NEW ZEALAND HEALTH STRATEGY

DHB TOOLKIT

Suicide Prevention

*To reduce the rate of suicides and suicide attempts*

2001

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## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive summary</td>
<td>4</td>
</tr>
<tr>
<td>Introduction</td>
<td>5</td>
</tr>
<tr>
<td>Development of the toolkit</td>
<td>5</td>
</tr>
<tr>
<td>Linkages</td>
<td>6</td>
</tr>
<tr>
<td>Background</td>
<td>8</td>
</tr>
<tr>
<td>The costs of suicidal behaviour</td>
<td>9</td>
</tr>
<tr>
<td>Epidemiology of suicidal behaviour</td>
<td>9</td>
</tr>
<tr>
<td>Risk factors</td>
<td>12</td>
</tr>
<tr>
<td>Risk factors for youth suicide</td>
<td>12</td>
</tr>
<tr>
<td>Risk factors for suicide amongst adults</td>
<td>14</td>
</tr>
<tr>
<td>Risk factors for suicide amongst older adults</td>
<td>15</td>
</tr>
<tr>
<td>Protective factors</td>
<td>15</td>
</tr>
<tr>
<td>Population-level determinants of suicide</td>
<td>15</td>
</tr>
<tr>
<td>Interventions to prevent suicidal behaviour</td>
<td>16</td>
</tr>
<tr>
<td>Using research to prevent suicide</td>
<td>16</td>
</tr>
<tr>
<td>Key components of suicide prevention</td>
<td>16</td>
</tr>
<tr>
<td>Intervention themes</td>
<td>16</td>
</tr>
<tr>
<td>Planning suicide prevention activities</td>
<td>19</td>
</tr>
<tr>
<td>Key considerations</td>
<td>19</td>
</tr>
<tr>
<td>How to prioritise</td>
<td>19</td>
</tr>
<tr>
<td>Accountability Indicators for District Health Boards</td>
<td>21</td>
</tr>
<tr>
<td>The policy context for planning</td>
<td>22</td>
</tr>
<tr>
<td>Maori suicide prevention and the Treaty of Waitangi</td>
<td>22</td>
</tr>
<tr>
<td>Suicide prevention amongst Pacific peoples</td>
<td>23</td>
</tr>
<tr>
<td>Other cultures</td>
<td>23</td>
</tr>
<tr>
<td>Reducing inequalities</td>
<td>23</td>
</tr>
<tr>
<td>The New Zealand Youth Suicide Prevention Strategy</td>
<td>24</td>
</tr>
<tr>
<td>Working across sectors</td>
<td>24</td>
</tr>
<tr>
<td>Evaluation</td>
<td>25</td>
</tr>
<tr>
<td>Future developments at a national level</td>
<td>25</td>
</tr>
<tr>
<td>Interventions</td>
<td>26</td>
</tr>
<tr>
<td>Theme 1: Mental health promotion including strengthening social cohesion and providing supportive environments</td>
<td>26</td>
</tr>
<tr>
<td>Theme 2: Training and skill development on suicide risk assessment and management</td>
<td>27</td>
</tr>
<tr>
<td>Theme 3: Effective, responsive and accessible services for people with mental health problems and/or suicidal behaviour</td>
<td>29</td>
</tr>
<tr>
<td>Theme 4: Reducing access to the means of suicide</td>
<td>31</td>
</tr>
</tbody>
</table>
Theme 5: Portrayal of suicide in the media .................................................................32
Theme 6: Postvention management and support for families and friends following suicide ..............................................................................................................33
Theme 7: Data collection, information dissemination, research and evaluation ..........34
Theme 8: A framework for community action .............................................................34
APPENDIX 1: ................................................................................................................36
APPENDIX 2: ..................................................................................................................38
APPENDIX 3: ..................................................................................................................40
New Zealand .................................................................................................................40
International ................................................................................................................40

Glossary of terms and abbreviations ............................................................................41
Endnotes .........................................................................................................................44
Bibliography ..................................................................................................................45
Executive summary

Suicide and suicide attempts are a significant public health issue in New Zealand, and a major source of morbidity, mortality and health costs.

Suicidal behaviour occurs on a continuum from thoughts and ideas to attempts and death.

There are multiple risk factors, many of which are generic to a range of poor health outcomes not just suicide. The presence of mental illness, principally depression, is a key factor.

At an individual level, suicide is difficult to predict. However the population rate of suicide can be reduced with a comprehensive approach at a number of levels and across a range of sectors.

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
- have a wide view of prevention as requiring interventions at a range of levels including the environment, whole population, specific population groups (e.g., Maori, youth, Pacific peoples, males) and individuals at risk (preferably in the context of the family/whanau)
- include a focus on improving data, research and evaluation.

District Health Boards (DHBs) are well placed to ensure there are comprehensive, integrated and intersectoral suicide prevention services in their region. Suicide prevention in the health sector is needed at a range of intervention points, involving public, primary, secondary and tertiary health services.

A comprehensive evidence base on effective interventions is still developing. However, there is general agreement that a comprehensive approach to suicide prevention needs interventions to address:

- mental health promotion including strengthening social cohesion and providing supportive environments
- effective, accessible and responsive services for people with mental disorders or suicidal behaviours
- training and skill development on suicide risk assessment and management
- a managed approach to media and publicity about suicide
- reducing access to the means of suicide
- postvention management and support for families and friends following suicide
- data collection, information dissemination and research
- a framework for community action.

DHBs are expected to work in accordance with the principles of the Treaty of Waitangi and involve Maori at all levels of service delivery in the prevention of suicide.

One of the key themes of the New Zealand Health Strategy is that of reducing inequalities in health. This theme is reflected throughout this Toolkit and additional information on reducing inequalities is also available.
Introduction

The New Zealand Health Strategy (Ministry of Health 2000a) has identified 13 priority areas for population health. District Health Boards (DHBs) will be required to report on progress towards each of these priority areas annually. The Minister of Health will then report to Parliament on overall progress in these areas (New Zealand Public Health and Disability Act 2000 s 8(4)). One of the 13 health priority areas is to reduce the rate of suicides and suicide attempts.

This toolkit provides guidance to DHBs on the most effective ways in which they can work to reduce the rate of suicide and suicide attempts in their region.

While suicide prevention requires interventions across a range of sectors, the health sector plays a pivotal role. With their regional focus, DHBs are well placed to ensure there is a comprehensive and integrated range of services in their region to address the spectrum of suicidal behaviour.

This toolkit briefly outlines some of the key service areas and issues that DHBs need to consider when planning how to address this important health priority area. It does not replicate nor replace best practice guidelines on how to recognise, assess and manage people at risk of suicide.

The New Zealand Public Health and Disability Act 2000 (the Act) outlines the responsibilities DHBs have in relation to Maori. These responsibilities reflect the Crown’s overall partnership with Maori under the Treaty of Waitangi. The Act has put in place a number of measures as a response to the Crown’s desire to have greater participation by Maori in the health and disability sector with a view to improving Maori health outcomes and reducing health disparities between Maori and other population groups (Ministry of Health 2001). DHBs are expected to act in accordance with these requirements in all their work relating to the health priority objective of reducing the rate of suicide and suicide attempts.

More information about DHB responsibilities under the New Zealand Public Health and Disability Act can be found here.

Appendix 1 outlines the DHB accountability indicator regarding suicide prevention for 2001/02. It is envisaged that accountability indicators will change from year to year. The toolkits are not accountability documents in themselves. It is intended, however, that any new accountability indicators that are developed will reflect the issues raised within the toolkits.

Development of the toolkit

This toolkit has been developed with reference to national and international research and literature on suicide prevention, and has been guided by an expert reference group. Comment and input were also received from DHBs, as the primary audience of this toolkit, to ensure it meets their needs.

This toolkit is a living document. Over time and as new evidence appears it will be refined and updated.

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Linkages

As mental health disorders, including drug and alcohol disorders, and a history of emotional, physical or sexual abuse are major risk factors for suicidal behaviour, this toolkit has clear linkages to three other health priority areas:

• improving the health status of people with severe mental illness
• minimising the harm caused by alcohol, illicit and other drug use to both individuals and the community
• reducing violence in interpersonal relationships, families, schools and communities

This toolkit on suicide prevention will not replicate material in the toolkits that address these related priority areas. Rather, DHBs are expected to be familiar with all relevant toolkits to ensure their planning and purchasing of services is consistent and well integrated.

District Health Boards should also refer to key strategic policy documents when planning services. Several of the more significant resources relevant to this toolkit include:


DHBs will be expected to be familiar with a number of key policy documents currently in development, once they are finalised. These include:

- the Maori Health Strategy
- the [Maori Mental Health Strategy](#)
- [Building on Strengths: A Springboard for Action: The Mental Health Promotion Strategy](#)
- [Pacific Health and Disability Action Plan](#)
- the [Health of Older People Strategy](#)
- the Youth Health Strategy
- the Youth Development Strategy Aotearoa (Ministry of Youth Affairs).

See also the References for other relevant documents, research and reports. Appendix 3 includes some key national and international websites related to suicide prevention that will be of use.
Background

Key statistics

- On average, approximately 550 people die by suicide each year in New Zealand.
- The suicide rate for the total population has increased steadily over the last 20 years. The major contribution to the increase has been in the age groups of 15–24 and 25–34 years.
- A quarter of the deaths by suicide in 1998 were people aged between 15 and 24 years (140 deaths), though in recent years the rate of suicide in this age group has decreased.
- New Zealand has one of the highest rate of youth (15–24 years) suicide in a comparison of OECD countries.[1]
- Men are more than three times as likely to die from suicide than women. However, more women are likely to be hospitalised for self-inflicted injury and suicide attempt than men.
- There are now more deaths by suicide than by motor vehicle traffic crashes.[2]
- The Maori male rate of suicide in 1998 (30.5 per 100,000) was almost 50 percent higher than the non-Maori male rate (20.4 per 100,000).
- The Maori female rate of suicide (8.3 per 100,000) was 41 percent higher than the non-Maori female rate (5.9 per 100,000 population).
- Suicide among Pacific peoples increased from 13 deaths in 1997 to 24 in 1998. This increase was made up primarily of Pacific males aged 25 to 54 years.
- In 1998 the age group with the highest rate of suicide were those aged 15–24, followed by those aged 25–34 years.
- In 1998/99 there were 1,427 male and 2,204 female discharges from public hospitals for self-inflicted injuries/suicide attempts.
- Youth aged 15–24 years had the highest rates of hospitalisation for self-inflicted injury and suicide between 1991 and 1998.

