Suicide Facts

Provisional 2003 All-Ages Statistics

Public Health Intelligence

Monitoring Report No. 1

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Key Points

Suicide deaths in 2003

- A total of 515 people died by suicide, compared with 465 in 2002.
- The age-standardised suicide rate was 11.5 deaths per 100,000 population, compared with 10.8 in 2002.
- The three-year moving average age-standardised rate of suicide for the total population increased to a peak of 14.0 deaths per 100,000 population for the 1995–1997 and 1996–1998 periods. It then decreased until the most recent period (2001–2003).
- Males continue to have a higher age-standardised suicide rate than females (16.9 compared with 6.2 per 100,000 population respectively). From 1995, there was a decline in the male rate, and then after 2000 there was a general increase in the female rate.
- The all-ages sex ratio for the suicide rate in New Zealand was 2.7 male suicides to every female suicide per 100,000 population.
- The age-standardised rate of suicide was higher for Māori than for non-Māori. For Māori males and females, the age-standardised rates were 21.1 and 6.4 deaths per 100,000 population respectively, and for non-Māori males and females, they were 15.6 and 5.9 deaths per 100,000 population respectively.
- For life-cycle age groups, for females, 15–24-year-olds had the highest age-specific suicide rate (11.0 per 100,000 population), while for males, 25–44-year-olds had the highest age-specific suicide rate (28.4 per 100,000 population).
- New Zealand's all-ages suicide rate was the sixth highest among selected OECD countries for males, and the fourth highest for females.
- The least deprived areas of New Zealand had a suicide rate of 8.8 per 100,000 population compared with 13.2 per 100,000 population in the most deprived areas of New Zealand.
- Trends by ethnicity, age group and region will be further explored in the upcoming publication *Suicide Trends*, due for release later in 2006. Three-year moving averages will be used in this document.

Hospitalisation for suicide and intentional self-harm in 2002/03

- The age-standardised hospitalisation rate for suicide and intentional self-harm for the total population was 131.5 per 100,000 population, compared with 128.2 in 2001/02.
- The sex ratio for hospitalisation for suicide and intentional self-harm in New Zealand was 2.1 female hospitalisations to every male hospitalisation per 100,000 population.

Technical Notes

Data

Source

All data in this publication were sourced from the New Zealand Health Information Service (NZHIS), except for two figures. Figure 1 data were sourced from the Injury Prevention Research Unit, University of Otago, and the international rates in Figure 13 were sourced from the World Health Organization (WHO).

Suicide deaths

The suicide mortality data contained in this report are provisional 2003 data for all ages. There are a small number of deaths (18) still subject to coroners' findings, for which a cause of death has not yet been assigned. Final data will be released by the NZHIS.

Hospitalisation for suicide and intentional self-harm

Hospitalisation for suicide and intentional self-harm is an internationally recognised proxy measure for attempted suicide. It is a measure of the number of people who intentionally harmed themselves and were admitted to hospital. People who intentionally harm themselves and later die in hospital are included.

Data are collected from inpatient and day patient hospital admissions. Hospitalisation discharge data in this report are for the 2002/03 financial year (1 July–30 June).

People who intentionally harm themselves but are not admitted to hospital are not included; for example, those people treated by a general practitioner (GP) or an emergency department but not admitted to hospital.

When comparing data for hospitalisation for intentional self-harm between years, caution should be exercised due to changes in coding and treatment practices. In 1999 and 2000, New Zealand introduced the ICD-10-AM international classification of disease for morbidity and mortality statistics. This resulted in a modified inclusion criterion for the diagnosis of intentional self-harm. From 2000/01 psychiatric hospital discharges, previously excluded from the data, were included, greatly increasing the number of discharges recorded.

In addition, new treatments for overdose have increased the number of people treated on an outpatient basis; previously such cases would have been included in the hospitalisation data.

Some of the regional differences in hospitalisation for intentional self-harm rates between District Health Boards (DHBs) are due to different practices in reporting and patient management.

ICD codes

The ICD-9 codes used for both mortality and hospitalisations were E950–E959. The ICD-10 codes used were X60–X84.

Definitions

Age-specific rates

An *age-specific rate* refers to the frequency with which suicide occurs relative to the number of people in a defined age group. Age-specific rates are presented for both five-year and life-cycle age groups.

Age-standardised rates or rate ratios

Age-standardised rates are rates that have been adjusted to take account of differences in the age distribution of the population over time or between different groups (eg, different ethnic groups).

Age-standardised rate ratios are the ratio of the two rates, taking into account differences in the group size and age structure.

The standard population used was Segi's world population. The *International Comparisons* section used the WHO World population.

Deaths by suicide

Classification of a death as suicide is subject to a coroner's inquiry, and only on completion of an inquest can a death be officially classified as suicide. In some cases the inquest will be heard over a year after the death, particularly if there are other factors surrounding the death that need to be investigated first, meaning that the suicide may be counted in a different year from the one in which it occurred.

District Health Board rates

Age-standardised rates were calculated for each District Health Board (DHB). Deaths from the years 2001 to 2003 were averaged to provide sufficient numbers to calculate robust rates. For hospitalisations for suicide and intentional self-harm, sufficient numbers allowed rates for a single year (the 2002/03 financial year) to be calculated.

New Zealand Deprivation Index

The New Zealand Deprivation Index 2001 (NZDep2001)[1] was used as the key indicator of socioeconomic status. It is an area-based index of deprivation based on Census 2001 variables (eg, income, house ownership and qualifications) and calculated at meshblock-level and also at census area unit (CAU) level. In this report, 1996 domicile codes were mapped forward to the 2001 domicile code (boundaries for 2001 domicile codes and 2001 CAUs are the same) for the assignation of deprivation. NZDep2001 CAUs were divided into five quintiles, where quintile 1 is the least deprived and quintile 5 the most deprived.

Suicide numbers, rates and ratios

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

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

Rate ratios indicate how many times suicide is reported in one population group compared to another.

Three-year moving average

Three-year moving average age-standardised rates are the average age-standardised rates for rolling three-year periods, that is, 1983–1985, 1984–1986, 1985–1987, etc. The three-year moving averages are plotted on the mid-point year. For example, the 2001–2003 three-year moving average is plotted on the year 2002. Rates based on individual years tend to exhibit pronounced variation. By using the three-year moving average this variation is 'smoothed' for graphical presentation. This also allows for the underlying trends over time to be more clearly illustrated.

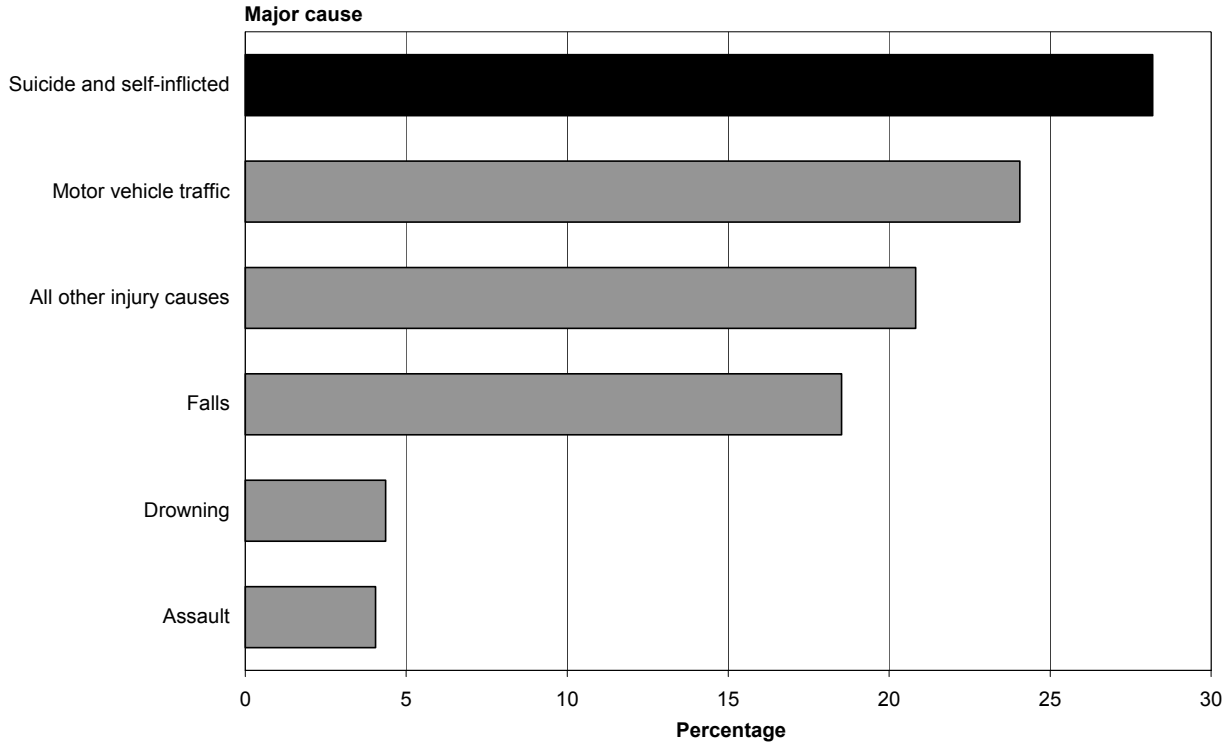
Three-year moving averages will be used in the *Suicide Trends* publication, which will be released in 2006.

