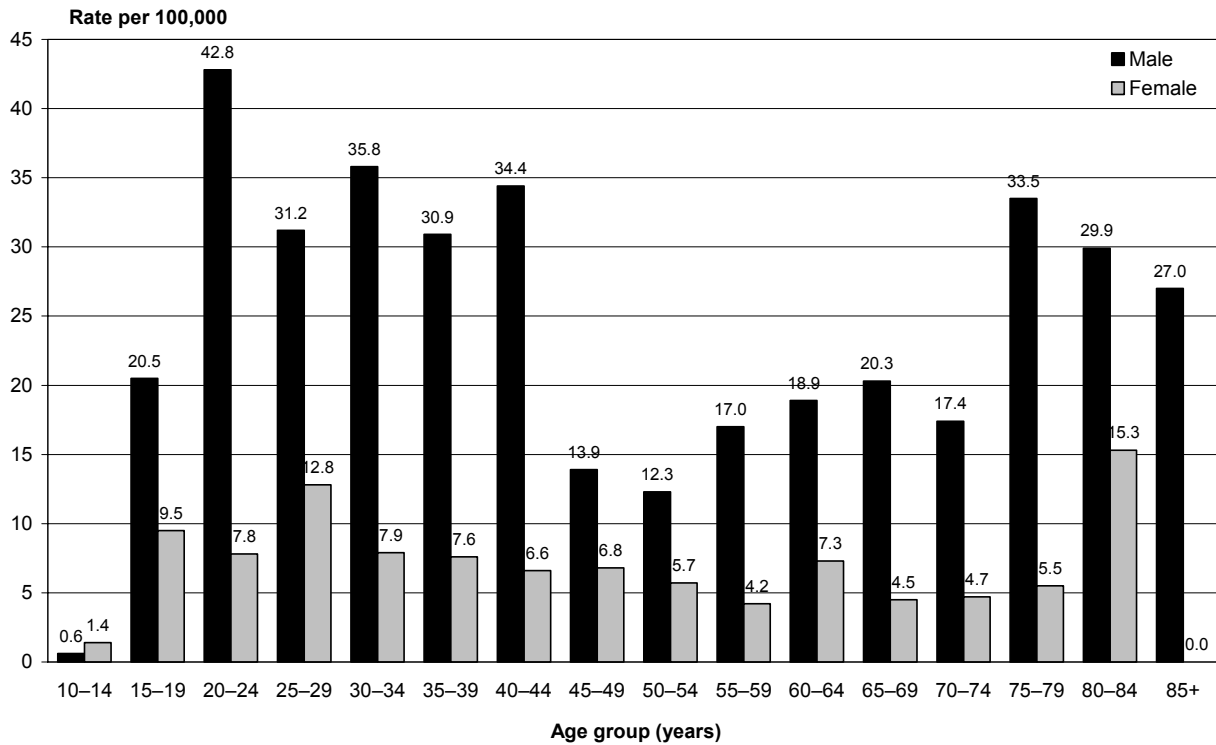
Source: NZHIS

## Suicides by age group

- In 2001, people aged 20–24 years had the highest age-specific suicide rate (25.3 deaths per 100,000 population) followed by people aged 25–29 years (21.7 deaths per 100,000 population) and people aged 30–34 years (21.2 deaths per 100,000 population).
- Among males, those aged 20–24 years had the highest age-specific suicide rate (42.8 deaths per 100,000 population) followed by those aged 30–34 years (35.8 deaths per 100,000 population) and those aged 40–44 years (34.4 deaths per 100,000 population).

- Among females, 80–84 year olds (15.3 per 100,000), 25–29 year olds (12.8 per 100,000 population) and 15–19 year olds (9.5 per 100,000 population) had the highest rates (Figure 3).

**Figure 3:** Suicide death rates by age group and gender, 2001



Source: NZHIS

Note: The high suicide rates in the older age groups are influenced by the smaller population sizes in those age groups. Therefore relatively smaller numbers of suicide deaths produce higher suicide death rates than in some of the younger age groups.

**Figure 4:** Suicide death rates by age group, 1948–2001



Source: NZHIS

## What is the male–female suicide ratio?

- In 2001, the all-ages sex ratio for suicide in New Zealand was 3.3 male suicides to every female suicide. The youth suicide (15–24 years) ratio was 3.7 male suicides to every female suicide.
- Research<sup>2</sup> suggests that the difference in male and female suicide is associated with choice of methods. Females, however, make more non-fatal suicide attempts.