For more statistics
For more detailed statistical information see Suicide Trends in New Zealand 1978–1998 (NZHIS 2001)

To find out what other statistics are available check out New Zealand Health Information Service (NZHIS) web site at www.nzhis.govt.nz/stats/statscontents.html. If you would like specific data produced-to-order, send an e-mail message to NZHIS at inquiries@nzhis.govt.nz

Some important notes on statistics

Data on suicidal behaviour are frequently misunderstood or misinterpreted. It is important that DHB planners have a good understanding of how suicide data are compiled so they are able to ascertain the trends of suicidal behaviour in their region over time and the impact of interventions or hazards.

Key problems in analysing data on suicidal behaviour include incorrectly drawing conclusions from small numbers of suicide deaths; comparing data over a period that is too short; or incorrectly comparing city or regional data.
The data themselves are also problematic because of changing ethnicity classifications, delays and a lack of uniformity of coronial reports, and the lack of a national system to systematically gather emergency department data.

Appendix 3 outlines some important notes and cautions for DHBs regarding statistics on suicidal behaviour.

It is advisable to seek advice from the New Zealand Health Information Service for the best ways to use regional data.

**The costs of suicidal behaviour**

Suicide mortality and morbidity are a major cost not only to the health sector but to society in general. Broadly, these costs include:

- premature loss of life
- the provision of medical, surgical, mental health and rehabilitative services to those making non-fatal suicide attempts
- bereavement and other psychological impacts on family and others closely involved with individuals making fatal or non-fatal suicide attempts
- loss of productivity for those involved in the suicidal behaviour and those affected by it.

It is important to note that the costs and consequences of intervention (or failure to intervene) are borne out not simply by health services, but by other government sectors (eg, education, justice and child, youth and family services) and non-government services. Accurate cost–benefit evaluations would require long-term follow-up and, in relation to suicide specifically, continued tracing throughout the life span. Available information, however, suggests that the economic benefits of early childhood and adolescent interventions are likely to be substantial.

An analysis of potential years of life lost (PHYLL) as a result of suicide in comparison with other selected leading causes of death shows that while suicide accounted for a small proportion of total deaths in 1997 (2 percent), the potential years of life lost from suicide was only 15 percent lower than the number lost from ischaemic heart disease. This disproportionately heavy loss is because more suicide deaths occur at younger ages than do deaths from ischaemic heart disease (NZHIS 2001).

**Epidemiology of suicidal behaviour**

During the last few years approximately 550 New Zealanders have died each year from suicide.

The overall rate of suicide in New Zealand has increased from 9.9 per 100,000 in 1978 to 14.3 per 100,000 population in 1998, with much of this increase due to an increase in male and in youth deaths. In 1998 suicide accounted for 2 percent of all deaths in New Zealand. However, amongst young people aged 15–24 years, suicide was the second leading cause of death (after motor vehicle deaths) and this age group accounted for a quarter of all deaths by suicide. While the rate of youth suicide has decreased in recent years, New Zealand still has one of the highest rates of youth suicide among OECD countries. Maori have a significantly higher rate of suicide than non-Maori.

Suicidal behaviours occur on a continuum from ideas and thoughts about suicide, which are not acted on, through to suicide attempts and completed suicide. A far greater number of people attempt suicide each year than die by suicide. Numbers of suicide attempts are difficult to quantify because many do not result in serious physical injury and do not need medical treatment. However, population surveys suggest that from 5 to 10 percent of the general population and 7.5 percent of young people aged 21 years report having made suicide attempts in their lifetime. Each month approximately 300 New Zealanders are admitted to hospital for treatment following
suicide attempts. Regardless of their medial severity, all suicide attempts should be taken seriously as those who attempt suicide are at high risk of making further suicide attempts or of completing suicide.

In New Zealand the most common methods used for suicide are hanging and vehicle exhaust gas.

Population differences

Gender differences

Four times as many males as females die by suicide each year in New Zealand. However, females make more suicide attempts than males, and report suicidal ideation and depression more than males.

The gender difference in completed suicide is explained in part, but not completely, by males’ tendency to use methods of suicide that are more immediately lethal than methods chosen by females.

Age differences

Children. The risk of suicide varies with age. Suicide is very rare amongst children and young adolescents under the age of 15 years, but appears to be increasing. Most suicides in this age groups occur in 13- and 14-year-olds, with twice as many deaths occurring amongst 14-year-olds than 13-year-olds.

Children and younger adolescents may be less likely to make suicide attempts because they lack the cognitive ability to plan and conduct a suicide attempt, lack access to means of suicide, and are less likely to have developed depression and substance abuse problems associated with suicidal behaviour. The risk factors for suicide amongst young adolescents under 15 years appear to be same as those for older youth.

Youth. Amongst young people aged 15–24 years, the risk of suicide increases with age up to the age of 20 years. Suicide rates amongst males aged 20–24 are higher, often almost twice as high, as suicide rates amongst males aged 15–19 years. It is important to recognise that most youth suicides do not occur amongst teenagers nor amongst high school students. Rather, the majority of youth suicide deaths occur amongst young people aged 18 to 24 who have left school. It is estimated that only 15 percent of youth suicides are accounted for by young people who are high school students.

Females of high school age, while not at high risk of suicide, tend to be at a high risk of non-fatal suicide attempt behaviour. This higher risk may be due to the tendency for females to develop depressive and anxiety disorders earlier than males. Programmes that attempt to improve recognition of depression and suicidal behaviour by adults, including teachers and counsellors, in contact with school students may have some benefit in reducing suicide attempt behaviour among young females.

Adults. The comparative rise in youth suicide over the last 20 years has tended to obscure the high suicide rates amongst adults and older adult males. This group still constitutes the clear majority of all suicide deaths. In 1998 deaths amongst those aged 25 and older accounted for 75 percent of all suicide deaths in New Zealand. In recent years, half of all suicide deaths have occurred in adult males aged 25–64 years and suicide rates amongst males aged 25–29 years have been higher than rates amongst youth aged 15–24 years.

Nevertheless, over the last 20 years, suicide amongst the 55–64 age group has decreased by two thirds. In addition, adult females aged 25–64 years have comparatively low rates of suicide and constitute a little over 10 percent of all suicide deaths annually.
**Older adults.** Over the last 20 years the rate of suicide amongst older adults aged 65 and over has decreased significantly. In 1998 suicide in this age group made up 10 percent of all suicide deaths and is made up predominantly of male deaths.

The progressive ageing of populations in the industrialised world suggests that absolute numbers of suicides and suicide attempts among the elderly will rise as both the number and proportion of older people in the population increase.

**Ethnic differences**

While non-Maori account for the majority of suicides, a significantly higher proportion of Maori than non-Maori is involved. The suicide rate in young Maori is higher than the overall rate for young adolescents aged 10–14 years (18.8 per 100,000 vs 4.3 per 100,000), for youth aged 15–24 years (40.3 per 100,000 vs 26.1 per 100,000) and for adults aged 25–44 years (27 per 100,000 vs 21.2 per 100,000).

Research has suggested that Maori are overrepresented amongst those with social and health problems. It is likely that the higher rates of suicidal behaviour amongst Maori reflect these disadvantages. Further explanations include the enduring impact of colonisation, the difficulties Maori face within mainstream institutions (eg, schools and health services), the loss of land, and the breakdown of cultural identity and Maori social structures such as the whanau.

In 1995 the method of recording ethnicity for death statistics was changed. This change precludes comparison of statistical data for Maori suicide deaths for the years prior to 1995 with the years after 1995. Effectively, 1996 marks the beginning of a new time series for ethnicity data.

The number of suicide deaths accounted for by Pacific and Asian peoples is small. In recent years, Pacific and Asian peoples suicide deaths have each accounted for about 2 percent of all suicide deaths. The numbers are so small that it would be misleading to attempt to calculate suicide rates for these populations.

**Sexual orientation**

Being gay, lesbian or bisexual has been linked with a higher risk of suicidal behaviour. It is thought that this higher risk is due to the impact of negative societal attitudes towards homosexuality and bisexuality.

Longitudinal research from the Christchurch Health and Development Study has found that gay, lesbian and bisexual young people were more likely to have a range of mental disorders. Amongst this group, suicidal thinking was 5.4 times more likely and suicide attempt 6.2 times more likely than amongst heterosexual young people (Fergusson, Horwood and Beautrais 1999).

Australian research has found that most suicide attempts amongst gay males occurred after the person had self-identified as gay, but before having a same-sex experience and before publicly identifying themselves as gay (Nicholas and Howard 1998).
Risk factors

Key points

• The evidence from New Zealand and international studies strongly suggests that suicide is rarely the response to a single stress. Instead it is the outcome of a culmination of stressors and adverse life-course sequences in a person with few protective factors to draw upon and whose resilience may be compromised.

• Mental disorder, most commonly depression, is the most important risk factor for suicide and suicide attempts. The risk is amplified where a person has multiple mental disorders or has a drug/alcohol problem.

• Other factors in the causal pathway to suicide include a socioeconomically disadvantaged background, childhood physical or sexual abuse, poor parent–child relationships, loss of a parent though separation or divorce, and suicide or violence in the family.

• In most cases, prior to suicidal behaviour, a person experiences a life stress or crisis that acts as a trigger event. This event is often centred around the breakdown of an emotional or supportive relationship.

• Risk factors for suicide appear to be remarkably consistent across countries and cultures, but may vary to some extent with age, gender and ethnicity.

It is important to note that the risk factors identified in this section are common to a range of poor outcomes, not just suicide. It is probable that limiting exposure to certain risk factors or ameliorating their effects can result in other beneficial outcomes such as a reduction in adolescent pregnancy, child abuse and neglect, drug and alcohol disorders, injury or depression. Moreover, because suicidal behaviour is difficult to predict, it is necessary to treat all people who have this risk factor profile with optimal service.

Risk factors are outlined here with reference to three broad age groups: youth, adults and older adults.

Risk factors for youth suicide

Most research into risk factors for suicide has focused on youth populations. This focus has produced a generally consistent set of risk factors, which are listed below.

*Mental disorders and a mental health history including prior suicide attempts*

Most suicidal behaviour occurs in the context of mental illness and mental illness is the strongest risk factor for suicidal behaviour. The clear majority of those who die by suicide or make serious suicide attempts have at least one diagnosable psychiatric disorder at the time of their attempt. The most common disorders are mood or affective disorders (including depression and bipolar disorder). Other disorders include alcohol and other substance use disorders, antisocial behaviours (including conduct disorder and antisocial personality disorder) and, much less commonly, anxiety disorders. While psychotic disorders (including schizophrenia) occur infrequently in the general population, amongst the small group with these disorders the risk of suicide is high.