[1] Salmond C, Crampton P. 2002. *NZDep2001 Index of Deprivation*. Wellington: Department of Public Health, Wellington School of Medicine and Health Sciences.

Introduction

Suicide is an important and serious health issue. It can be used as an indicator of mental health and wellbeing in the population. Reducing the rate of suicide and suicide attempts is a priority in the New Zealand Health Strategy[2] and the New Zealand Injury Prevention Strategy.[3] The Injury Prevention Research Unit, University of Otago, has estimated that, in 2002, suicide and intentional self-inflicted injury made up the greatest proportion of all injury-related fatalities (Figure 1).

Figure 1: Percentage of total fatal injuries, by major cause, 2002



Source: Injury Prevention Research Unit, University of Otago

[2] Minister of Health. 2000. *The New Zealand Health Strategy*. Wellington: Ministry of Health.

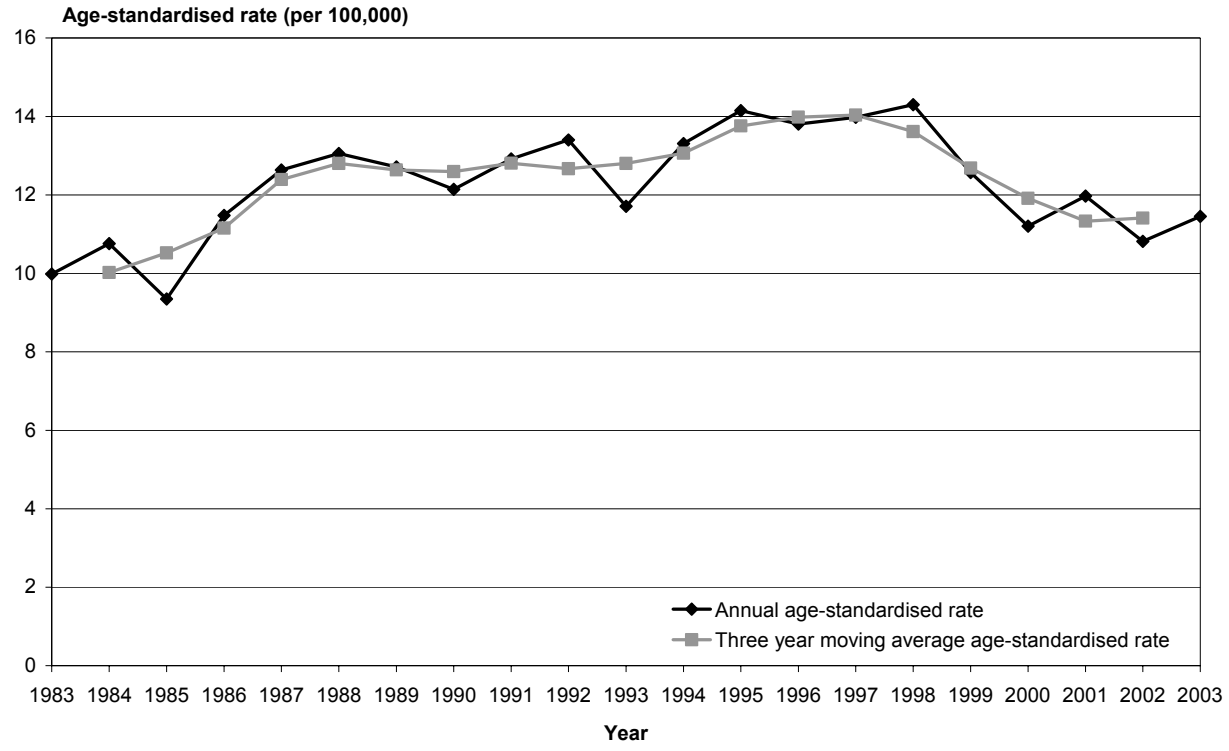
[3] Dyson R. 2003. *The New Zealand Injury Prevention Strategy*. Wellington: ACC.

Suicide Deaths in 2003

General trends

- A total of 515 people died by suicide, compared with 465 in 2002.
- The age-standardised suicide rate for the total population was 11.5 per 100,000, compared with 10.8 per 100,000 population in 2002 (Figure 2).
- The three-year moving average age-standardised rate of suicide for the total population increased to a peak of 14.0 deaths per 100,000 population for the 1995–1997 period and then declined until the most recent period (2001–2003) to 11.4 deaths per 100,000 population.
- The age-standardised rate and three-year moving average age-standardised rate are presented in Figure 2. The three-year moving average age-standardised rate provides a clearer picture of trends over time, smoothing out the annual variations in the age-standardised rate.

Figure 2: Suicide death rates, 1983–2003



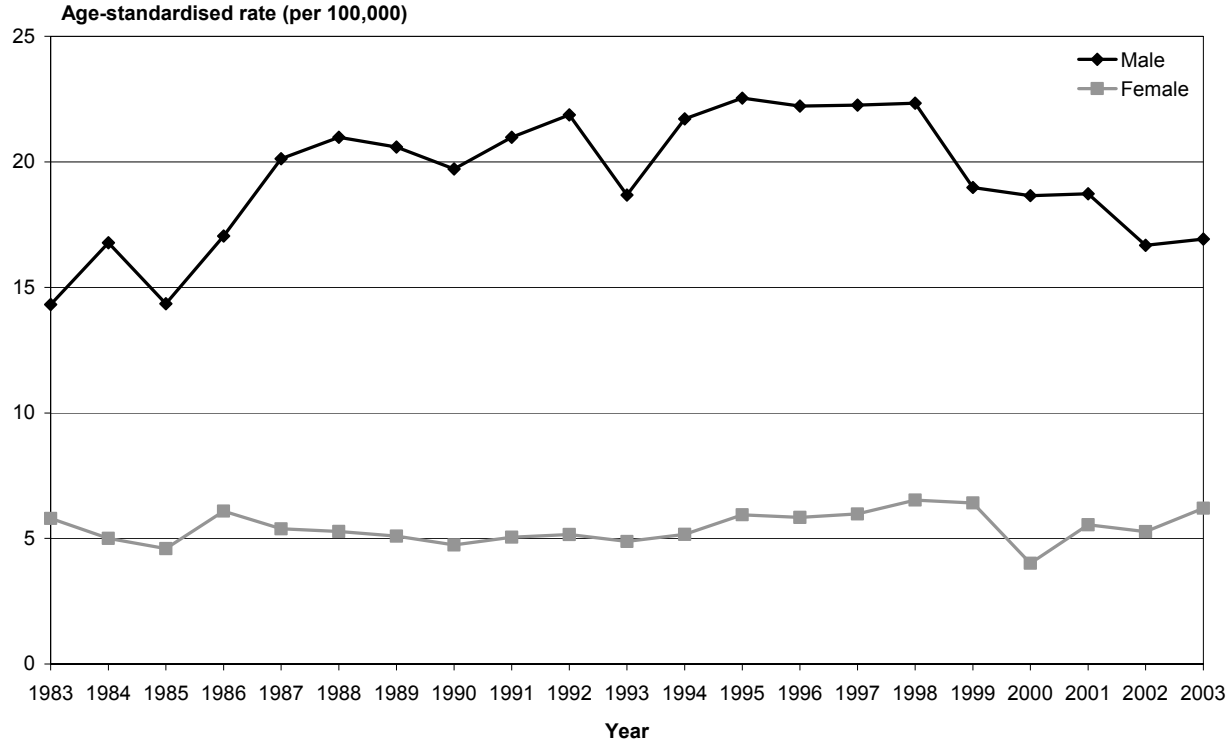
Source: New Zealand Health Information Service

Note: Rates per 100 000, age-standardised to Segi's world population.