## What was the rate of suicide among Māori in 2001?

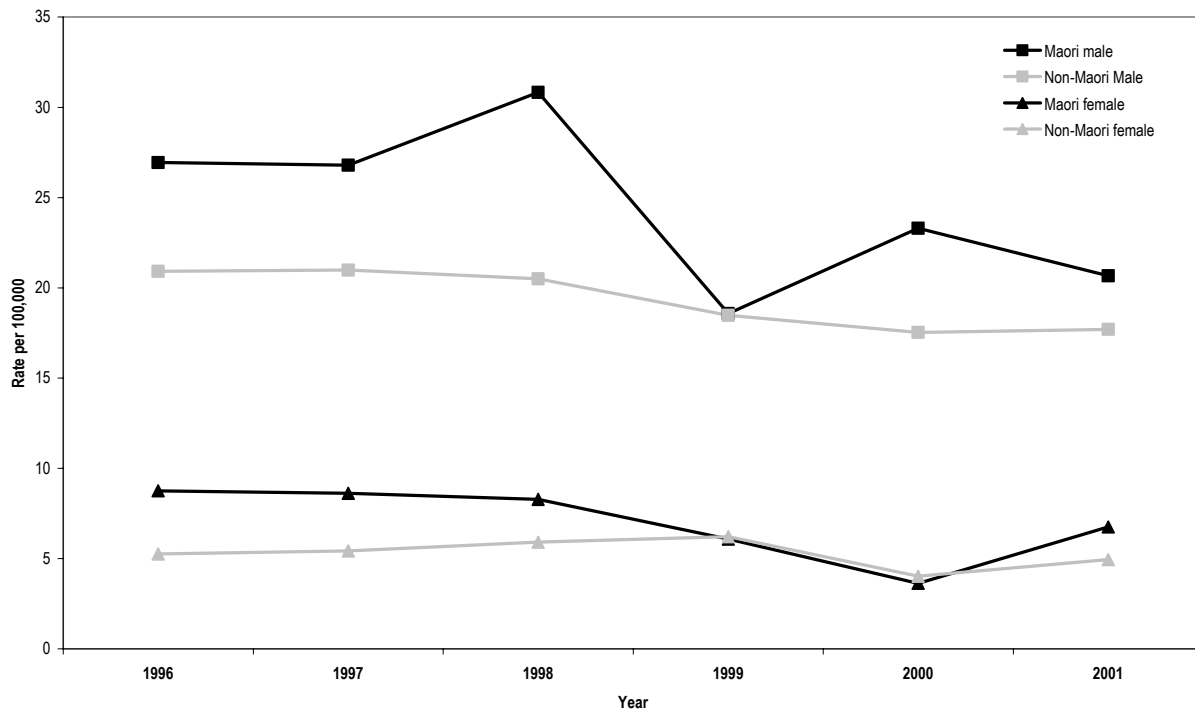
- In 2001, the rate of suicide for Māori was 13.4 deaths per 100,000 population, compared with 13.1 per 100,000 in 2000 and 12.1 per 100,000 population in 1999.
- The rate of suicide for Māori males was 20.7 deaths per 100,000 population, compared to the non-Māori rate of 17.7 per 100,000 population.
- The rate of suicide for Māori females was 6.8 deaths per 100,000 population, compared to the non-Māori rate of 4.9 per 100,000 population.

<sup>2</sup> 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.

## How many Māori died by suicide in 2001?

- Seventy-nine Māori died by suicide in 2001, compared to 80 in 2000 and 78 in 1999.
- Fifty-seven were male compared to 69 in 2000 and 58 in 1999.
- Twenty-two were female compared to 11 in 2000 and 20 in 1999.

**Figure 5:** Māori and non-Māori suicide death rates, 1996–2001



Source: NZHIS

## How many Pacific peoples died by suicide in 2001?

- In 2001, 22 Pacific peoples died by suicide (20 males and two females), compared to 12 deaths in 2000 and 14 deaths in 1999.

## How many Asian people died by suicide in 2001?

- In 2001, 20 Asian people died by suicide (15 males and five females).

# Suicide – Youth (15–24 years)

## Relevance

Suicide is a leading cause of death among youth. New Zealand has one of the highest youth suicide rates in OECD countries (see International Comparisons section).