Frequently, those with serious suicidal behaviour have co-morbid (or co-occurring) mental disorders. Most commonly, the disorders that co-occur are depression and substance use disorder. Those with more than one disorder, compared with those with a single disorder, tend to have markedly increased risks of suicidal behaviour.
Those with serious suicidal behaviour often have a history of previous suicide attempts, and of inpatient or outpatient care for mental health problems. Young males who have made a prior suicide attempt are at particularly high risk of suicide.

Other suggested risk factors are discrimination and negative attitudes towards people with mental illness and a lack of awareness of available services. These factors may cause isolation, loneliness and delays in seeking help.

**Family history of suicidal behaviour**

Individuals who have family histories of attempted or completed suicide are themselves at higher risk of suicidal behaviour. This observation suggests either a role modelling effect or a possible role of genetic factors in the risk of suicidal behaviour. However, it is not yet clear whether what is being transmitted in families is a genetic tendency for mental disorders such as depression and alcoholism (with which suicidal behaviour is associated), a genetic tendency towards aggressive, impulsive and violent behaviours, or suicidal behaviour per se.

**Social and educational disadvantage**

Suicidal behaviour tends to be more common amongst people from backgrounds characterised by low socioeconomic status, limited educational achievement and low income. Some evidence demonstrates population increases in suicide rates with rises in unemployment. However, it is not yet clear whether unemployment is a cause of adverse social, family and personal factors including mental illness, or whether suicide and unemployment both arise from similar causal factors.

**Family and childhood risk factors**

Young people with suicidal behaviour tend to come from family backgrounds characterised by dysfunctional or difficult circumstances. These circumstances include: parental disharmony, parental separation and divorce; parental mental illness (including alcohol and other substance abuse problems, affective disorders and antisocial behaviours); a family history of suicidal behaviour; parental and family discord; physical, sexual or emotional abuse during childhood; and poor family relationships and communication styles.

Often young people at risk of suicidal behaviour tend to come from backgrounds in which several of these family risk factors are present. This tendency suggests that the chronicity and density of family risk factors, rather than exposure to a single risk factor, increase suicide risk.

The role of family and childhood risk factors has been explored less well in adult and older adult suicide than in youth suicide. Moreover, there are methodological difficulties in recalling and assessing how events that occurred in childhood may have contributed to adult suicidal behaviour. Nevertheless, some evidence indicates that exposure to serious adversity in childhood (eg, sexual abuse) may convey a risk of suicidal behaviour that endures into old age.

**Personality disorders and traits**

Some evidence relates suicidal behaviour to certain personality traits and cognitive styles, including cognitive inflexibility, neuroticism, a pervasive sense of hopelessness, poor problem-solving skills, impulsivity and a negative or hopeless outlook.

Some studies suggest that personality disorders may be present in up to one third of those who die by suicide. The most common disorders are borderline, antisocial and avoidant personality disorders.

**Stressful life events and circumstances**
Suicidal behaviour is often preceded by stressful events, particularly losses and conflicts (usually relationship breakdown) and, less commonly, legal or financial crises. While such events are common in the general population, they seem to precipitate suicidal behaviour in those individuals who are vulnerable to suicidal behaviour because they have some of the other risk factors for suicide.

A frequent tendency is to explain suicide as being caused by the events that immediately precipitated the suicide death, such as the breakdown of a relationship. This approach oversimplifies, and inadequately explains, the complex behaviour of suicide.

**Exposure to suicidal behaviour**

Exposure to the suicidal behaviour of other people, whether in person or in the media, may encourage suicidal behaviour in people who are vulnerable to suicidal behaviour. Suicide clusters tend to be confined to young people, who seem particularly vulnerable to this imitative aspect of suicidal behaviour.

There are concerns that frequent discussion of suicide, particularly in the media, may convey the impression that suicide is a common event. Such coverage brings the risk of normalising suicide and increasing suicidal behaviour as people may come to see suicide as a commonly used approach to solving life problems.

To address these concerns, many countries and the World Health Organization have developed guidance material to encourage the safe reporting and portrayal of suicide in the media. In New Zealand, the Ministry of Health’s (1999b) *Suicide and the Media: the reporting and portrayal of suicide in the media: a resource* is widely available.

**Accumulative risk of suicidal behaviour**

Often risk factors for suicidal behaviour act cumulatively. Thus individuals with greater exposure to risk factors are at substantially higher risk of suicidal behaviour than those with fewer, or no, risk factors.

**Access to the means of suicide**

Evidence suggests that availability of a particular means of suicide (firearms, prescription drugs, toxic chemicals, motor vehicle exhaust) increases the likelihood of that means being used. Rates of suicide among Australian women fell after access to barbiturates became more difficult. Rates fell in the United Kingdom after the detoxification of domestic gas and the restriction of access to paracetamol (Hawton et al 2001) and in Asia after the restriction of paraquat weed killer.

In New Zealand the most common methods used for suicide are hanging and vehicle exhaust gas. The ubiquitous availability of both vehicles and the means for hanging suggests that there are very limited opportunities to reduce suicide deaths in New Zealand by restricting access to methods of suicide. Nevertheless a series of best practice recommendations are outlined in *Restricting Access to Means of Suicide in New Zealand* (Beautrais 2000) regarding ways of restricting access to various means of suicide.

**Risk factors for suicide amongst adults**

There has been less research about suicide in the adult population than on youth suicide. However, New Zealand research suggests that the risk factors for suicidal behaviour in adults have much in common with the risk factors for youth suicide, discussed above. These risk factors include male gender, mental disorders (in particular, mood, substance use and psychotic disorders), a history of admission and contact with services for mental health care, exposure to recent stressful life events and low socioeconomic status.
The single most significant risk factor for suicidal behaviour in adults is mood disorder. Adults at high risk of suicide are characterised by a high burden of risk factors (listed with youth suicide above) for suicide. By this means they may also be clearly differentiated from adults without such risk.

Risk factors for suicide amongst older adults

The progressive ageing of the population has given rise to increasing concern about suicidal behaviour in older adults. Research in New Zealand and internationally suggests that suicide in this age group shares many of the risk factors for suicide in youth and in adults. The risk is greater amongst older people with mental disorders, histories of mental disorder, mental health treatment and prior suicide attempts, limited social interaction, and recent relationship and financial stresses.

In contrast to studies that consistently suggest that suicide in young people has multiple and complex causes, studies attribute serious suicidal behaviour in older adults, very largely, to mood disorders (predominantly major depression). This link indicates a single, specific focus for suicide prevention in older adults. That is, it is necessary to improve identification, treatment and management of major depression, and to prevent and better recognise the life events, social, family and related factors that may contribute to the development of depression in older adults.

Protective factors

Although most research into suicide has focused on risk factors, in recent years there has been growing interest in the issue of resiliency. Resiliency factors are those factors that may mitigate, compensate or protect individuals from exposure to risk factors.

At this stage the available research on this topic is limited. However, the following factors have been suggested as protecting against suicide:

- good problem-solving skills
- family and community social supports
- connectedness (eg, to family, peer group, school or community)
- secure cultural identity
- cultural, religious and personal beliefs that discourage suicidal behaviour
- skills in managing conflicts and disputes.

Research and carefully evaluated programmes are needed in this area to build a strong evidence base upon which effective programmes can sit.

Population-level determinants of suicide

Rates of suicide vary over time across different ages, gender, ethnic groups and countries. Although valuable research has confirmed individual risk factors for suicide, there is still an absence of evidence that confirms the wider social, economic and cultural determinants that may be associated with trends in suicide.

As such, the Ministry of Health is looking to contract research to examine population-based explanations for New Zealand’s suicide trends, which may lead to possible population-based interventions to reduce the rate of suicide.
Interventions to prevent suicidal behaviour

Using research to prevent suicide

Although we need more information about the role of protective factors and the wider social, economic and cultural determinants of suicidal behaviour, we do know a great deal about the risk factors for suicide. The challenge lies in continuing to build our understanding of suicide, while at the same time using the available research knowledge on risk factors to develop, implement and evaluate a range of prevention, assessment and treatment approaches and interventions to reduce suicide risk.

At a clinical level it is difficult to predict who will attempt or die by suicide and who will not. Within such settings therefore the focus needs to be on effective best practice, risk recognition and management, and addressing and treating the major risks factors of suicide, particularly mental illness. Also needed are processes and quality improvement measures to manage and address organisational risks.

Internationally, much of the research into suicidal behaviour is now concerned with identifying effective suicide prevention interventions at individual levels and at population levels. It is acknowledged that research in this area is very complex given the multifactorial nature of suicide. Its complexity is compounded by ethical issues, a lack of funding, and the need for long timeframes and use of proxy measures given the comparative rarity of suicide.

Key components of suicide prevention

In the absence of conclusive empirical evidence on all facets 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
- 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, Maori, youth, Pacific peoples, males) and individuals at risk (preferably in the context of the family/whanau)
- 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 eight 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
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
7. data collection, information dissemination and research
8. a framework for community action.

Further explanations on these interventions, including their rationale and actions DHBs can take, are described more fully under ‘Interventions’. Please note these themes are not listed in any priority.