Trends by sex

- Three hundred and seventy-four males died by suicide, compared with 352 in 2002.
- The age-standardised suicide rate for males was 16.9 per 100,000 population, compared with 16.7 per 100,000 population in 2002.
- One hundred and forty-one females died by suicide, compared with 113 in 2002.
- The age-standardised rate of suicide for females was 6.2 per 100,000 population, compared with 5.3 per 100,000 population in 2002.
- The age-standardised rate of suicide for females was stable between 1983 and 1999. After 2000 there was a general increase in the female rate (Figure 3).

Figure 3: Suicide death rates, by sex, 1983–2003



Source: New Zealand Health Information Service

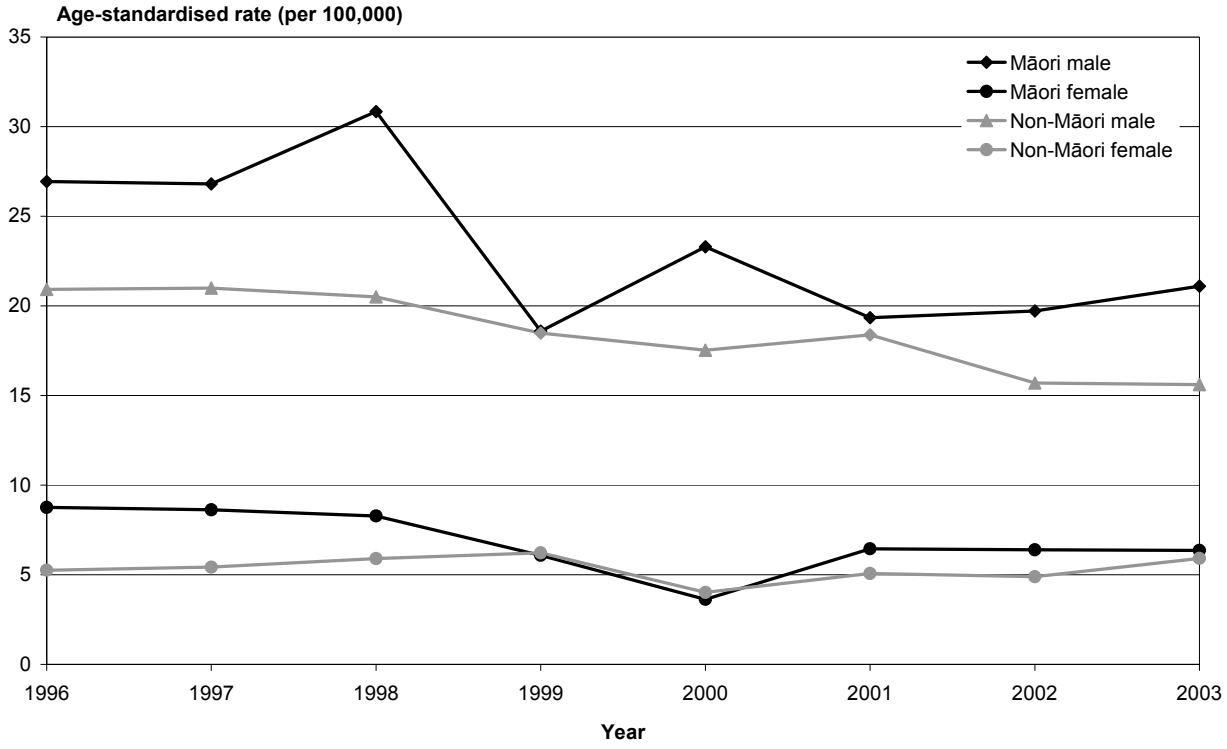
- The all-ages sex ratio for the age-standardised suicide rate in New Zealand was 2.7 male suicides to every female suicide per 100,000 population. The youth suicide (15–24 years) rate ratio was 2.0 male suicides to every female suicide per 100,000 population.

Trends by ethnicity

Māori

- Eighty-seven Māori died by suicide, compared to 80 in 2002.
- The age-standardised rate of suicide for Māori was 13.5 deaths per 100,000 population, compared to 12.8 per 100,000 population in 2002.
- Sixty-seven were male, compared to 59 in 2002.
- Twenty were female, compared to 21 in 2002.

Figure 4: Māori and non-Māori suicide death rates, 1996–2003



Source: New Zealand Health Information Service

- The age-standardised rate of suicide for Māori males was 21.1 deaths per 100,000 population, compared to the non-Māori male rate of 15.6 per 100,000 population.
- The age-standardised rate of suicide for Māori females was 6.4 deaths per 100,000 population, compared to the non-Māori female rate of 5.9 per 100,000 population (Figure 4).

Pacific

- Twenty-two Pacific peoples died by suicide (15 males and 7 females), compared to 18 deaths in 2002.

Asian

- Twenty-eight Asian people died by suicide (16 males and 12 females), compared to 12 deaths in 2002. However, this change is not statistically significant.

Trends by age group

Five-year age groups

- In 2003, among males, those aged 80–84 years had the highest age-specific suicide rate (34.2 deaths per 100,000 population), followed by those aged 75–79 years (31.4 deaths per 100,000 population) and then those aged 30–34 years (31.1 deaths per 100,000 population).
- In 2003, among females, 35–39-year-olds (14.6 per 100,000), 15–19-year-olds (11.1 per 100,000 population) and 20–24-year-olds (10.9 per 100,000 population) had the highest rates (Table 1).

Table 1: Suicide death rates, by five-year age group and sex, 2000 and 2003

	2000				2003			
	Males		Females		Males		Females	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate
5–9	0	–	0	–	0	–	0	–
10–14	3	–	1	–	4	–	1	–
15–19	31	22.0	11	8.3	35	23.1	16	11.1
20–24	50	38.3	4	–	29	20.5	15	10.9
25–29	58	45.0	13	9.5	35	28.4	11	8.6
30–34	47	34.3	8	5.4	44	31.1	11	7.1
35–39	40	26.8	11	7.0	37	25.2	23	14.6
40–44	25	17.6	6	4.1	44	28.7	7	4.3
45–49	23	18.1	7	5.4	34	24.9	13	9.2
50–54	25	21.0	6	5.1	28	22.8	13	10.4
55–59	21	23.0	5	–	21	19.7	4	–
60–64	11	14.8	5	–	18	21.3	6	6.9
65–69	12	18.9	2	–	8	12.1	4	–
70–74	13	22.9	0	–	11	19.2	6	9.5
75–79	5	–	0	–	14	31.4	3	–
80–84	6	27.0	3	–	9	34.2	5	–
85+	5	–	1	–	3	–	3	–
Total	375	19.9	83	4.3	374	19.0	141	6.9

Source: New Zealand Health Information Service

Note: – indicates that the rate was suppressed as there were less than or equal to five deaths in this age group.

Life-cycle age groups

- In 2003, among males, 25–44-year-olds had the highest age-specific suicide rate (28.4 per 100,000 population).
- In 2003, among females, 15–24-year-olds had the highest age-specific suicide rate (11.0 per 100,000 population) (Table 2).

Table 2: Suicide death rates, by life-cycle age group and sex, 2000 and 2003

	2000				2003			
	Males		Females		Males		Females	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate
5–14	3	–	1	–	4	–	1	–
15–24	131	29.9	15	5.8	64	21.9	31	11.0
25–44	170	30.5	38	6.4	160	28.4	52	8.7
45–64	80	19.4	23	5.5	101	22.4	36	7.8
65+	41	20.8	6	2.4	45	21.4	15	7.9
Total	375	19.9	83	4.3	374	19.0	141	6.9

Source: New Zealand Health Information Service

Note: – indicates that the rate was suppressed as there were less than or equal to five deaths in this age group.