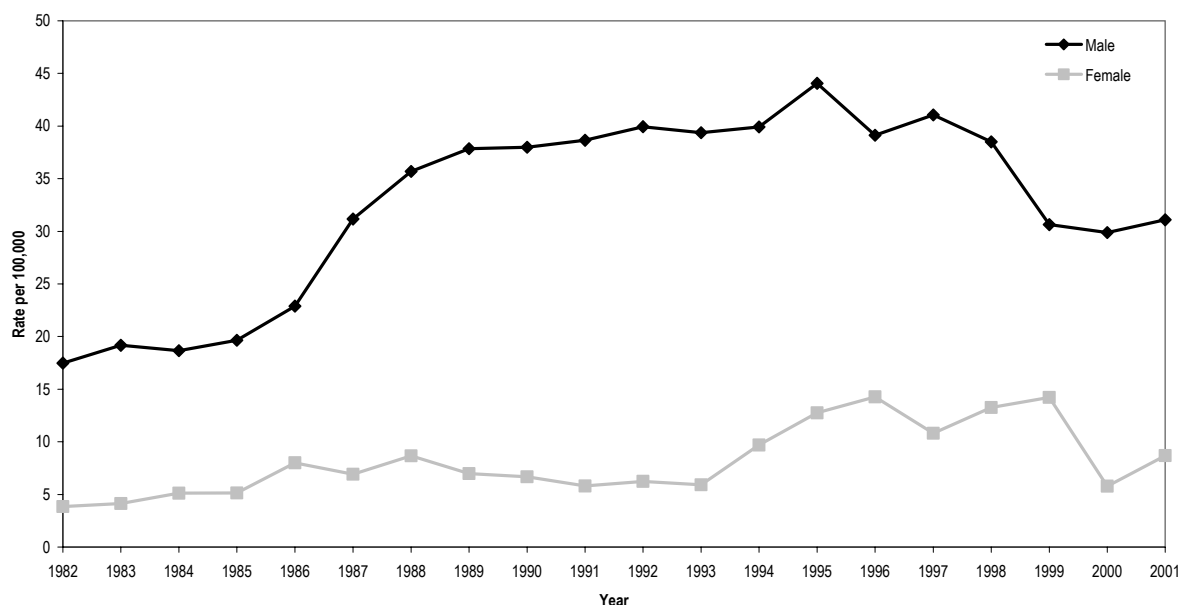
## What is the rate of youth suicide (15–24 years) in New Zealand?

- The total rate of youth suicide in 2001 was 20.0 deaths per 100,000 population compared with 18.1 per 100,000 population in 2000.
- The rate of youth suicide for males (aged 15–24) in 2001 was 31.1 deaths per 100,000 population compared with 29.9 per 100,000 population in 2000.
- The rate of youth suicide for females (aged 15–24) in 2001 was 8.7 deaths per 100,000 population compared with 5.8 per 100,000 population in 2000.

## How many young people (15–24 years) died by suicide in 2001?

- In 2001, a total of 107 young people aged 15–24 years died by suicide, compared with 96 in 2000 and 120 in 1999.
- Of these 107 young people, 84 were male and 23 were female.

**Figure 6:** Youth suicide rates (aged 15–24), 1982–2001

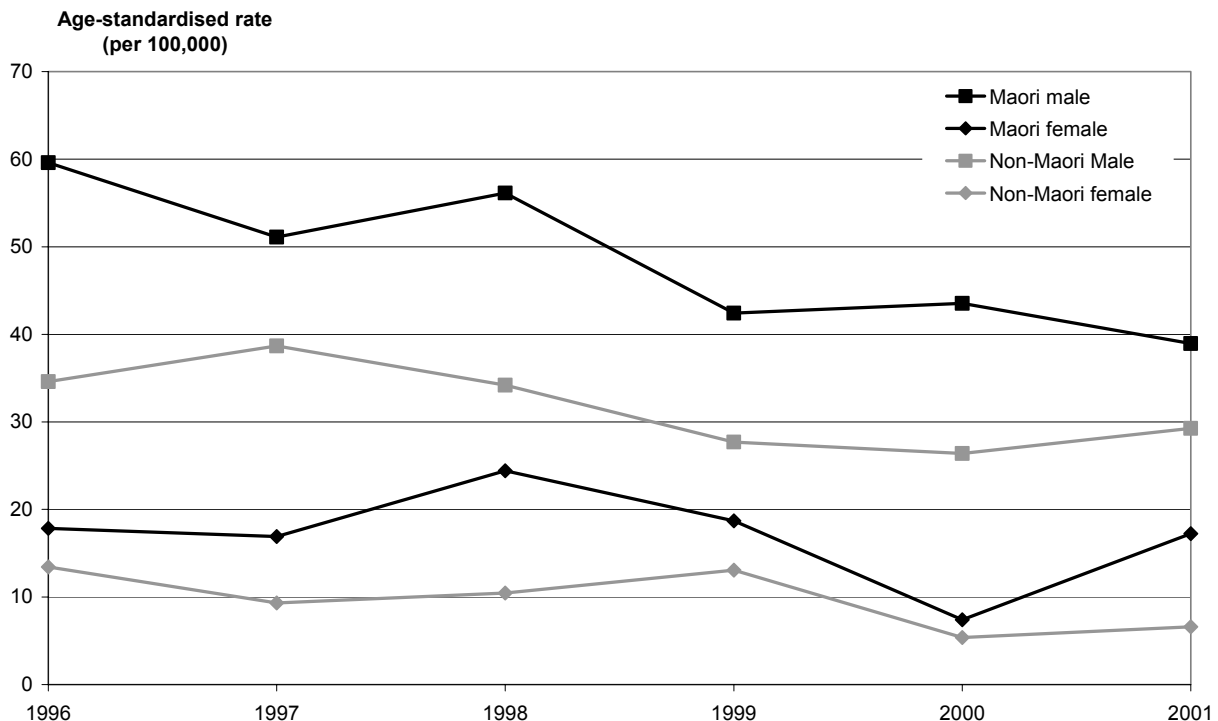


Source: NZHIS

## What was the rate of suicide and number of deaths by suicide for Māori youth (15–24 years) in 2001?

- The suicide rate for Māori youth in 2001 was 28.0 deaths per 100,000 population, compared with the non-Māori rate of 18.1 per 100,000 population.
- In 2001, the rate of suicide for young Māori males was 38.9 deaths per 100,000 population, compared with the non-Māori rate of 29.2 per 100,000 population.
- In 2001, the rate of suicide for young Māori females was 17.2 deaths per 100,000 population, compared with the non-Māori rate of 6.6 per 100,000 population.
- In 2001, 29 Māori young people (15–24 years) died by suicide (20 males, nine females), compared to 28 in 2000 and 33 in 1999.