Figure 1 illustrates the range of interventions that the health sector can engage in to interrupt the progression of risk factors from suicidal thoughts to death.
Figure 1: Framework of health sector interventions to interrupt the pathway to suicide

Progression of suicidal thoughts and behaviours

Risk factors
- Socioeconomic disadvantage
- Stressful life events
- Family instability
- Personality and beliefs
- Sexual/physical abuse/violence
- Exposure to suicidal behaviour
- Access to methods of suicide
- Mental disorder (including alcohol and drug disorders)

Suicidal thoughts

Enhancing protective factors
- Mental health promotion programmes
- Universal and targeted family/whanau support
- Programmes and services to strengthen cultural identity
- Advocacy and programmes to increase community cohesion
- Advocacy and programmes to reduce violence, abuse bullying, discrimination etc
- Advocacy to limit access to means of suicide
- Encouragement of ‘safe’ media reporting
- Programmes to build resilience such as coping skills, problem-solving

Primary prevention
- Build resilience such as coping skills, problem solving, connectedness
- Services and training to improve early identification of risk factors and intervention
- Mental health literacy & depression awareness programmes
- Treatment of emerging mental disorders (including alcohol and drug disorders)

Secondary prevention
- Identification and treatment of mental disorders including drug and alcohol abuse
- Screening for suicide risk
- Advocacy to reduce access to means of suicide
- Training and resources to improve responsiveness

Tertiary intervention
- Emergency care
- Specialist mental health treatment and assertive follow-up
- Screening for subsequent suicide risk
- Advocacy and action to reduce access to means of suicide
- Training and resources to improve responsiveness

Postvention
- Management to prevent contagion
- Support for bereaved
- Suicide case review and audit

Responses

Suicide attempts

Consequences
- Death or disability
- Negative psychological impacts on others including risk of imitation
Planning suicide prevention activities

Key considerations
When considering planning suicide prevention activities, it is important that DHBs consider the whole spectrum of prevention, what group is being targeted and at what level of risk the group is placed. In particular, DHBs should consider:

• the purpose of the suicide prevention activity, which may range from health promotion and community development through crisis response services
• the target group, which may range from the whole population, through high risk groups, to individuals
• the evidence base for the effectiveness of many activities including, where evidence is limited, at least a demonstrated change in the estimated level of risk
• the likely costs and benefits of a proposed strategy
• whether the intervention holds any risks or potential for harm
• its place and role in the overall continuum of care of suicide prevention including its nature, potential scope, boundaries and limitations
• a collaborative approach, including relating to other sectors to provide a more integrated and effective approach (Commonwealth Department of Health and Aged Care 2000)
• how the needs of Maori are to be addressed, such as the use of Maori frameworks, Maori participation in the design and delivery of service and initiatives, and involvement of whanau, hapu and iwi
• how the needs of Pacific peoples and peoples from other cultures are being addressed.

Suicide-specific versus suicide non-specific interventions
Some interventions are relatively suicide-specific. Others address risk and protective factors that have outcomes not only for suicidal behaviour but also for sectors such as justice, educational, health and employment. Identifying the broader benefits is likely to be important for securing broad community support, securing funding and ensuring maximum co-ordination of suicide prevention with related initiatives.

How to prioritise
It is recognised that funding is limited for DHBs and that they are unlikely to be in an immediate position of purchasing a full range of services and initiatives for suicide prevention. DHBs need to examine the full continuum of care needed in their region and make decisions based on the best health gain for the expenditure. Suicide prevention need not always require more services but often it will require better services. In many cases greater investment at a public or primary health level may result in downstream savings in the secondary and tertiary health sectors.

There is no one intervention that on its own is likely to reduce the rate of suicide significantly. DHBs are encouraged to develop a plan that includes a range of interventions outlined in this toolkit. However, in the short term DHBs should consider giving priority to the following broad-based approaches to address suicide:

• funding training and skill development on suicide risk management (across community, primary, public, mental health and emergency department personnel)
• funding a range of effective and accessible services for people with mental illness and/or suicidal behaviour
• improving current processes for documentation, follow-up and support of people who have received medical treatment for a suicide attempt
• funding programmes that encourage help-seeking for emotional distress and mental illness
• funding programmes that improve community understanding and awareness of depression
• developing a regional plan of action to address the spectrum of suicide prevention interventions.
Accountability Indicators for District Health Boards

Appendix 1 outlines the interim DHB accountability indicator regarding suicide prevention for 2001/02. This indicator PR1–02: Progress in developing the capacity of primary care providers to impact on suicide states that:

'DHBs are expected to report to the Ministry of Health by 30 June 2002 on the extent to which they have promoted and encouraged the use of the following guidelines by its contracted primary care providers:

- Guidelines for Primary Care Providers: Detection and Management of Young People at Risk of Suicide
- Guidelines for the Treatment and Management of Depression by Primary Healthcare Professionals
- Guidelines for Assessing and Treating Anxiety Disorders
- Guidelines for Recognising, Assessing and Treating Alcohol and Cannabis Abuse in Primary Care'.

This indicator framework is considered interim. It reflects the transitional constraints placed on DHBs, in terms of the staged devolution of funding and assumption of responsibility for pre-existing contractual arrangements. In practical terms, this transition has created the need to select indicators that measure activity in areas where it is expected funding will be devolved, and where DHBs have the ability to influence provider activity within the context of existing arrangements with providers.

In the future, this interim framework will be further refined to include:

- other service areas that are devolved later (Public Health, Disability Support)
- indicators from finalised toolkits
- indicators of performance that become available through improvements in data availability and quality (ie, outcome indicators)
- evaluation of the indicators for 2001/02.

Future indicators for suicide might, for example, include a focus on how mental health services and emergency departments assess and manage people at risk of suicide, or who have been treated at emergency departments, reflecting the current development of guidelines and best practice material by the Ministry of Health.

As with the 2001/02 indicators, DHBs will be consulted on the development of any new indicators.
The policy context for planning

Maori suicide prevention and the Treaty of Waitangi

As a Treaty of Waitangi partner, the Government recognises the special relationship between Maori and the Crown. It appreciates that the principles of the Treaty of Waitangi – partnership, participation and protection – must underpin health service delivery to Maori. For District Health Boards this recognition means:

- **partnership**, working together with iwi, hapu, whanau and Maori communities to develop strategies for reducing the rate of Maori suicide and suicide attempts
- **participation**, involving Maori at all levels of the sector in planning, development and delivery of health and disability services that are put in place to reduce the rate of suicide and suicide attempts
- **protection**, ensuring Maori rates of suicide and suicide attempts are lowered to at least the same level as those of non-Maori and safeguarding Maori cultural concepts, values and practices.

The New Zealand Public Health and Disability Act 2000 sets out a number of measures that recognise and respect the principles of the Treaty of Waitangi in the health and disability sector. These measures include:

- minimum Maori membership of Boards of DHBs
- provision for membership of DHB committees
- training for Board membership, for familiarity with Treaty issues, for Maori health issues, and for Maori groups or organisations in the DHBs
- a requirement for DHBs to establish and maintain processes to enable Maori to participate in and contribute to strategies for Maori health improvement
- continued fostering of the development of Maori health capacity for DHBs participating in the health and disability sector and for providing for their own needs
- provision of relevant information to Maori to enable effective participation.

The Act also recognises the need for service delivery that positively reduces disparities and is targeted at population-related initiatives, rather than any preferential treatment sought by an individual person.

As in non-Maori, suicidal behaviour in Maori is closely linked to mental health status. However, it has been suggested that the risk status is amplified because of the presence (and high prevalence) of multiple factors that are linked to suicide for Maori (eg, high rates of unemployment, low rates of educational achievement, high rates of poverty, increasing domestic violence and family dysfunction) set against an historical context of colonisation and the trauma of cultural loss (Lawson-Te Aho 1998).

While there is an absence of Maori-specific suicide research, the Health Research Council is funding a major study on Maori suicidal behaviour that will be completed in the next few years.

Central to the Treaty relationship and implementation of Treaty principles is a common understanding that Maori will have an important role in implementing health strategies for Maori and that the Crown and Maori will relate to each other in good faith with mutual respect, cooperation and trust.

The New Zealand Health Strategy clearly states that Maori should be able to define and provide for their own priorities for health and be encouraged to develop the capacity for delivery of services to their communities.
Given the high Maori rate of suicide, it is essential that approaches are designed with Maori to be effective for Maori. Maori models for health and wellbeing mean that while the whole spectrum of prevention should be designed to be appropriate for Maori, there is a strong focus on addressing the broader determinants of suicide within a Maori cultural framework. This specific focus emphasises whanau, hapu and iwi development and the use of cultural practices as a means to strengthen and protect Maori youth against suicidal behaviour (Lawson-Te Aho 1998).

Although programmes and services designed and delivered by Maori must be emphasised, Maori also require access to high quality, appropriate and effective mainstream services.

These principles are reflected in Kia Piki te Ora o te Taitamariki, the Maori-specific component of the New Zealand Youth Suicide Prevention Strategy. Kia Piki te Ora o te Taitamaiki was developed to prevent Maori youth suicide; nevertheless the framework has relevance across the life span.

**Suicide prevention amongst Pacific peoples**

Although the actual numbers are still low, recent data show an increase in suicide among Pacific adult males. Despite concerns about the accuracy of ethnicity classification in mortality and morbidity data, the recorded increase is a concern that warrants action.

The high prevalence of risk factors for suicide amongst Pacific peoples indicates that this trend may continue. Moreover, given the high level of stigma associated with suicide amongst Pacific peoples and a reluctance to seek help for mental health problems from mainstream services, innovative solutions are required.

In planning services to address Pacific suicidal behaviour it is important that Pacific peoples living in New Zealand are not treated as a homogenous group. Instead, service planning and delivery must reflect their diversity of origin, culture, traditions, values, language and social institutions (eg, the church).

District Health Boards are expected to assess the needs of Pacific peoples in their region, including the risk and protective factors. In consultation with Pacific peoples, DHBs are also expected to develop a comprehensive plan that addresses the spectrum of suicide prevention and that includes both mainstream and Pacific specific services where appropriate. Meaningful community consultation and involvement must underpin all stages of planning, service development, implementation and evaluation.

There is an absence of research into suicidal behaviour amongst Pacific peoples living in New Zealand. However, the Health Research Council is funding a study that will be completed in the next few years. This research is expected to contribute to a greater understanding of both the nature of suicidal behaviour amongst Pacific peoples and possible opportunities for prevention.

**Other cultures**

There is little information on the suicidal behaviour of other cultures living in New Zealand. As the ethnic make-up of our population changes and becomes more diverse, such as with the increasing Asian population, it is important that we continue to monitor suicidal behaviour across all ethnic groups. Likewise it is important that health services monitor such changes closely and reflect the needs of their population in all aspects of their service delivery.

**Reducing inequalities**

Reducing inequalities is a theme running through the New Zealand Health Strategy. DHBs are mandated to act in this area. The recent report on social inequalities in health (Ministry of Health 2000b) demonstrates that the health status of some population groups is better than that of others. Such differences also exist for trends in suicidal behaviour. For example, Maori have higher
suicide rates than non-Maori, and socioeconomic and educational disadvantage is a key risk factor for suicide.

All DHB funding programmes and services need to work towards raising the health status of all groups and reducing the gap between the worst off and the best off. Achieving this goal requires consideration of health on a population basis, and consideration of the wider determinants of health, in addition to the more direct biomedical causes of disease and their treatment.

**The New Zealand Youth Suicide Prevention Strategy**

The New Zealand Youth Suicide Prevention Strategy (Ministry of Youth Affairs, Ministry of Health, Te Puni Kokiri 1998) was developed to provide a planning framework to guide government, providers and communities in their efforts to reduce suicidal behaviour amongst young people.