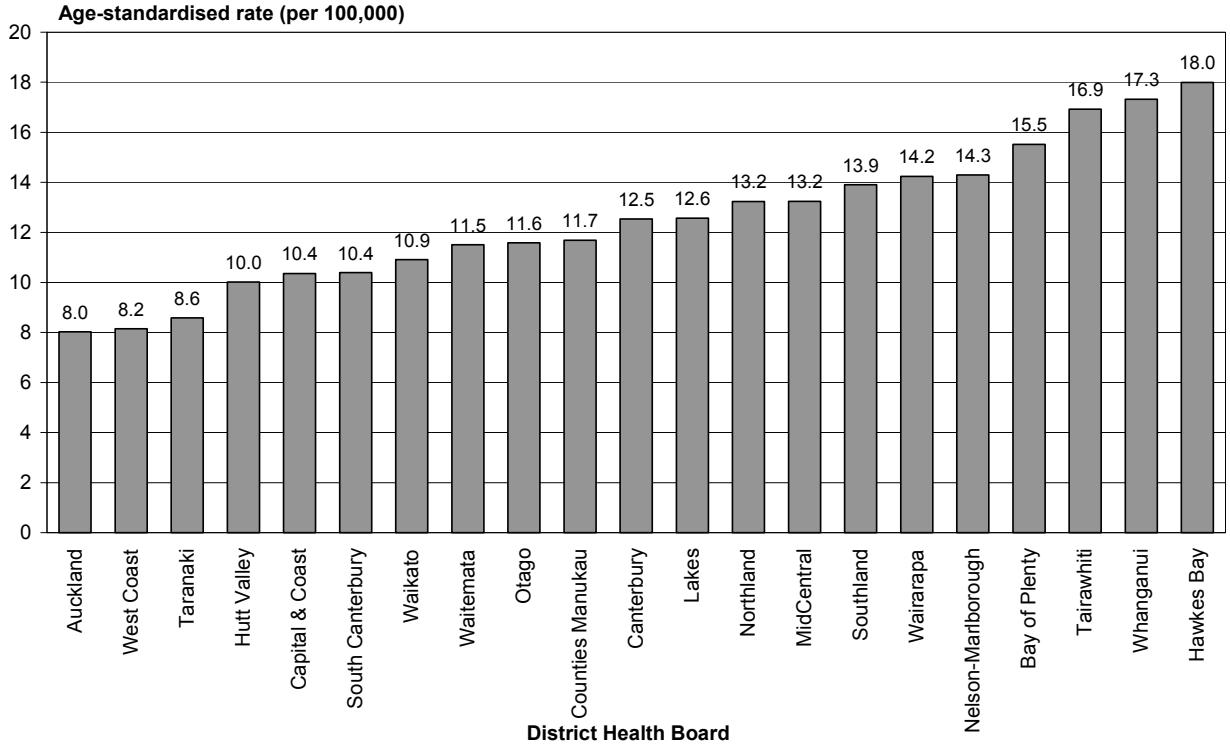
- The age-specific rate of suicide among 15–24-year-olds was 16.5 deaths per 100,000 population (95 deaths). The rate was 21.9 deaths per 100,000 population for males (64 deaths) and 11.0 deaths per 100,000 population for females (31 deaths).
- The age-specific rate of suicide among 25–44-year-olds was 18.2 deaths per 100,000 population (212 deaths). The rate was 28.4 deaths per 100,000 population for males (160 deaths) and 8.7 deaths per 100,000 population for females (52 deaths).
- The age-specific rate of suicide among 45–64-year-olds was 15.1 deaths per 100,000 population (137 deaths). The rate was 22.4 deaths per 100,000 population for males (101 deaths) and 7.8 deaths per 100,000 population for females (36 deaths).
- The age-specific rate of suicide among people aged 65+ years was 13.9 deaths per 100,000 population (66 deaths). The rate was 21.4 deaths per 100,000 population for males (45 deaths) and 7.9 deaths per 100,000 population for females (21 deaths).

Trends by region

District Health Boards (2001–2003)

- Figure 5 displays age-standardised suicide rates in 2001–2003 per 100,000 population by DHB.
- The lowest rate of suicide in 2001–2003 was recorded in Auckland DHB (8.0 suicides per 100,000 population).
- The highest rate of suicide in 2001–2003 was recorded in Hawke's Bay DHB (18.0 suicides per 100,000 population).

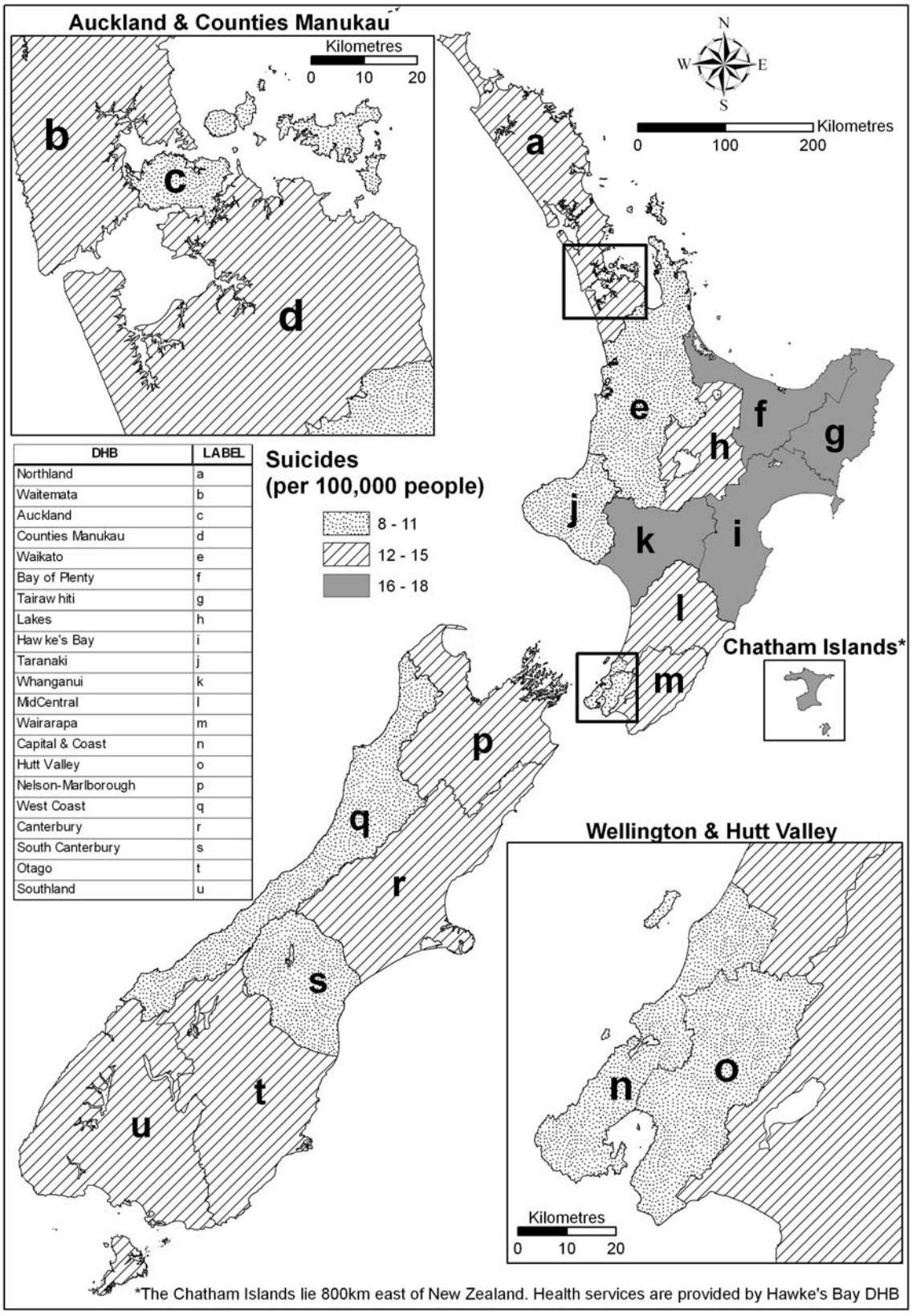
Figure 5: Suicide death rates, by District Health Board, 2001–2003



Source: New Zealand Health Information Service

- Figure 6 shows high rates of suicide in eastern North Island DHBs compared to the rates in other DHBs.