**Figure 7:** Māori and non-Māori youth suicide rates (aged 15–24), 1996–2001



Source: NZHIS

## Is the overall rate of youth suicide decreasing?

- According to Figure 4, the rate of youth suicide was stable between 1948 and 1968. From this time, the rate seemed to increase considerably to peak in 1995 (28.7 deaths per 100,000 population).
- Since this time however, the rate dropped every year until 2000 to a rate of 18.1 deaths per 100,000 population, the lowest rate since 1986. This was mainly due to a considerable decrease in the male youth suicide rate over this time (from 44.1 deaths per 100,000 population in 1995 to 29.9 per 100,000 population in 2000). However, the rate increased in 2001 to 31.1 deaths per 100,000 population for males and 8.7 deaths per 100,000 population for females.
- The rates of youth suicides have increased for both non-Māori males and females and for Māori females between 2000 and 2001. There has been a decrease in the Māori male rate between 2000 and 2001.

# Hospitalisation for Intentional Self-harm

## What was the rate of hospitalisation for intentional self-harm in 2002?

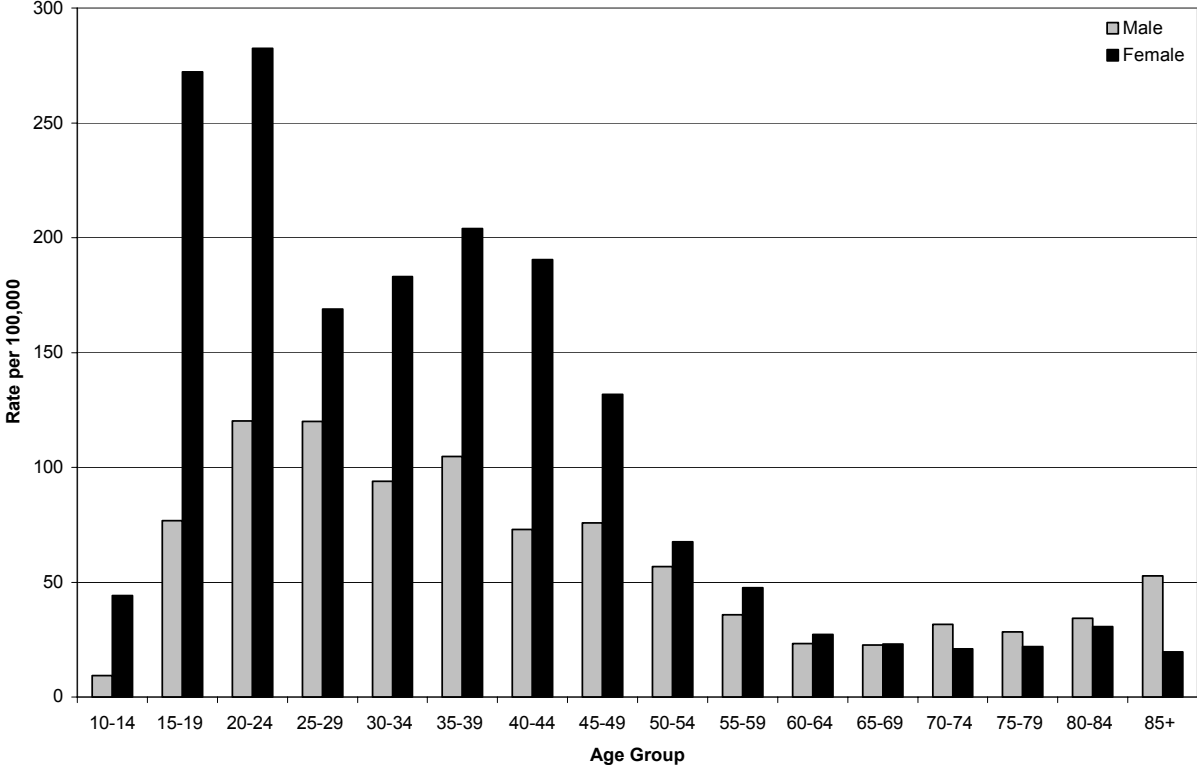
### All ages

- The hospitalisation rate for intentional self-harm in 2002 was 85.5 cases per 100,000 population. It is not possible to compare this rate with those in previous publications as the definition of intentional self-harm has changed so that now cases of hospitalisation are only included once, whereas in the past they could be counted more than once.
- In 2002, the male hospitalisation rate for intentional self-harm was 55.0 cases per 100,000 population (1044 cases). The female hospitalisation rate for intentional self-harm was 115.3 cases per 100,000 population (2223 cases).
- Among Māori in 2002 the hospitalisation rate for intentional self-harm was 79.2 cases per 100,000 population (431 cases). The hospitalisation rate for Māori females for intentional self-harm was 97.9 cases per 100,000 population (279 cases) compared to 59.8 per 100,000 population (152 cases) for Māori males.
- Among non-Māori in 2002 the hospitalisation rate for intentional self-harm was 86.3 cases per 100,000 population (2836 cases). The hospitalisation rate for non-Māori females for intentional self-harm was 118.3 cases per 100,000 population (1944 cases) compared to 53.9 per 100,000 population (892 cases) for non-Māori males.
- 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 2002 was 2.1 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 2002 was 186.5 cases per 100,000 population (931 cases). For female young people the rate was 277.0 cases per 100,000 population (688 cases), compared to 97.2 per 100,000 population (243 cases) for males.
- The Māori rate was 179.0 cases per 100,000 population, which was lower than the non-Māori rate of 188.2 per 100,000 population.
- In 2002, the hospitalisation rate for Māori females was 238.6 cases per 100,000 population, lower than the non-Māori female rate of 285.8 per 100,000 population. For Māori males, the hospitalisation rate was 117.2 cases per 100,000 population, higher than the non-Māori male rate of 93.1 per 100,000 population.