The New Zealand Youth Suicide Prevention Strategy is an intersectoral strategy. It contains two components: *Kia Piki te Ora o te Taitamariki* is the Maori-specific approach and *In Our Hands* is focused on all youth, including Maori.

Although its focus is on preventing suicidal behaviour in young people, the strategy has relevance for preventing suicide in the whole population. DHBs are expected to use the New Zealand Youth Suicide Prevention Strategy to guide their planning activities.

The Ministry of Youth Affairs is now the lead government agency for the leadership and co-ordination of the New Zealand Youth Suicide Prevention Strategy. It co-ordinates the implementation of the strategy across a range of agencies and sectors to attain a full picture of national and regional services and programmes. By this means, duplication may be minimised and collaboration maximised.

**Working across sectors**

The health sector is a key player in the prevention of suicide. Nevertheless, it needs to work closely with other sectors to effect change and to collaborate on joint initiatives where possible.

In their planning and in undertaking suicide prevention activities, DHBs and their providers are expected to have close partnerships with organisations and sectors outside the health sector that are involved in suicide prevention. The key sectors include: police, local authorities, social services, Child Youth and Family Services, schools and educational institutions, Specialist Education Services, Department of Work and Income, Te Puni Kokiri, Youth Affairs, coroners, media, researchers, local councils, hapu, iwi and Maori organisations, Pacific Affairs, Internal Affairs, and Corrections.

Much of the health sector’s work may involve advocacy and mobilisation of other sectors. Its goal would be to refocus the activities of other sectors so that they contribute to suicide prevention more effectively or by collaborating on particular projects.

Over the next year the Ministry of Youth Affairs will be updating the work programme of the Inter-Agency Committee on Youth Suicide Prevention, which covers the work of 14 government agencies. When complete, this programme will be available for viewing on the [Ministry of Youth Affairs web site](http://www.ministryofyouthaffairs.govt.nz).

**Working with special interest groups**

In recent years special interest groups have increased their activity around suicide prevention. Many of these groups are implementing programmes in regions throughout New Zealand using a range of approaches. DHBs need to be sure that suicide prevention organisations in their region are operating in ways that are aligned with best practice. In some cases DHBs may need to
provide these organisations with guidance and advice on evidence, as well as encouraging collaborative and evidenced-based practice.

**Potential to do harm**

Although it is important that DHBs are responsive to the needs of their community, it is vital that interventions are informed by research and agreed best practice. Some interventions, though well meaning, have been shown to place vulnerable people at a greater risk of suicide. Key examples include suicide-specific school-based awareness programmes and dramatic television depiction of suicide to raise awareness of suicide.

The Ministry of Education [youth suicide guidelines](#) for schools state that there is no evidence to support suicide-specific programmes in schools. They warn of the need for a cautious approach to supporting such programmes and instead suggest that schools implement programmes targeting mental wellbeing generally (Beautrais et al 1997).

**Evaluation**

DHBs are encouraged to place a high priority on funding well-conducted evaluations of suicide prevention interventions. Before any programme, service or project is implemented widely, evaluation is necessary to measure whether it is effective. Evaluation in this field is complex and will require carefully designed evaluations that measure process and outcome over time.

Evaluation has four main purposes:

- to increase the evidence base for future planning
- to ensure fidelity to good practice models and the stated intentions of programmes
- to describe outcomes for individual service uses and population groups
- to provide accountability for taxpayer or philanthropic funds.

Reduced rates of suicide, suicidal behaviour and suicidal thinking are the critical outcomes of suicide prevention programmes. Moreover, to indicate progress towards these outcomes it is necessary to include shorter-term measures, such as reduced risk factors or increased protective factors associated with suicide (Commonwealth Department of Health and Aged Care 2000).

**Future developments at a national level**

Over the next year the Ministry of Health will be working on the following areas that have relevance to the prevention of suicide within the health sector:

- guideline development and best practice resource development for mental health services and emergency department services regarding assessing and managing people at risk of suicide
- a multicomponent programme to address tāitamarihī Māori suicide that includes national training and skills development programme and an intensive community-based programme in several sites
- a stocktake of New Zealand suicide research and the development of a research agenda to help guide future research
- research to examine broader population level explanations for New Zealand’s suicide rates and trends.

For more information on these initiatives, contact Maria Cotter at the Ministry of Health [maria_cotter@moh.govt.nz](mailto:maria_cotter@moh.govt.nz).
Interventions

Theme 1: Mental health promotion including strengthening social cohesion and providing supportive environments

Rationale and evidence

Given that suicide rates are associated with social, economic and cultural factors, broad programmes directed at increasing protective factors and reducing social and cultural risk factors may influence suicide rates (Commonwealth Department of Health and Aged Care 2000).

Mental health promotion and community development strategies tend to focus on a broad range of social, educational, health, economic and psychological aspects of people’s lives. They do not necessarily target a reduction of mental disorder or suicide specifically (Disley 1997).

By limiting experiences that compromise mental health (e.g., childhood physical or sexual abuse, poor parent–child relationships, or violence in the family) and by ameliorating the effects in those already exposed, the likelihood of developing some mental disorders can be reduced.

There is good and growing evidence that family support interventions, such as family start, can be effective in diminishing conflict and childhood abuse (MacMillan et al 1994) and in enhancing cohesion. Such interventions can have ongoing benefits in terms of behaviour and mental health of offspring (Beautrais 1998; National Health and Medical Research Centre 1999).

A variety of cognitive, behavioural and socially based interventions has been shown to be effective with children who experience traumatic life events such as parental separation, divorce and bereavement (NHS Centre for Reviews and Dissemination 1997).

Positive benefits have also come from school-based programmes that modify the environment so that it is more supportive of mental health. Examples of modifications are anti-bullying policies and attempts to help negotiate stressful transitions (Durlak and Wells 1997).

Planning and purchasing strategies

- Ensure that in planning, implementation and evaluation of all funded health programmes and services, themes towards reducing inequalities are integrated.
- Fund and support initiatives that facilitate community cohesion and encourage mental health by promoting features of social and physical environments.
- Fund health programmes that strengthen Maori social structures such as whanau, hapū and iwi, and that strengthen Maori identity.
- Fund initiatives (including evaluation) that strengthen family/whanau and community support networks, and diminish stresses facing families such as poverty, social exclusion, family conflict and discord, violence, substance abuse, adolescent pregnancy.
- Fund further implementation of effective parenting skills and family/whanau support programmes (particularly for young parents) such as home visiting initiatives that can address a wide range of social, emotional, educational and other difficulties.
- Fund programmes to reduce isolation and improve social support, particularly amongst older adults.
- Fund programmes to reduce violence, racism, homophobia and other forms of discrimination that impact on health and wellbeing.
- Fund school-based mental health promotion programmes, such as Health Promoting Schools and Mentally Healthy Schools Guidelines (in development).
- Fund programmes that build resiliency and protective factors in young people.
• Fund regional initiatives in line with the national campaign to counter stigma and discrimination associated with mental illness.
• Fund programmes that work with employers to encourage workplace initiatives to support mental health.
• Fund programmes to improve community awareness about the early signs and symptoms of mental illness, where to get help and how to provide support.
• Fund targeted programmes to improve personal and social functioning such as coping, problem-solving and interpersonal skills, mental health literacy, and help-seeking behaviour.

**Partnerships**

Public health providers, local Health Promoting Schools Co-ordinators, primary health care services, mental health services, national and regional providers of Like Minds Campaign, Mental Health Foundation, Maori health providers, Pacific health providers, mental health service providers and consumers, schools/post-secondary training institutions, Corrections, media, local government community development units, Safe Community Councils, Healthy Cities, Department of Work and Income, family support and social services, non-government organisations etc.

**Resources**

A national approach to mental health promotion is in development. In August to September 2001 consultation was conducted for [Building on Strengths: A Springboard for Action](#). It is envisaged the finalised document will highlight key priorities and examples of evidence-based initiatives.

Within the New Zealand Youth Suicide Prevention Strategy, both [In Our Hands](#) and [Kia Piki te Ora o te Taitamariki](#) have goals and objectives relating to improving wellbeing by using models and processes of community development and Maori development.

For service descriptions for public health services on mental health promotion and suicide prevention see Chapter 11 of the [Public Health Services Handbook 2000–2001](#).

**Comment**

In funding and planning mental health promotion programmes for suicide prevention it is advisable to extend the programme scope wider than suicide to mental health generally. In this way programmes can focus on encouraging a social climate in which mental health issues are better understood, mental illness is destigmatised, the public more readily understand the value and efficacy of appropriate treatment for mental illness, and skills that enhance resilience are promoted (Beautrais 1998).

**Theme 2: Training and skill development on suicide risk assessment and management**

**Rationale and evidence**

Given that mental disorder has a strong relationship to suicidal behaviour, early recognition and effective treatment for people with mental illness are a key to preventing subsequent suicidal behaviour. It is important that key community personnel and professionals have the skills and capacity to identify and help someone with a mental illness or who is displaying high-risk behaviour for suicide. To this end, tailored training should be targeted at a range of personnel such as:

• community personnel (clergy, teachers, counsellors, corrections staff, youth workers, police etc)
primary health professionals (general practitioners, midwives, public health nurses, practice nurses, Maori health workers, Pacific health workers etc)
mental health professionals (residential, community and inpatient services)
emergency department professionals.

In a study of the effect of a programme to enhance general practitioners’ recognition and treatment of depression on the Swedish island of Gotland, it was found that suicide decreased immediately after the educational programme but not over the long term (NHS Centre for Review and Dissemination 1993; Rutz et al 1980). The result indicates that training needs to be sustained over time, updated following evaluation and available both in preclinical training and inservice training.

As confirmed by a critical appraisal of the literature on youth suicide prevention by primary health care professionals, education programmes to assist general practitioners to recognise and treat mental illness appear to be effective in youth suicide prevention (New Zealand Health Technology Assessment 1998).

It is also important that protocols and quality improvement measures are put in place to manage organisational risks.

Planning and purchasing strategies

- Fund ongoing workforce development through inservice and preservice training programmes on mental health issues and on suicide risk assessment and management, for the following groups:
  - primary health professionals (general practitioners, midwives, public health nurses, practice nurses, Maori health workers, Pacific health workers, etc)
  - mental health professionals (residential, community and inpatient services)
  - emergency department professionals
  - community personnel (youth workers, caregivers, etc).
- Ensure service contracts have protocols and quality improvement measures in place to manage organisational risks.