Figure 6: Map of age-standardised suicide rates, by District Health Board, 2001–2003



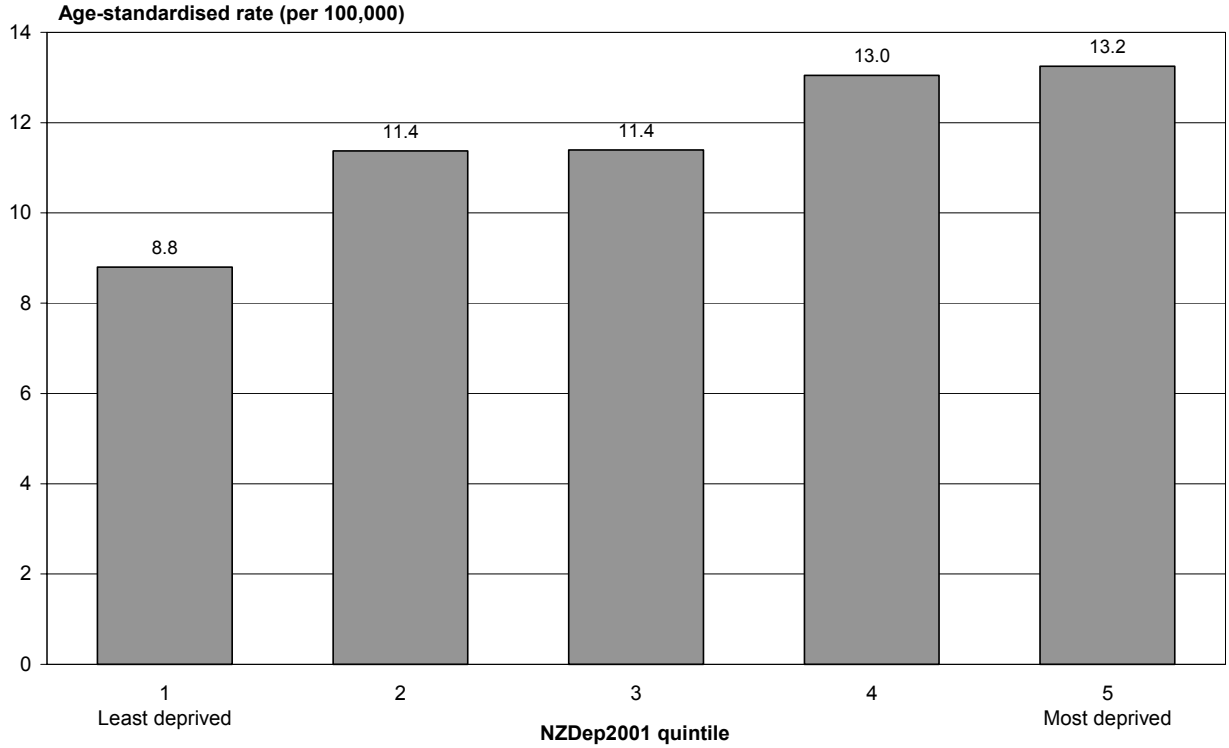
DHB	LABEL
Northland	a
Waitemata	b
Auckland	c
Counties Manukau	d
Waikato	e
Bay of Plenty	f
Tairawhiti	g
Lakes	h
Hawke's Bay	i
Taranaki	j
Whanganui	k
MidCentral	l
Wairarapa	m
Capital & Coast	n
Hutt Valley	o
Nelson-Marlborough	p
West Coast	q
Canterbury	r
South Canterbury	s
Otago	t
Southland	u

Source: New Zealand Health Information Service

Deprivation

- Age-standardised suicide rates for 2001–2003 were calculated by NZDep2001 quintiles and are presented in Figure 7.
- The least deprived areas of New Zealand had a suicide rate of 8.8 per 100,000 population compared to 13.2 per 100,000 population in the most deprived areas of New Zealand.

Figure 7: Suicide death rates, by NZDep2001 quintile, 2001–2003



Source: New Zealand Health Information Service

Hospitalisation for Suicide and Intentional Self-harm in 2002/03

When comparing hospitalisation for intentional self-harm data between years, caution should be exercised due to changes in coding and treatment practices (see Technical Notes, page 2). Some of the regional differences between DHBs are due to different practices in reporting and patient management.

Hospitalisation data are counts of the number of episodes of care rather than the number of individual people. Therefore, readmissions for the same condition are counted as additional discharges, and patients who are transferred to another hospital are counted twice.

General trends

- The hospitalisation rate for intentional self-harm in the 2002/03 financial year was 131.5 per 100,000 population (5292 hospitalisations), compared with 128.2 per 100,000 population in 2001/02.

Trends by sex

- More females are hospitalised for intentional self-harm than males. The female–male rate ratio for intentional self-harm in New Zealand was 2.1 female hospitalisations to every male hospitalisation per 100,000 population. Females more commonly choose methods that are less likely to be fatal.
- The male hospitalisation rate for intentional self-harm was 84.2 per 100,000 population (1682 hospitalisations). The female hospitalisation rate for intentional self-harm was 178.6 per 100,000 population (3610 hospitalisations).

Trends by ethnicity

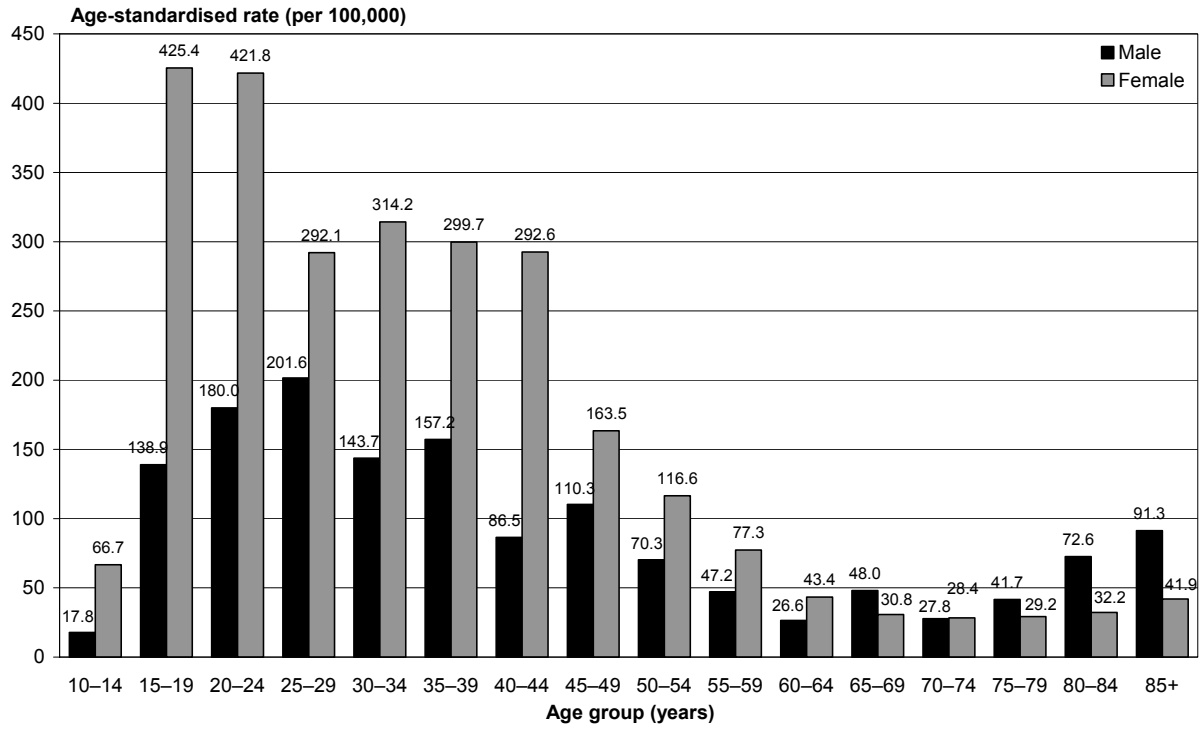
- Among Māori, the age-standardised hospitalisation rate for intentional self-harm was 115.1 per 100,000 population (719 hospitalisations), compared to 134.1 per 100,000 population (4573 hospitalisations) for non-Māori.
- The age-standardised hospitalisation rate for Māori females for intentional self-harm was 143.9 per 100,000 population (467 hospitalisations), compared to 185.0 per 100,000 population (3143 hospitalisations) for non-Māori females.
- The age-standardised hospitalisation rate for Māori males for intentional self-harm was 85.0 per 100,000 population (252 hospitalisations), compared to 83.3 per 100,000 population (1430 hospitalisations) for non-Māori males.

Trends by age group

Five-year age groups

- People in the 20–24 years age group had the highest age-specific hospitalisation rate for intentional self-harm (300.0 per 100,000 population, 797 hospitalisations) (Figure 8).
- For males, the age group with the highest age-specific hospitalisation rate for intentional self-harm was the 25–29 years age group (201.6 per 100,000 population, 248 hospitalisations).
- For females, the age groups with the highest age-specific hospitalisation rate for intentional self-harm were the 15–19 years age group (425.4 per 100,000 population, 596 hospitalisations) and the 20–24 years age group (421.8 per 100,000 population, 556 hospitalisations).
- Māori in the 20–24 years age group had the highest age-specific hospitalisation rate for intentional self-harm (277.5 per 100,000 population, 134 hospitalisations).
- For Māori males, the age group with the highest age-specific hospitalisation rate for intentional self-harm was the 20–24 years age group (210.0 per 100,000 population, 50 hospitalisations) (excluding age groups with less than five hospitalisations).
- For Māori females, the age group with the highest age-specific hospitalisation rate for intentional self-harm was the 20–24 years age group (343.4 per 100,000 population, 84 hospitalisations).