**Figure 8:** Rates of suicide and self-inflicted injury hospitalisation by age, 2002



Source: Public Health Intelligence, Ministry of Health

## Regional Comparisons

### 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 100.
- The SMR for a DHB is significant if the 95 percent confidence interval does not include one hundred. If the confidence interval includes one hundred, then the region's rate is not significantly different from the national rate.

### 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.
- SMRs for 1997–2001 show that Bay of Plenty, Hawke's Bay, Nelson-Marlborough and West Coast District Health Boards have suicide rates significantly higher than the national rate<sup>3</sup> (Table 1). Auckland, Counties Manukau and Capital and Coast District Health Board's suicide rates for males and their total populations were significantly lower than the national rate.

<sup>3</sup> These regions have been highlighted because the SMR is high and the 95 confidence interval does not include one hundred. Other areas above the national average like Tairāwhiti are excluded because the confidence interval includes one hundred.

**Table 1:** Suicide deaths by DHB region and sex, 1997–2001

DHB region	Male		Female		Total	
	SMR	95% CI	SMR	95% CI	SMR	95% CI
Northland	103.8	80.0–127.6	146.2	93.9–198.5	113.6	91.6–135.5
Waitemata	91.3	79.0–103.5	89.8	67.3–112.4	90.8	80.1–101.6
Auckland	82.7	70.6–94.9	104.3	78.7–129.8	87.1	76.1–98.0
Counties Manukau	83.8	71.0–96.6	88.3	64.1–112.5	84.4	73.2–95.7
Waikato	100.5	85.4–115.5	80.3	55.1–105.5	96.5	83.4–109.5
Lakes	121.6	91.1–152.1	150.9	87.9–214.0	128.1	100.5–155.7
Bay of Plenty	124.8	101.8–147.8	108.5	69.0–148.1	120.7	100.9–140.6
Tairāwhiti	127.6	80.4–174.9	45.9	–6.0–97.9	108.4	70.3–146.6
Hawke's Bay	128.3	102.5–154.1	106.2	62.8–149.6	123.2	101.0–145.5
Taranaki	92.8	67.1–118.5	122.6	67.5–177.8	100.0	76.4–123.6
MidCentral	86.2	66.3–106.1	156.8	107.0–206.7	101.9	82.9–121.0
Whanganui	118.5	81.3–155.6	147.5	70.2–224.7	125.4	91.6–159.1
Capital and Coast	76.0	61.6–90.4	88.8	59.8–117.8	78.3	65.4–91.1
Hutt Valley	92.7	70.3–115.0	103.4	59.2–147.6	95.3	75.2–115.3
Wairarapa	71.9	34.2–109.5	53.0	–7.0–113.1	67.8	35.6–100.1
Nelson Marlborough	129.5	102.0–157.1	96.8	52.1–141.5	123.6	99.7–147.4
West Coast	184.0	118.2–249.9	113.9	14.1–213.7	172.6	115.4–229.8
Canterbury	108.7	95.5–121.9	88.2	65.9–110.6	104.4	93.0–115.9
South Canterbury	130.2	87.6–172.7	88.6	23.0–154.2	121.9	85.4–158.3
Otago	94.7	75.2–114.3	82.5	48.8–116.2	91.6	74.7–108.5
Southland	117.6	89.5–145.8	88.4	42.1–134.7	112.7	88.1–137.2

Source: Public Health Intelligence, Ministry of Health

Note: Shaded areas indicate regions with significantly higher or lower SMRs. For DHBs where there are very small numbers of suicides and very wide confidence intervals, no conclusion can be drawn. Numbers in this table are rounded to one decimal place.