Partnerships

Training colleges and universities, professional bodies, general practitioners, practice nurses, school nurses, midwives, mental health services, emergency health services, marae-based health services, Maori providers, community and social services, religious leaders, providers of public health services, teachers, Pacific providers, counsellors, corrections staff, youth workers, Lifeline, Youthline, Samaritans, Suicide Prevention Information New Zealand (SPINZ), police etc.

Resources


Mental Health Foundation. 1997. *Young People and Depression*. Auckland: Mental Health Foundation of New Zealand.


Comment

The Ministry of Health has contracted the New Zealand Guidelines Group to develop guidelines for mental health services and emergency departments on the identification, assessment and management of people at risk of suicide. The guidelines are expected to be completed in July 2002.

The Ministry of Health has also contracted with Kahui to develop and implement national skills development programmes on Maori suicide prevention for Maori providers and community personnel. These resources will be developed over 2001–2002 and implemented over 2002–2004.

Guidelines and training material were developed in 1999 by the Royal New Zealand College of General Practitioners on the Detection and Management of Young People at Risk of Suicide.

A number of other sector-specific training programmes on suicide prevention are in place. These include programmes for school counsellors, police, Corrections staff, and Child Youth and Family social workers. Some suicide prevention training to community personnel is also available through SPINZ.

Training on suicide risk assessment and management needs to be ongoing rather than a one-off event. In addition, regular and ongoing dissemination of resources, and the development of protocols (including audit) are needed to ensure that best practice is being followed.

Theme 3: Effective, responsive and accessible services for people with mental health problems and/or suicidal behaviour

Rationale and evidence

Mental disorders are strongly linked to a higher risk of suicidal behaviour. One of the strongest indicators of likely suicide is a previous suicide attempt (Beautrais 1999). Critical to suicide prevention are effective and seamless assessment, treatment and support for people who have a mental illness or who have made a suicide attempt.

Research has shown that where people are actively followed up after presenting to an emergency department for attempted suicide, they may be less likely to reattempt and more likely to gain access to appropriate treatment (Brent and Perper 1995).

Many experts suggest one of the most effective approaches to preventing suicide is to target people with mental disorder and suicidal behaviour with improved assessment, treatment and management strategies (Beautrais 1998). Such an approach involves primary, mental health and emergency health services.

Primary health services are well placed to provide early intervention for mental health problems and assessment of suicidal behaviour. However, to be effective, they need to be accessible and appropriate to the service user. Establishing these qualities may require innovative models of service delivery to ensure that services see those most at risk, such as young people, males, people on low incomes facing multiple difficulties, Maori, older adults and Pacific peoples.
DHBs are expected to have processes in place to ensure that all aspects of planning, development, implementation and evaluation of programmes and services involve and are appropriate to Maori.

Treatment for mental disorder associated with suicide needs to be guided by agreed best practice coupled with effective risk assessment and management strategies. In most situations this approach will combine pharmacological and psychotherapeutic interventions with social and family support. (Refer to the toolkit for mental health for more detail.)

**Planning and purchasing strategies**
- Fund innovative models of primary health services to ensure those at risk of suicide are assessed and treated early and comprehensively.
- Implement funding and service development strategies to increase the proportion of service providers who use models of care that are acceptable and appropriate to meet the needs of Maori, such as kaupapa Maori mental health services.
- Implement funding and service development strategies to increase the proportion of service providers who use models of care that are acceptable to and appropriate to meet the needs of young people.
- Fund services that provide a continuum of care for older adults experiencing mental illness.
- Fund models of care that remove financial barriers to primary mental health care, including the costs of psychotherapeutic interventions.
- Continue to fund the growth of a full range of effective mental health services.
- Ensure service providers have processes or protocols in place to forge effective links among services responding to people who have attempted suicide (eg, mental health services, Child Youth and Family Services, general practitioners, emergency departments, police, ambulance services).
- Ensure service providers have effective protocols in place for assessment, treatment and follow-up of those who present at emergency departments following a suicide attempt, including processes to monitor the implementation of such protocols.
- Fund support services for families and caregivers of mental health service users.
- Ensure mental health service providers have protocols in place to review critical events such as the suicide of a mental health service user.

**Partnerships**
Mental health services, emergency departments, primary health care services, police, ambulance services, Maori services, Pacific services, consumer groups, Ministry of Health, professional bodies, non-government organisations etc.

**Resources**
Refer to the mental health toolkit for further resources.

**Comment**
The Ministry of Health is developing a Sentinel Events System for health services to review and report critical events. It is envisaged this system will include processes for reviewing and responding to critical events such as the suicide of a mental health service user.
Theme 4: Reducing access to the means of suicide

Rationale and evidence
Experience from several countries suggests that reducing access to the means of suicide can reduce the rate of suicide by that means significantly, at least in the short term. However, the effectiveness of this intervention depends on the availability of the particular means and the feasibility of restricting it.

A recent Ministry of Health review (Beautrais 2000) examined opportunities for influencing suicide rates in New Zealand by reducing access to the means of suicide. Given that the two most common methods are hanging and vehicle exhaust gas, there are limited opportunities to make major reductions in the suicide rate through this approach. Nevertheless it is prudent to implement a range of best practice recommendations that have the potential to make modest reductions in suicide, at least in the short term.

Planning and purchasing strategies
The Ministry of Health is undertaking further policy work to investigate some national level approaches. At a regional level DHBs need to consider the following actions.

- Ensure service providers have policies and practices to restrict supply of toxic and lethal drugs commonly used in suicide (eg, modifying type and amount of drugs prescribed at one time and limiting access to large quantities of paracetamol at one time; Hawton et al 2001).
- Ensure service providers have in place policies, practices and construction to ensure safety in seclusion areas (eg, in psychiatric inpatient units, residential homes).
- Advocate for limiting access to firearms.
- Advocate for modification of vehicle exhausts, and engine cut-out switches for high carbon-monoxide levels in vehicle cabs.
- Advocate for barriers to be put in place at known suicide jump spots.

Partnerships
Local authorities, Land Traffic Road Safety Authority, Safer Community Councils, police, Corrections, providers of public health services, primary health care professionals, emergency departments, mental health consumer groups, mental health services, Ministry of Health, coroners etc.

Resources
For an in-depth analysis of trends in suicide methods in New Zealand and a review of opportunities for prevention, see:


Comment
Many of the actions to modify or restrict access to the means of suicide initiatives lie outside the health sector. DHBs and their providers, however, have an important role in advocating for changes that affect the health of people in their area and to join regional efforts at a national level where possible.
Theme 5: Portrayal of suicide in the media

Rationale and evidence
There is consistent evidence that publicity and portrayal of suicide in the media can increase suicidal behaviour. Likewise, a Viennese study shows that after the introduction of media guidelines to encourage responsible reporting, the number of suicides and suicide attempts decreased.

To encourage safe reporting, the Ministry of Health has developed suggestions for the media in *Suicide and the Media: the reporting and portrayal of suicide in the media: a resource* (1999). District Health Boards and providers are encouraged to develop good working relationships with a range of media to encourage them to safely report and portray suicide in line with this resource.

Planning and purchasing strategies
- Fund service providers to work with local, regional and national media to reduce the potential of imitation and normalisation of suicide, in line with the advice in: Ministry of Health. 1999. *Suicide and the Media: the reporting and portrayal of suicide in the media: a resource.* Wellington: Ministry of Health.

Partnerships
Media (film, television, radio, documentaries, magazines, Māori media, daily and community newspapers etc), and those who have influence eg, editors, subeditors, film script writers, journalism tutors, Office of Film and Literature Classification, Broadcasting Standards Authority, Press Council. Also SPINZ, Ministry of Health, primary, public and mental health services etc.

Resources


Theme 6: Postvention management and support for families and friends following suicide

Rationale and evidence
Research suggests family members, associates and friends of suicide victims show increased rates of depression and other mental illnesses and are at a higher risk of suicidal behaviour. Effective bereavement support can help minimise the risk of suicidal thinking and behaviour after any bereavement.

Postvention management plans are activities after a suicide to contain the negative consequences such as widespread trauma and suicide contagion. While postvention activities are widely supported by most suicide prevention strategies, few interventions have been evaluated. Despite this lack of evaluation, most experts agree that there is a strong need for postvention interventions to prevent further deaths by imitation, and to assist with providing support and counselling to the family and peers of the victim (Centres for Disease Control 1994). Postvention plans are particularly important where large numbers of vulnerable people could potentially be affected by a suicide, such as in secondary schools.

It is crucial that all postvention plans and support responses are developed, implemented and evaluated in close partnership with Maori.

Planning and purchasing strategies
• Fund health services to work with key organisations to implement intersectoral postvention plans for managing a suicide and providing support to those affected in a range of settings.
• Fund services to establish effective, appropriate and responsive support groups for people bereaved or affected by suicide.
• Ensure models of care relating to the provision of postvention support are appropriate to Maori.
• Fund specialised training in suicide bereavement for appropriate service providers.

Partnerships
Public health services, mental health, primary health care services, schools and educational institutions, Maori community leaders, Maori health providers, Lifeline, Youthline, Samaritans, SPINZ, Skylight, Mental Health Foundation, Specialist Education Services, media, community leaders, Pacific providers, religious leaders, coroners, funeral directors, grief support services, Victim Support, police, etc.

Resources

Comment
Specialist Education Services have a particular role in working with educational institutions following a traumatic incident, including suicide. In doing so they frequently are central to the establishment of postvention plans, working closely with relevant agencies such as police, media, community leaders, Maori providers and iwi organisations, public health units, and mental health services.
Theme 7: Data collection, information dissemination, research and evaluation

**Rationale and evidence**

To implement effective suicide prevention activities, we need a clear picture of the extent and nature of suicidal behaviour, along with well-evaluated interventions.

Key barriers to obtaining good data about suicidal behaviour include: the delay in annual suicide mortality statistics; variation in the quality of data in coroner’s reports; lack of standardised review protocols for all suicides; poor ethnicity recording practices and inconsistency of data systems to collect information about those who receive treatment in emergency departments for suicide attempt.

It is critical to evaluate the effectiveness of suicide prevention programmes. Evaluation in this area is complex and requires well-designed methodologies. It also needs to be explicitly funded. Given the statistical rarity of suicide it is important to assess the effectiveness of a programme or intervention by measuring process outcomes, such as a decrease in suicide attempts, increased help seeking, and greater confidence and accuracy in assessing people at risk of suicide.

It is important that any services and programmes that have impact on Maori are assessed for their effectiveness and appropriateness for Maori. This requirement means involving Maori in all stages of evaluation.