Figure 8: Suicide and intentional self-harm hospitalisation rates, by age, 2002/03



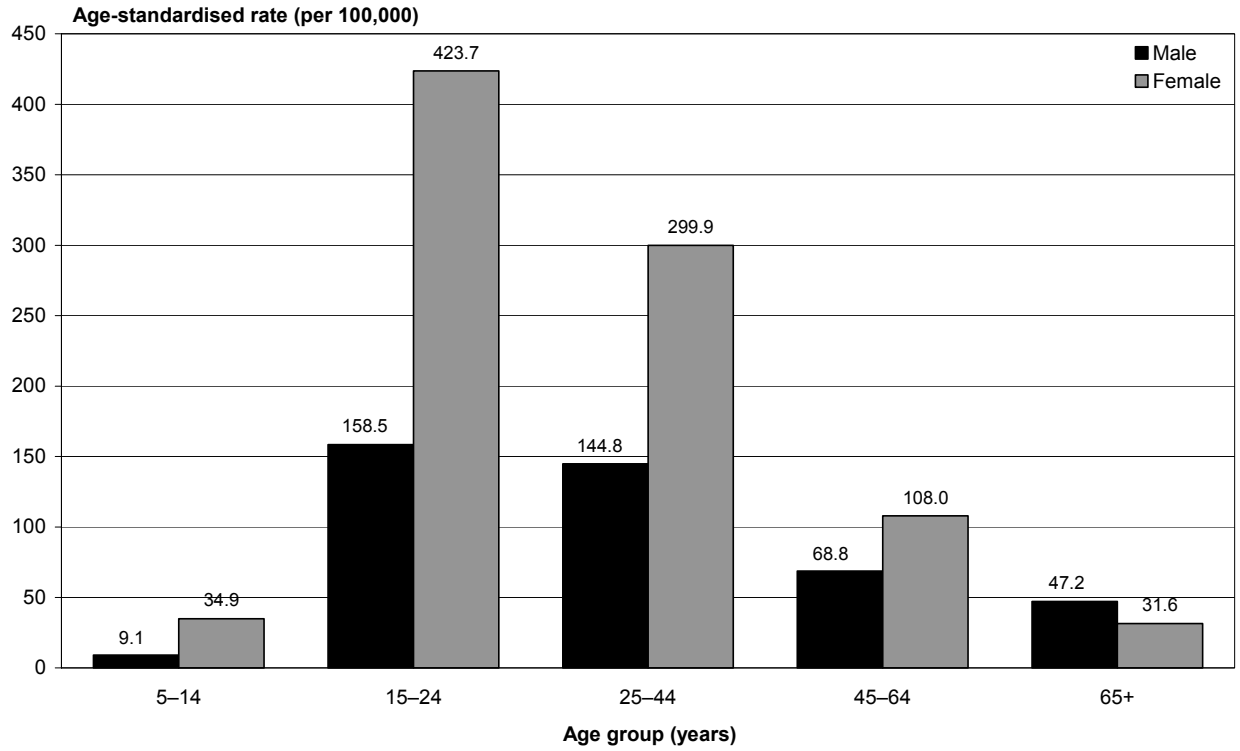
Source: New Zealand Health Information Service

Note: The rate for the 5–9 years age group was suppressed as there were less than five hospitalisations in this age group.

Life-cycle age groups

- The intentional self-harm age-specific hospitalisation rate among 5–14-year-olds was 21.6 per 100,000 population. The rate was 34.9 per 100,000 population for females and 9.1 per 100,000 population for males.
- The highest age-specific hospitalisation rate for intentional self-harm was among 15–24-year-olds (289.0 per 100,000 population). For females the rate was 423.7 per 100,000 population, and for males the rate was 158.5 per 100,000 population.
- The intentional self-harm age-specific hospitalisation rate among 25–44-year-olds was 224.8 per 100,000 population. The rate was 299.9 per 100,000 population for females and 144.8 per 100,000 population for males.
- The age-specific hospitalisation rate for intentional self-harm among 45–64-year-olds was 88.6 per 100,000 population. For females the rate was 108.0 per 100,000 population, and for males the rate was 68.8 per 100,000 population.
- The intentional self-harm age-specific hospitalisation rate among people aged 65+ years was 38.5 per 100,000 population. The rate was 31.6 per 100,000 population for females and 47.2 per 100,000 population for males (Figure 9).

Figure 9: Suicide and intentional self-harm hospitalisation rates, by life-cycle age group, 2002/03



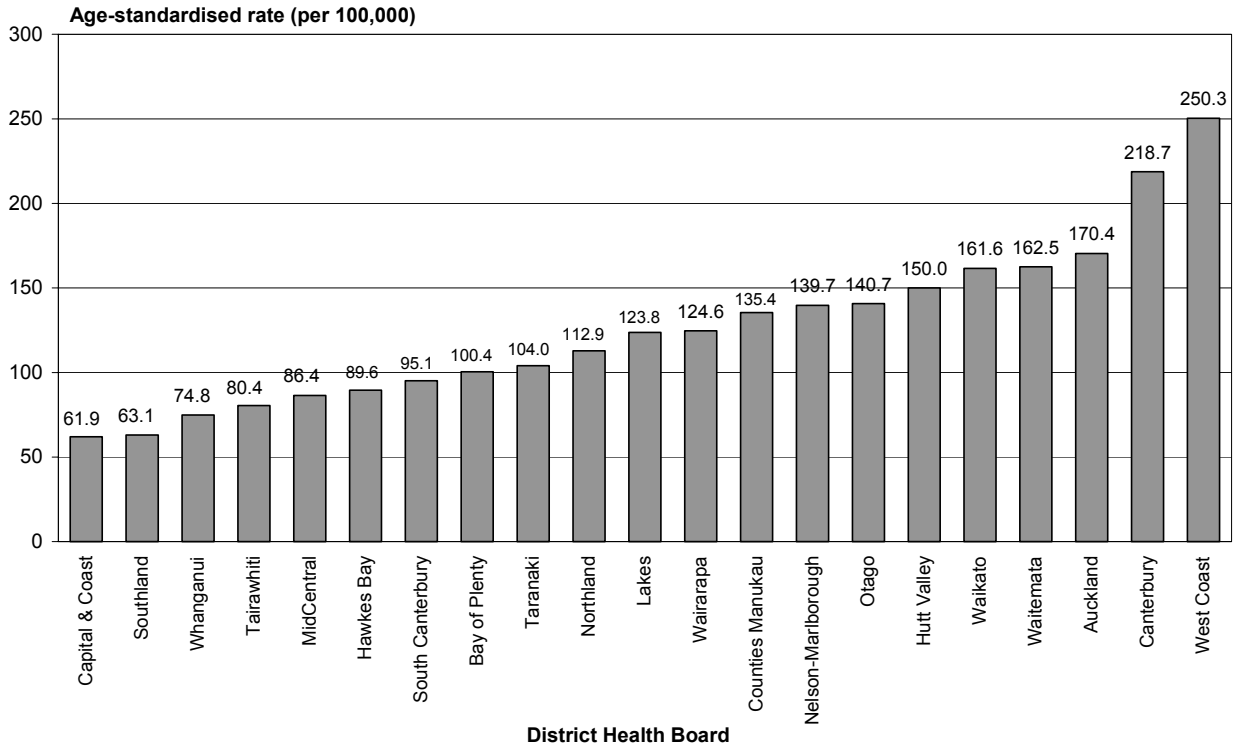
Source: New Zealand Health Information Service

Trends by region

District Health Boards (2002/03)

- Figure 10 displays the age-standardised suicide and intentional self-harm hospitalisation rate (per 100,000 population) for each DHB for the 2002/03 financial year.
- The lowest rate of hospitalisation for suicide and intentional self-harm was recorded in Capital & Coast DHB (61.9 hospitalisations per 100,000 population).
- The highest rate of hospitalisation for suicide and intentional self-harm was recorded in the West Coast DHB (250.3 hospitalisations per 100,000 population).
- Some of the regional differences between DHBs are due to different practices in reporting and patient management.