# International Comparisons

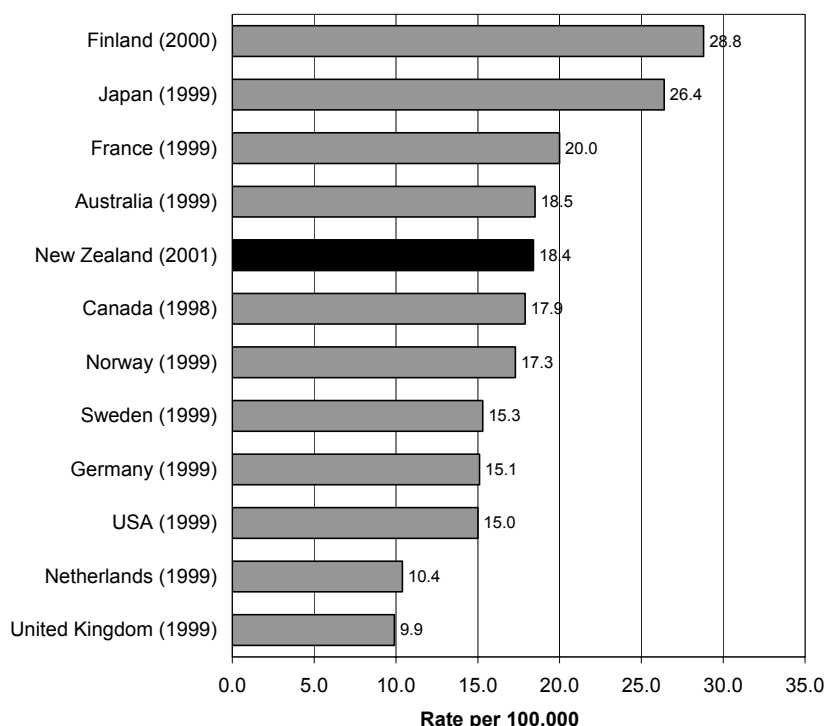
## How accurate are international comparisons?

Comparing international rates of suicide is inherently problematic as countries may have different evidentiary standards when ascertaining whether a death was a suicide<sup>4</sup>..

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

- In comparison with selected OECD countries, New Zealand's 2001 suicide rates are high for males, particularly male youth.
- In 2001, New Zealand's all-age suicide rates for males were the fifth highest among selected OECD countries. However, New Zealand's female all-age suicide rates were sixth 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 females among selected OECD countries (Figures 11 and 12).

**Figure 9:** Total male suicide rates for selected OECD countries (2001 New Zealand)

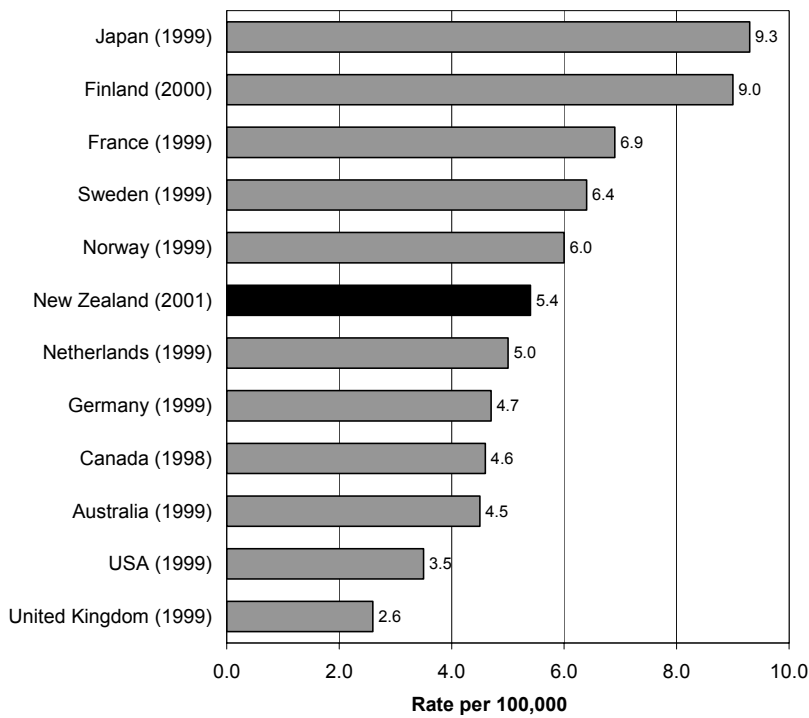


Source: NZHIS for New Zealand rates and WHO for other rates.

Note: Comparison years vary by country between 1998 and 2001.

<sup>4</sup> The New Zealand age standardised rate in the international comparison data has been calculated in a manner consistent with the international figures available. Consequently there may be a slight discrepancy with the New Zealand rates presented elsewhere.