**Planning and purchasing strategies**

- Establish processes to improve the quality and consistency of data (including ethnicity classifications) on people presenting to hospital emergency departments for suicide attempt.
- Ensure health services utilise protocols for standardised critical incident review and reporting protocols following all suicides.
- Establish partnerships with the local coroner(s) to improve the usefulness and consistency of information gathered in coronial reports.
- Fund evaluation of key suicide prevention initiatives and disseminate findings.
- Establish processes for the dissemination of best practice information about suicide prevention to all key stakeholders and sectors in the region, eg, electronic media, newsletters, meetings, fono, training sessions, training the trainer processes, and hui.

**Partnerships**

New Zealand Health Information Service, Ministry of Health, Ministry of Youth Affairs, Department for Courts, SPINZ, hospital emergency departments, research and evaluation experts, Maori research and evaluation units, community leaders, mental health, primary health and public health services, key suicide prevention providers, coroners, Maori providers, Pacific providers, police etc.

**Resources**


**Comment**

DHBs are encouraged to work alongside the New Zealand Health Information Service in improving data collection to ensure a consistent approach nationally.

Theme 8: A framework for community action

**Rationale and evidence**
Research suggests that reliance on a single preventive strategy is inappropriate for suicide, given its multifactorial aetiology (Coggan C et al 2000). For this reason it seems prudent to ensure all sectors and interventions are well aligned and co-ordinated.

Bringing together the key stakeholders and providers in suicide prevention to develop a regional action plan is a key step to ensuring an integrated approach to suicide prevention at all levels and across all sectors. Developing an action plan will involve the following steps.

1. Identify and bring together key stakeholders in suicide prevention.
2. Stocktake existing initiatives.
3. Collate relevant regional statistics on suicides and attempted suicide.
4. Prepare a needs assessment by identifying gaps and areas for development.
5. Prepare an action plan, including priorities, timeframes and responsibilities.
6. Implement the action plan and review it regularly.

Planning and purchasing strategies
- Fund and support the establishment of a regional suicide prevention planning group to develop a regional action plan.

Partnerships
SPINZ, schools and educational institutions, Safer Community Councils, local authorities, Child Youth and Family Services, Specialist Education Services, media, community leaders, Maori providers and iwi organisations, mental health, primary health and public health services, religious leaders, coroners, funeral directors, grief support services, Pacific providers, youth workers, Victim Support, police, etc.

Resources


Comment
In some regions active groups may have already developed suicide prevention action plans. In such cases DHBs may be able to collaborate with these plans, rather than duplicate them. Some regions may have plans that address Maori suicide prevention, some may be focused on youth, and others may broadly address all ages and all population groups.

SPINZ has a role in working with communities to help them to develop community action plans for suicide prevention. DHBs are encouraged to liaise closely with SPINZ and seek their assistance where required. Contact SPINZ at info@spinz.org.nz.
APPENDIX 1:

Performance indicator regarding suicide prevention for District Health Boards 2001–2002

The Ministry of Health has negotiated accountability agreements with District Health Boards which contain indicators related to NZHS priority areas. These indicators will be re-examined, in conjunction with DHBs, in the light of work carried out in completing this Toolkit. Current accountability agreements with DHBs contain the indicator discussed below.

Suicide prevention
PRI-02 Progress in developing the capacity of primary care providers to impact on suicide prevention.

Objective
Reducing the rate of suicide and suicide attempts is a population health objective under the New Zealand Health Strategy. The prevention of suicide requires action across many sectors and at all levels targeting the whole population, specific population subgroups and individuals at risk. In the health sector it requires a co-ordinated approach across public health, primary health, personal health (emergency care) and community and inpatient mental health services (including alcohol and drug services).

Suicide prevention in primary health care involves the identification and management of people who may be at risk of suicide. This requires recognition of and treatment for risk factors associated with suicide such as depression, and the assessment and management of the suicide risk in people who have engaged in self-harming behaviour or expressed suicidal thoughts. Best practice guidelines have been developed which aim to assist primary care providers in the detection and management of suicide and associated risk factors:

- Guidelines for Primary Care Providers: Detection and Management of Young People at Risk of Suicide.
- Guidelines for the Treatment and Management of Depression by Primary Healthcare Professionals.
- Guidelines for Assessing and Treating Anxiety Disorders.
- Guidelines for Recognising, Assessing and Treating Alcohol and Cannabis Abuse in Primary Care.

Measure
The DHB will promote and encourage the use of the guidelines by its contracted Primary Care providers.
**Frequency**

Annually

The reporting period is 30 June 2002

<table>
<thead>
<tr>
<th>DHB Reporting Requirement</th>
<th>Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Care</strong></td>
<td></td>
</tr>
<tr>
<td>Report on promoting and encouraging the use of the specified guidelines by its contracted primary care providers.</td>
<td>PRI-02 Progress in developing the capacity of primary care providers to impact on suicide prevention.</td>
</tr>
</tbody>
</table>
APPENDIX 2:

Some important notes on suicide statistics

The role of NZHIS
The New Zealand Health Information Service (NZHIS) collects national and regional data on suicide death and hospitalisation for self-inflicted injury/suicide. Periodically it publishes reports that summarise trends. Suicide Trends in New Zealand 1978–1998 documents some of the most recent data on suicide and suicide attempt, with information in relation to factors such as age, gender, ethnicity, method and locality.

How is suicide data collected?
Annual suicide data are subject to delay as only coroners can rule a death to be a suicide, and annual suicide statistics can only be finalised when all outstanding death certificates have been accounted for. At the time of writing, the most recent data available for suicide deaths were from 1998 for all ages, and from 1999 for provisional figures for youth.

How is suicide attempt data collected?
Suicide attempt data comprise only those people who are admitted to hospital as inpatients or day patients for ‘suicide and self-inflicted injury’. This definition may include people who have engaged in self-inflicted injury but whose intent was not suicidal. Suicide attempt statistics are not routinely collected on people who are treated in emergency departments as patients, or by general practitioners.

In addition, regional and year-to-year comparisons can be problematic as the methods for treatment may vary. For example, improved treatments for overdose have meant more people can be treated as outpatients and will not appear in hospitalisation figures on suicide attempts. Some hospitals have developed new systems to collect data on people treated in emergency departments for suicide attempts. These data are valuable as they provide a fuller picture of people who engage in suicidal behaviour. They can also assist health service responses and follow-up.

The limitations of ethnicity data
Ethnicity data for suicide and suicide attempts are problematic, with changing definitions and variable accuracy in recording ethnicity. In September 1995 the methods used for recording ethnicity for all mortality changed from a system of biological concept (50 percent or more ancestry) to one of self-identification. The purpose was to match with census changes.

These changes have had a significant impact on the relative rates of all mortality data for Maori, non-Maori and Pacific peoples. As a result, we can only examine trend data up until 1995. In 1996 a new time series for ethnic specific mortality data began; 1996 data are only comparable with data from 1997 onwards.

The dangers of interpreting small numbers
When numbers are small, any change can cause fluctuations in rates, which can be misleading. This tendency may be an issue for data broken down into small population groups, such as Maori or Pacific peoples or Asian, narrow age bands or regional or DHB areas, if the numbers are not aggregated across a number of years. Considerable caution should be exercised in interpreting regional data for this reason. Comparison across cities is also problematic and unreliable.

Mortality review developments
A number of initiatives are looking to improve the quality of mortality data. The Office of the Coroner is under review following a Law Commission report. The Department for Courts and the Ministry of Justice are working on the establishment of a database that would require mechanisms to achieve greater consistency in data collected for deaths and would improve the consistency and quality of suicide data. Such changes would, in turn, greatly benefit analysis to ascertain trends in greater depth.

DHBs also need to be aware that the Ministry of Health is establishing a process of Child and Youth Mortality Review. This would provide audit and review processes for all deaths of people aged between four weeks and 30 years.

*Keeping an eye on the trend data*

Planners and providers of suicide prevention services and programmes need to ensure that the needs of populations at particular risk are effectively targeted. As trends of those at high risk change over time, so interventions need to change their focus and approach.

For example, 20 years ago, adults aged 55–64 had the highest rate of suicide and youth aged 15–24 had the lowest rate. This trend has now completely reversed. Moreover, Maori now have a higher rate of suicide than non-Maori and show different patterns of methods used for suicide.
## APPENDIX 3:

### Key web sites

#### New Zealand

<table>
<thead>
<tr>
<th>Organization</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ministry of Health</td>
<td><a href="http://www.moh.govt.nz">www.moh.govt.nz</a></td>
</tr>
<tr>
<td>New Zealand Health Information Service</td>
<td><a href="http://www.nzhis.govt.nz">www.nzhis.govt.nz</a></td>
</tr>
<tr>
<td>Ministry of Youth Affairs</td>
<td><a href="http://www.youthaffairs.govt.nz">www.youthaffairs.govt.nz</a></td>
</tr>
<tr>
<td>SPINZ</td>
<td><a href="http://www.spinz.org.nz">www.spinz.org.nz</a></td>
</tr>
<tr>
<td>Mental Health Foundation</td>
<td><a href="http://www.mentalhealth.org.nz">www.mentalhealth.org.nz</a></td>
</tr>
<tr>
<td>National Health Committee</td>
<td><a href="http://www.nhc.govt.nz">www.nhc.govt.nz</a></td>
</tr>
<tr>
<td>Royal New Zealand College of General Practitioners</td>
<td><a href="http://www.rnzcp.org.nz">www.rnzcp.org.nz</a></td>
</tr>
<tr>
<td>The Clearing House for Health Outcomes and Health Technology Assessment</td>
<td><a href="http://www.nzhta.chmeds.ac.nz">www.nzhta.chmeds.ac.nz</a></td>
</tr>
<tr>
<td>Canterbury Suicide Project</td>
<td><a href="http://www.chmeds.ac.nz/research/suicide/suicide.htm">www.chmeds.ac.nz/research/suicide/suicide.htm</a></td>
</tr>
<tr>
<td>Injury Prevention Research Unit (Dunedin)</td>
<td><a href="http://www.otago.ac.nz/ipru">www.otago.ac.nz/ipru</a></td>
</tr>
<tr>
<td>Injury Prevention Research Centre (Auckland)</td>
<td><a href="http://www.auckland.ac.nz/ipc">www.auckland.ac.nz/ipc</a></td>
</tr>
<tr>
<td>Wellington School of Medicine</td>
<td><a href="http://www.wnmeds.ac.nz">www.wnmeds.ac.nz</a></td>
</tr>
<tr>
<td>Urge/Whakamanawa (youth health web site)</td>
<td><a href="http://www.urge.co.nz">www.urge.co.nz</a> or <a href="http://www.whakamanawa.co.nz">www.whakamanawa.co.nz</a></td>
</tr>
<tr>
<td>Trippin (youth health web site)</td>
<td><a href="http://www.trippin.co.nz">www.trippin.co.nz</a></td>
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</tbody>
</table>