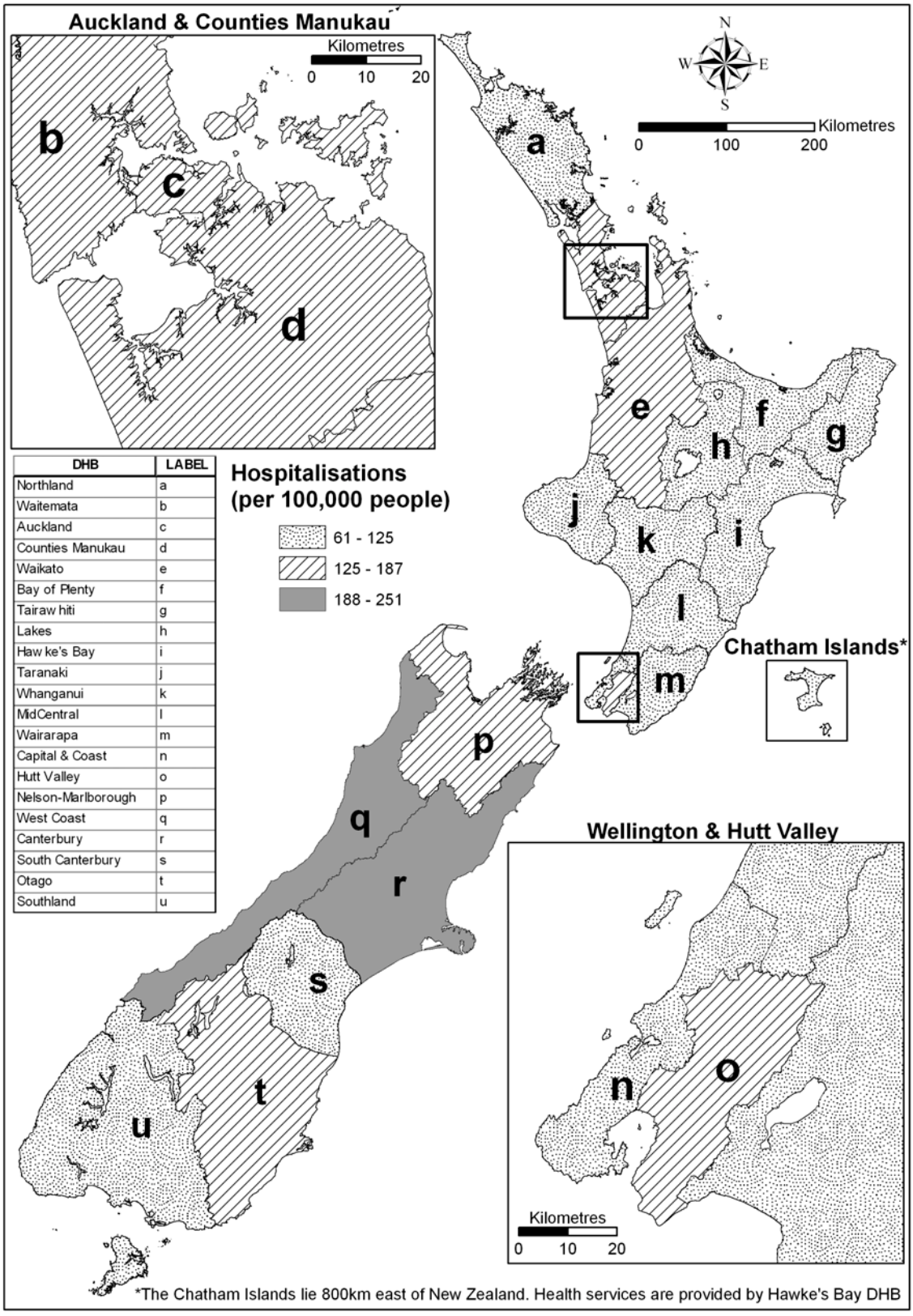
Figure 10: Suicide and intentional self-harm hospitalisation rates, by District Health Board, 2002/03



Source: New Zealand Health Information Service

- A map of the data (Figure 11) shows that West Coast and Canterbury DHBs have the highest age-standardised hospitalisation rates for suicide and intentional self-harm.

Figure 11: Map of suicide and intentional self-harm hospitalisation rates, by District Health Board, 2002/03



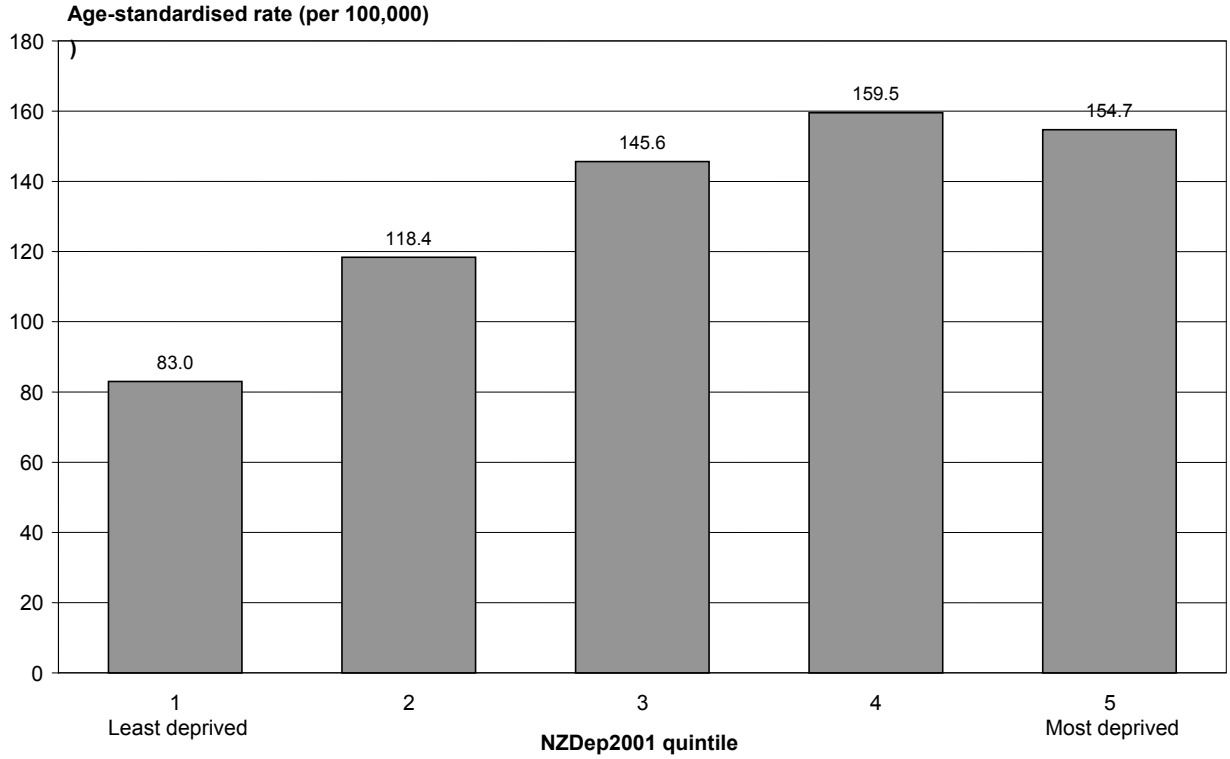
DHB	LABEL
Northland	a
Waitemata	b
Auckland	c
Counties Manukau	d
Waikato	e
Bay of Plenty	f
Tairawhiti	g
Lakes	h
Hawke's Bay	i
Taranaki	j
Whanganui	k
MidCentral	l
Wairarapa	m
Capital & Coast	n
Hutt Valley	o
Nelson-Marlborough	p
West Coast	q
Canterbury	r
South Canterbury	s
Otago	t
Southland	u

Source: New Zealand Health Information Service

Deprivation

- Hospitalisation rates generally increased with increasing deprivation, from quintile 1 to quintile 5 (Figure 12).
- The least deprived areas of New Zealand had a suicide and intentional self-harm age-standardised hospitalisation rate of 83.0 per 100,000 population.
- The most deprived areas of New Zealand had a suicide and intentional self-harm age-standardised hospitalisation rate of 154.7 per 100,000 population, almost double that in quintile 1.