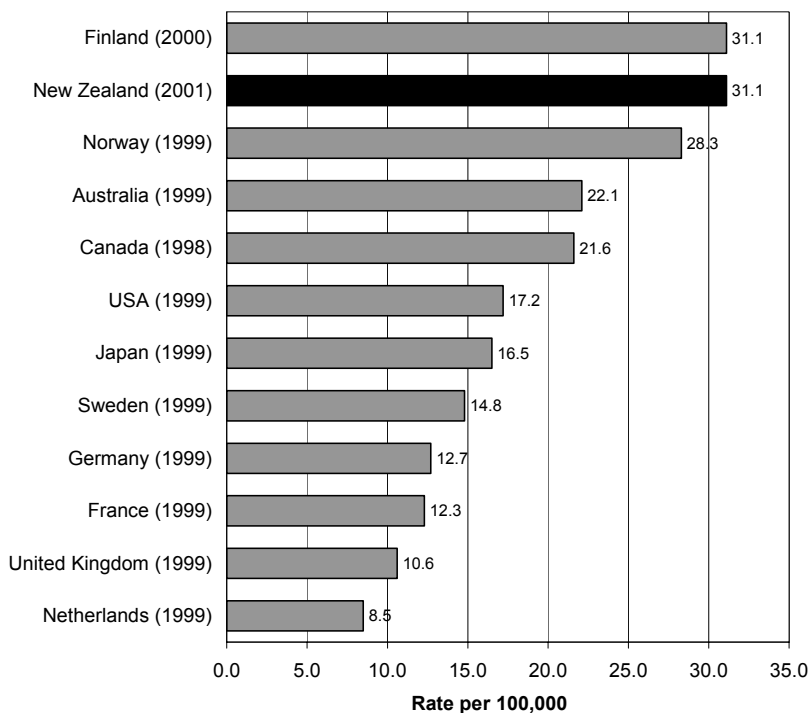
**Figure 10: Total female suicide rates for selected OECD countries (2001 New Zealand)**



Source: NZHIS for New Zealand rates and WHO for other rates.

Note: Comparison years vary by country between 1998 and 2001.

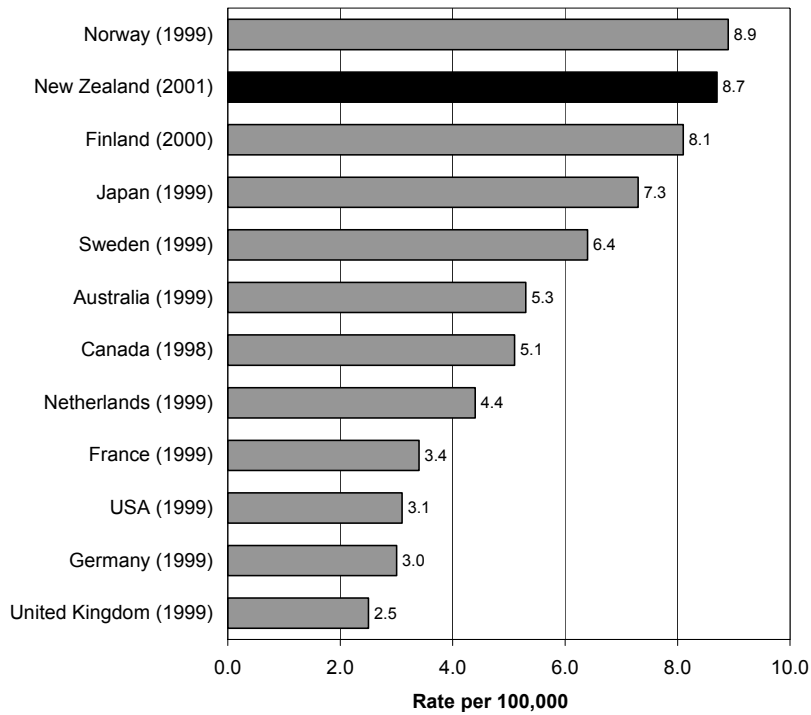
**Figure 11: Male youth suicide rates (15–24 years) for selected OECD countries (2001 New Zealand)**



Source: NZHIS for New Zealand rates and WHO for other rates.

Note: Comparison years vary by country between 1998 and 2001.

**Figure 12:** Female youth suicide rates (15–24 years) for selected OECD countries (2001 New Zealand)



Source: NZHIS for New Zealand rates and WHO for other rates.

Note: Comparison years vary by country between 1998 and 2001.

# Background Information on Suicide

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

There has been an increasing amount of research into the factors that place people at risk of taking their own lives. This research is beginning to present a clear picture of the mix of conditions that contribute to the endpoint of suicide at an individual level. These factors include:

- socioeconomic and educational disadvantages
- exposure to childhood adversity and trauma
- mental disorders including: depression; bipolar disorder; substance use disorders (alcohol, cannabis and other drug abuse and dependence); antisocial and offending behaviours; schizophrenia; anxiety disorders
- exposure to recent stress or life difficulty
- tendencies to react impulsively and aggressively under stress.