#### International

<table>
<thead>
<tr>
<th>Organization</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>World Health Organization</td>
<td><a href="http://www.who.int/mental_health/Topic_Suicide/suicide1.html">www.who.int/mental_health/Topic_Suicide/suicide1.html</a></td>
</tr>
<tr>
<td>American Association of Suicidology</td>
<td><a href="http://www.suicidology.org">www.suicidology.org</a></td>
</tr>
<tr>
<td>American Foundation for Suicide Prevention</td>
<td><a href="http://www.afsp.org">www.afsp.org</a></td>
</tr>
<tr>
<td>Reporting on Suicide- Recommendations for the Media</td>
<td><a href="http://www.afsp.org/education/newmediaquide2.html">www.afsp.org/education/newmediaquide2.html</a></td>
</tr>
<tr>
<td>Australian Institute for Suicide Prevention</td>
<td><a href="http://www.suicidoeventionaust.org">www.suicidoeventionaust.org</a></td>
</tr>
<tr>
<td>Suicide Prevention Australia (SPA)</td>
<td><a href="http://auseinet.flinders.edu.au">http://auseinet.flinders.edu.au</a></td>
</tr>
<tr>
<td>National Youth Suicide Prevention Strategy – Setting the evidence-based research agenda for Australia: a literature review</td>
<td><a href="http://www.suicideinfo.ca">www.suicideinfo.ca</a></td>
</tr>
<tr>
<td>Suicide Information and Education Centre (Canada)</td>
<td><a href="http://www.hhpub.com/journals/crisis">www.hhpub.com/journals/crisis</a></td>
</tr>
<tr>
<td>The Journal of Crisis Intervention and Prevention</td>
<td></td>
</tr>
</tbody>
</table>
### Glossary of terms and abbreviations

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attempted suicide</td>
<td>A deliberate or ambivalent act of self-destruction or other life-threatening behaviour that does not result in death.</td>
</tr>
<tr>
<td>Comorbidity</td>
<td>The co-occurrence of two or more disorders, such as depressive disorder with substance abuse disorder.</td>
</tr>
<tr>
<td>Evaluation</td>
<td>The systematic investigation of the value and impact of an intervention or programme.</td>
</tr>
<tr>
<td>Evidenced-based</td>
<td>Programmes that have undergone scientific evaluation and have proven to be effective.</td>
</tr>
<tr>
<td>Intentional</td>
<td>Injuries resulting from purposeful human action whether directed at oneself (self-inflicted) or others (assaultive); sometimes referred to as violent injuries.</td>
</tr>
<tr>
<td>Intervention</td>
<td>A strategy or approach that is intended to prevent an outcome or to alter the course of an existing condition.</td>
</tr>
<tr>
<td>Means</td>
<td>The instrument or object whereby a self-destructive act is carried out (eg, firearm, poison, medication).</td>
</tr>
<tr>
<td>Means restriction</td>
<td>Techniques, policies and procedures designed to reduce access or availability to means and methods of deliberate self-harm.</td>
</tr>
<tr>
<td>Mental disorder</td>
<td>Any clinical significant behavioural or psychological syndrome characterised by the presence of distressing symptoms or significant impairment of cognitive, emotional or social functioning; term often used interchangeably with mental illness.</td>
</tr>
<tr>
<td>Mental health problem</td>
<td>Diminished cognitive, social or emotional abilities but not to the extent that the criteria for a mental disorder are met.</td>
</tr>
<tr>
<td>Mental health promotion</td>
<td>Action to maximise mental health and wellbeing among populations and individuals</td>
</tr>
<tr>
<td>Mental health services</td>
<td>Health services specially designed for the care and treatment of people with mental illness, eg, home-based support, residential care, outpatient community services, case management, psychiatric emergency services, hospital inpatient services, rehabilitation services and other intensive outreach services to the care of individuals with severe mental illness. In New Zealand specialist mental health services aim to meet the needs of the 3 percent of the population with the most severe needs.</td>
</tr>
<tr>
<td>Methods</td>
<td>Actions or techniques that result in an individual inflicting self-harm (eg, asphyxiation, jumping, overdose).</td>
</tr>
<tr>
<td>Mood disorders</td>
<td>Mental disorders characterised by a prominent or persistent mood disturbance. Disturbances can be either elevated emotional states (eg, mania) or depressed emotional states. Included are dysthymia, major depression and bipolar disorder.</td>
</tr>
<tr>
<td>Morbidity</td>
<td>The relative frequency of illness or injury, or the illness or injury rate, in a community or population.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
<tr>
<td>----------------------</td>
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</tr>
<tr>
<td><strong>Mortality</strong></td>
<td>The relative frequency of death, or the death rate, in a community or population.</td>
</tr>
<tr>
<td><strong>OECD</strong></td>
<td>Organization for Economic Co-operation and Development. Its members include the industrialised counties of western Europe together with Australia, United States, Canada, Japan and New Zealand.</td>
</tr>
<tr>
<td><strong>Outcome</strong></td>
<td>A measurable change in the health of an individual or group of people that is attributable to an intervention.</td>
</tr>
<tr>
<td><strong>Postvention</strong></td>
<td>Interventions after a suicide, largely taking the form of support for the bereaved (family, friends, professionals and peers). The aim is to support and debrief those affected; and reduce the possibility of suicide contagion. Interventions recognise that those bereaved by suicide may be vulnerable to suicidal behaviour themselves and may develop complicated grief reactions.</td>
</tr>
<tr>
<td><strong>Primary health services</strong></td>
<td>Services that form the first point of contact for those in the community seeking health care. They include community-based care from general practitioners, practice nurses, school nurses, Maori health workers, Pacific health workers.</td>
</tr>
<tr>
<td><strong>Primary prevention</strong></td>
<td>Concerned with preventing the development of problems that place people at risk of suicide (eg, preventing mental disorders or sexual abuse). Primary prevention can be universally or selectively targeted. Universal strategies target whole populations and include mental health promotion activities that aim to enhance resilience, optimism and the quality of social relationships and environments. Strategies can selectively target subgroups in the population that have a higher than average chance of developing risk factors for suicide. Measures that restrict access to means of suicide may be included as primary prevention since they are basically with the quality of environments and are universally targeted.</td>
</tr>
<tr>
<td><strong>Protective factors</strong></td>
<td>Factors that make it less likely that individuals will develop a problem or disorder. Protective factors may encompass biological, psychological or social factors in the individual, family and environment.</td>
</tr>
<tr>
<td><strong>Public health services</strong></td>
<td>Activities designed to promote, improve and protect the health status of populations (as distinct from personal health care services which meet the needs of individuals) and reduce inequalities in population health status. Providers include public health units, Maori public health provider organisations, Pacific public health providers, and non-government organisations such as the Mental Health Foundation.</td>
</tr>
<tr>
<td><strong>Psychotic disorders</strong></td>
<td>Mental disorders characterised by severe impairment in reality testing, as evidenced by delusions, hallucinations, and disorganised or agitated behaviour without insight, eg, schizophrenia, bipolar disorder, postnatal psychosis.</td>
</tr>
<tr>
<td><strong>Rate</strong></td>
<td>The number per unit of the population (most commonly 100,000 population) with a particular characteristic, for a given unit of time.</td>
</tr>
<tr>
<td><strong>Resilience</strong></td>
<td>Capacities within a person that may mitigate, compensate or provide protection from factors that might otherwise place that person at risk of suicide.</td>
</tr>
<tr>
<td><strong>Schizophrenia</strong></td>
<td>A mental disorder or group of disorders characterised by disturbances in the form of thought (delusions and hallucinations), mood, sense of self and relationship to the external world, and behaviour.</td>
</tr>
<tr>
<td><strong>Substance use disorders</strong></td>
<td>Mental disorders involving maladaptive behaviour associated with regular use of mood or behaviour altering substances, eg, alcohol, prescription drugs, sedatives, tranquillisers, stimulants, cannabis, heroin.</td>
</tr>
<tr>
<td><strong>Suicide</strong></td>
<td>Death where there is evidence that a self-inflicted and deliberate act led to the person’s death.</td>
</tr>
<tr>
<td><strong>Suicidal behaviour</strong></td>
<td>Includes the spectrum of activities related to suicide and self-harm including suicidal thinking, self-harming behaviours not aimed at causing deaths, suicide attempts and death by suicide.</td>
</tr>
<tr>
<td><strong>Suicidal ideation</strong></td>
<td>Thinking about attempting suicide.</td>
</tr>
<tr>
<td><strong>Unintentional</strong></td>
<td>Term used for an injury that is unplanned; in many settings these are terms accidental injuries.</td>
</tr>
<tr>
<td><strong>Youth</strong></td>
<td>People aged between 15 and 24 years.</td>
</tr>
</tbody>
</table>
Endnotes

1 OECD countries compared were New Zealand, Finland, Australia, Canada, United States, Norway, France, Denmark, Sweden, Germany, Japan, United Kingdom and the Netherlands.

2 In 1998, 316 people died on the roads compared with 574 deaths by suicide. For up-to-date road toll statistics, see the Land Transport Safety Authority http://www.ltsa.govt.nz/research/toll.html

3 PHYLL is a method of measuring premature mortality. It assigns an arbitrary age at which deaths would not be considered premature. The calculation given here takes into account all deaths before the age of 75 years. See NZHIS (2001) for more information.

4 To date, research that has focused on treating people with mental illnesses has demonstrated a direct reduction in suicidal behaviour, including through:
   • treatment with clozapine for those with schizophrenia
   • treatment with lithium for those with bipolar disorder (manic depression)
   • dialectical behavioural therapy for those with borderline personality disorder
   • treatment with a range of medications for people with depression who have relatively low levels of suicidality. (However to date this treatment has not been shown to be effective for depressed people with higher levels of suicidality.)
Bibliography


Journal of the American Academy of Child and Adolescent Psychiatry has a supplement on guidelines for management of suicide and attempted suicide.


Mental Health Foundation. 1997. *Young People and Depression*. Auckland: Mental Health Foundation of New Zealand.


For copies of Ministry of Health publications, contact Wickliffe tel: 0800 226-440.

For youth suicide prevention information and resources contact Suicide Prevention Information New Zealand: SPINZ, PO Box 10318, Dominion Road, Auckland. tel: (09) 638-7364 or e-mail info@spinz.org.nz or www.spinz.org.nz.