Figure 12: Suicide and intentional self-harm hospitalisation rate, by NZDep2001 quintile, 2002/03

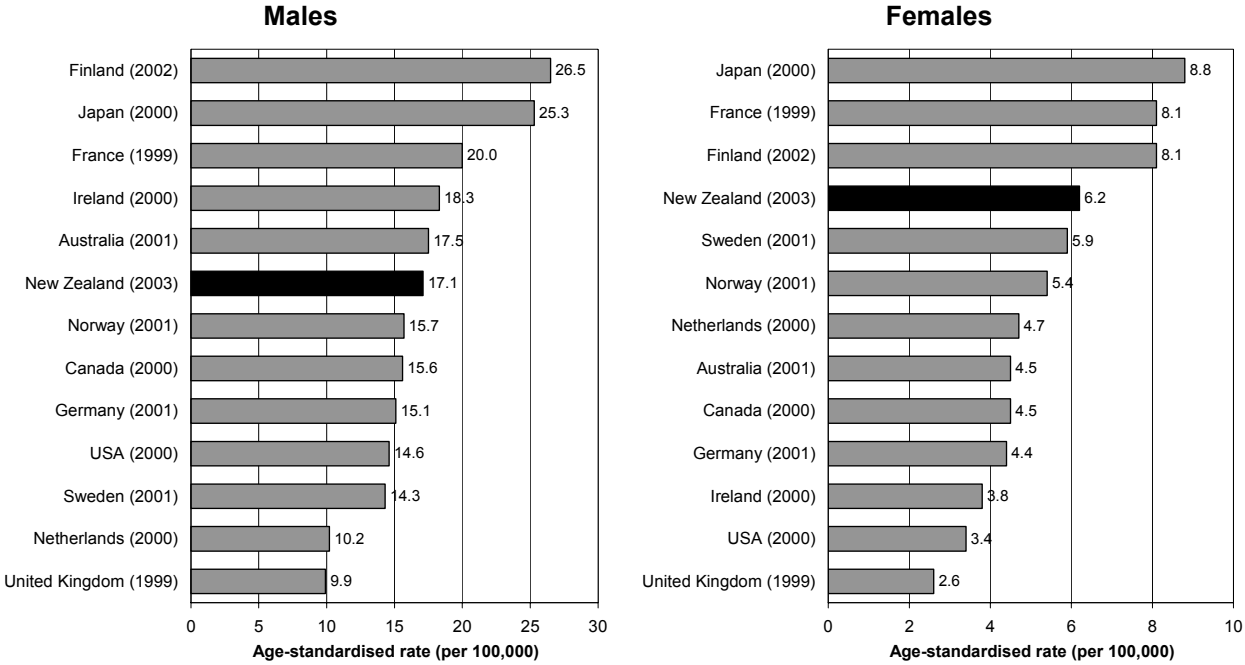


Source: New Zealand Health Information Service

International Comparisons

- Comparing international rates of suicide is inherently problematic because countries have different evidentiary standards in determining death by suicide.[4]
- In 2003, New Zealand's all-ages suicide rate for males was sixth highest among selected OECD countries.
- In 2003, New Zealand's all-ages suicide rate for females was fourth highest among selected OECD countries (Figure 13).

Figure 13: Total male and female suicide rates for selected OECD countries



Source: World Health Organization (WHO)

Note: Rates have been age-standardised to the WHO world population.

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

Background Information on Suicide

Risk factors for suicide

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

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

International and New Zealand research has found that 63 to 98 percent of people who die by suicide or make serious suicide attempts have one or more mental disorders at the time of their attempt. Typically these disorders are accompanied by other sources of life stress and difficulty.[5]

Risk factors for different age groups

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

The typical profile of youth (< 25 years) suicide describes a young male, characterised by family and social disadvantage, a history of attempted suicide, current mood disorder, and stressful interpersonal and legal life events.

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

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

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[5] Beautrais AL, Collings SCD, Ehrhardt P, et al. 2005. *Suicide Prevention: A review of evidence of risk and protective factors, and points of effective intervention.* Wellington: Ministry of Health.

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

Protective factors for suicide

Less is known about factors that protect against suicidal behaviour. Factors that have been suggested as playing a potentially protective role include good coping skills and problem-solving behaviours, positive beliefs and values, feelings of self-esteem and belonging, connections to family or school, secure cultural identity, supportive family/whānau, hapū and iwi, responsibility for children, social support, and holding attitudes against suicide. For older adults, having a hobby and participating in social organisations may protect against suicidal behaviour.

Suicide prevention

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

Key components of suicide prevention

In the absence of conclusive scientific evidence on all aspects of suicide prevention, there is strong agreement internationally on the key components for suicide prevention. These include:

- developing effective, accessible and responsive services for people with mental disorders or suicidal behaviours (including prevention, early recognition and treatment of mental disorders)
- undertaking training and skill development on suicide risk assessment and management
- reducing access to the means of suicide
- promoting mental health and wellbeing through strengthening social cohesion, building resilient communities and providing supportive environments
- taking a managed approach to the media and publicity about suicide
- providing management and support for families and friends following suicide or suicide attempts.

Examples of suicide prevention approaches

Suicide prevention approaches include:

- better treatment, management and delivery of services that have contact with people at risk of suicide (eg, primary health care; emergency services; mental health services; Corrections; Child, Youth and Family; school guidance counsellors)
- the prevention, recognition and treatment of the mental health problems associated with suicide (for example depression)
- the promotion of positive mental health in families, schools, workplaces and the community
- the promotion of awareness of mental health issues at the community level
- the support of initiatives to reduce the stigma of mental illness (eg, Like Minds, Like Mine campaign)
- the improvement of public understanding of what to do if someone is suicidal
- the improvement of support and treatment of those who have already attempted suicide, and their friends, families and whānau
- the implementation of measures to restrict access to the means of suicide
- the provision of guidance to the media about the reporting and publicity of suicide to minimise the potential for imitative suicides
- the expansion of research and information systems so that suicide prevention strategies can be targeted for the best outcomes
- the strengthening of communities, families and whānau to provide emotionally safe and nurturing environments for all people, particularly children and young people
- the expansion of family support and early intervention services to help keep children and young people safe and healthy.

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

National strategy to prevent suicide

In March 1998, the Government released the New Zealand Youth Suicide Prevention Strategy. This strategy provides a framework for understanding what suicide prevention is and signals the steps that a range of government agencies, communities, service providers, Māori whānau, hapū and iwi must take to reduce the incidence of suicide.

Through the strategy, all suicide prevention initiatives should become increasingly co-ordinated and any service gaps identified and addressed.

A ministerial and interagency committee support the implementation of the strategy.

The Ministry of Health is leading work on developing a new national strategy that will address the prevention of suicide and suicide attempts in all age groups. It is anticipated that the New Zealand Suicide Prevention Strategy will be finalised by the middle of 2006.

This new strategy will build on the lessons learned and gains made from the New Zealand Youth Suicide Prevention Strategy. In the meantime, many of the initiatives from the New Zealand Youth Suicide Prevention Strategy are taking an all-ages focus. The new strategy will supercede the New Zealand Youth Suicide Prevention Strategy.

In recognition of the move to an all-ages strategy, responsibility for leading and co-ordinating suicide prevention was transferred from the Ministry of Youth Development to the Ministry of Health in July 2005.

If you are concerned about someone

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

- A primary health care professional or GP
- A community mental health service
- A Māori community health service
- A counselling services such as the school guidance counsellor, iwi and other Māori health/counselling services, lesbian and gay support counselling services, sexual abuse counselling services, alcohol and drug services, or other specialist counselling services such as bereavement services, family counsellors, whānau support services or refugee support services
- Helplines such as Lifeline, Samaritans or Youthline (refer to the front pages of your telephone book).

In an emergency

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

- contact the nearest hospital or psychiatric emergency service/mental health crisis assessment team
- ring 111 and ask for ambulance or police
- remain with the person until support arrives
- remove any obvious means of suicide (guns, medication, car keys, knives, rope, etc).

Further Information

General information about suicide prevention

For general information about suicide and suicide prevention, contact:

SPINZ (Suicide Prevention Information New Zealand)
PO Box 10-318
Dominion Road
Auckland
Ph: (09) 300 7035
Fax: (09) 300 7020
Email: info@spinz.org.nz
Website: www.spinz.org.nz

To find out more about the New Zealand Youth Suicide Prevention Strategy or the development of the all-ages New Zealand Suicide Prevention Strategy, see the Ministry of Health's suicide prevention webpage (www.moh.govt.nz/suicideprevention).

General information about mental health

For a wide range of information about mental health, contact:

The Mental Health Foundation of New Zealand
Resource and Information Centre
PO Box 10-051
Dominion Road
Auckland
Ph: (09) 300 7010
Fax: (09) 300 7020
Resource Centre: (09) 300 7030
Website: www.mentalhealth.org.nz

Statistics

For health data, including suicide statistics, contact:

Public Health Intelligence
Ministry of Health
PO Box 5013
Wellington
Ph: (04) 496 2000
Fax: (04) 495 4401
Email: phi@moh.govt.nz
Website: www.moh.govt.nz/phi

Or contact:

New Zealand Health Information Service
Ministry of Health
PO Box 5013
Wellington
Ph: (04) 922 1800
Fax: (04) 922 1899
Email: inquiries@nzhis.govt.nz
Website: www.nzhis.govt.nz

More copies of this publication

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

Wickliffe Limited
PO Box 932
Dunedin
Ph: (04) 496 2277
Email: moh@wickliffe.co.nz