Research from the Canterbury Suicide Project has found that approximately 90 percent of people who die by suicide or make serious suicide attempts will have one or more mental disorders at the time of their attempt, with these disorders typically being accompanied by other sources of life stress and difficulty.

Less is known about the broader factors that influence suicide trends across population groups and over time. This is the subject of some research that the Ministry of Health is currently contracting.

## Are the risk factors the same for young people and older people?

The relative importance of specific risk factors for suicide and attempted suicide tend to vary with age. Factors such as childhood adversity and recent life stress tend to be more influential for younger people. Mood disorder plays an increasingly significant role with increasing age and makes a greater contribution to suicide risk amongst older adults rather than youth.

The typical profile of youth (< 25 years) suicide is one of predominantly young males, characterised by family and social disadvantage, a history of suicide attempt, current mood disorder; and stressful interpersonal and legal life events.

Amongst adult suicides, males predominate, and mental disorder (particularly mood disorder) and a history of psychiatric hospitalisation play a dominant role. Against this background of mental health problems, recent interpersonal and legal life events increase suicide risk.

Amongst older adults, depression and a history of psychiatric hospitalisation are the major contributions to suicide risk.

It is important to recognise, that while most people who die by suicide or make suicide attempts will experience a recognisable mental disorder, this does not mean that most people experiencing mental disorders and/or life difficulties will attempt to take their own lives.

## **Are there protective factors for suicide?**

Less is known about protective factors that protect against suicidal behaviour. Factors that have been suggested as playing a potentially protective role 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. For older adults, having a hobby and participating in social organisations protect against suicidal behaviour.

## **How can suicide be prevented?**

As there is no single reason that brings someone to take their own life, preventive initiatives need to be in place across a range of settings that are 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. This includes the following.

1. Promoting mental health and wellbeing through strengthening social cohesion, building resilient communities and providing supportive environments.
2. Developing effective, accessible and responsive services for people with mental disorders or suicidal behaviours (including prevention, early recognition and treatment of mental disorders).
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.
- Improvements in services that have contact with people at risk of suicide (eg, primary health care, emergency services, mental health 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 friends, families and whānau.
- 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 for imitative suicides.
- The expansion of research and information systems so suicide prevention strategies can be targeted for the best outcomes.
- Strengthening 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.moh.govt.nz> or the webpage

<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 Development 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 support the implementation of the strategy.

## Is there a national suicide prevention strategy targeting people in other age groups?

The Ministry of Health and the Ministry of Youth Development are leading work on developing a new national strategy that will address the prevention of suicide and suicide attempts in all age groups. This will build on the lessons learned and gains made from the *New Zealand Youth Suicide Prevention Strategy*. This new strategy will be completed by mid-2005. In the meantime, many of the new initiatives from the New Zealand Youth Suicide Prevention Strategy are taking an all-age focus.

## If you are concerned about someone

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

- primary health care professional or general practitioner (GP)
- 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
- helplines such as Lifeline, Samaritans or Youthline (refer to front pages of telephone book)
- Group Special Support, Ministry of Education (formerly 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/mental health crisis assessment team.

## Where can people find more information about suicide and suicide prevention?

### SPINZ (Youth Suicide Prevention Information New Zealand)

For general information on youth suicide and youth suicide prevention, contact:

SPINZ

PO Box 10318  
Dominion Road  
Auckland  
Ph (09) 300 7035  
Fax (09) 300 7020  
Email: [info@spinz.org.nz](mailto:info@spinz.org.nz)  
Website: [www.spinz.org.nz](http://www.spinz.org.nz)

## **General information about mental health for the public**

For a wide range of information on mental health contact The Mental Health Foundation of New Zealand:

The Mental Health Foundation of New Zealand  
Resource and Information Centre  
PO Box 10051  
Dominion Road  
Auckland  
Ph (09) 300 7010  
Fax (09) 300 7020  
Resource Centre: (09) 300 7030  
[www.mentalhealth.org.nz](http://www.mentalhealth.org.nz)

## **Statistics**

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

New Zealand Health Information Service  
Ph (04) 922 1800  
Fax (04) 922 1897  
Email: [inquiries@nzhis.govt.nz](mailto:inquiries@nzhis.govt.nz)  
Website: [www.nzhis.govt.nz](http://www.nzhis.govt.nz)

## **The New Zealand Youth Suicide Prevention Strategy**

To find out more about the New Zealand Youth Suicide Prevention Strategy contact SPINZ or see the Ministry of Youth Development's website: [www.youthaffairs.govt.nz](http://www.youthaffairs.govt.nz) or contact:

National Co-ordinator, Youth Suicide Prevention  
Ministry of Youth Development  
Ph (04) 916 3645  
Fax (04) 918 0091

## **More copies of this publication**

For more copies of this publication or Suicide Facts for previous years, see the Ministry of Health website, [www.moh.govt.nz](http://www.moh.govt.nz), or contact SPINZ (see above).