

New Zealand  
**Suicide Prevention**

Strategy

2006–2016



## Cover description

The pāua shell represents the protective structure that nurtures and supports the individual, the family/whānau and the community.

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## Foreword

The anguish and despair following the suicide of someone we love can be overwhelming. Two questions that we ask over and over are *WHY* and *WHAT* could we have done to stop them. At a national level, knowing that we continue to have high rates of suicide for some age groups compared with other countries raises the same questions; *WHY* and, as a nation, *WHAT* can we do about it.

Providing a plan to address these questions is the role of a national strategy. It is now eight years since the release of the *New Zealand Youth Suicide Prevention Strategy*. This strategy was an important milestone because it demonstrated the first comprehensive plan to address the problem of suicide amongst young people in this country.

Eight years on, there is much to be positive about; the rate of male suicide is now at its lowest since 1998; we have more responsive services, new best-practice guidelines and information resources, a greater community understanding about suicidal behaviour, and the body of research from both New Zealand and internationally has grown significantly.

Our research and evaluations have reinforced that we were on the right track with the general approach in the *New Zealand Youth Suicide Prevention Strategy*, but it is now time to expand our prevention efforts to address suicide and suicidal behaviour across all age groups.

While we should take some satisfaction from our accomplishments there is still much more to do. Suicide prevention is complex and there is no quick fix. It requires sustained action at a multitude of levels, co-ordinated across a range of sectors. By building on what we know works and refocusing our efforts on areas that need more attention, it is hoped that the release of this new strategy will mobilise renewed efforts to work together to prevent suicide and suicidal behaviour.

Given the many aspects of suicide prevention, the *New Zealand Suicide Prevention Strategy 2006–2016* sets out the framework to organise and co-ordinate a range of prevention efforts for the next 10 years. To ensure this strategy is translated into measurable and tangible activities, action plans will be developed every five years to guide implementation.

It is my hope that this new strategy will make a real difference to the lives of all New Zealanders.



Hon Jim Anderton

Associate Minister of Health

# Acknowledgements

We would like to thank the many people who have contributed to the development of this strategy: those providing support to people at risk of suicide, researchers, community organisations, funders and providers of health and social services, people who have experienced suicidal thoughts or engaged in suicidal behaviour, and those who have lost a loved one to suicide.

The input of the many individuals and organisations with personal and professional experience of suicidal behaviour has been vital in the shaping of this strategy. We have aimed at all times to make it an inclusive and collaborative process.

Addressing the myriad of perspectives to this complex issue has been a challenge and we are grateful for the support, encouragement and assistance we have received along the way.

We hope that the resulting strategy assists people to feel ownership of the approach taken, helps them to see how their role fits with the other approaches, and assists in mobilising a co-ordinated approach to suicide prevention.

We would like to acknowledge the contributions people made to the various steps in the development of this strategy, including:

- evaluation(s) of the *New Zealand Youth Suicide Prevention Strategy*
- review of international suicide prevention strategies
- review of evidence of risk and protective factors and points of effective intervention (Beautrais et al 2005)
- review of social explanations for suicide in New Zealand (Collings and Beautrais 2005)
- analysis of the cost of suicide to New Zealand society (O’Dea and Tucker 2005)
- consultation on the draft strategy, the *New Zealand Suicide Prevention Strategy: A Life Worth Living* (20 meetings, including hui and fono in three centres)
- report on the consultation hui
- review and summary of 106 written submissions (Ministry of Health 2005)
- peer review of draft strategy by international and national experts with knowledge in suicide prevention
- advice and input from the Inter-Agency Committee on Suicide Prevention
- advice and input from the Suicide Prevention External Advisory Group
- advice and input from the Ministerial Committee on Suicide Prevention.

# Contents

Foreword.....	iii
Acknowledgements.....	iv
<b>The New Zealand Suicide Prevention Strategy in Summary.....</b>	<b>1</b>
Vision.....	1
Purposes.....	1
Principles.....	1
Goals.....	1
<b>Part 1: Introduction.....</b>	<b>3</b>
The approach of this strategy.....	3
Making it happen.....	3
Definitions and scope.....	3
Extent of the problem.....	3
Trends over time.....	4
Māori suicide trends.....	5
Pacific suicide trends.....	5
Asian suicide trends.....	5
A plan for prevention.....	6
Addressing inequalities in the broader determinants of health.....	6
A multisectoral approach.....	6
Leadership and implementation of this strategy.....	7
National.....	7
Local.....	8
Monitoring and evaluating progress.....	8
Monitoring.....	8
Review and evaluation.....	8
Context.....	9
Building on past initiatives.....	9
International developments.....	9
Suicide prevention and Māori.....	9
Health inequalities for Māori.....	10
Responsiveness to Māori.....	10
Links with other activities.....	11
Links with other government strategies.....	12

<b>Part 2: Framework of this Strategy</b> .....	<b>13</b>
Vision .....	13
Purposes .....	13
Principles .....	13
Be evidence based .....	13
Be safe and effective .....	13
Be responsive to Māori .....	14
Recognise and respect diversity .....	14
Reflect a co-ordinated multisectoral approach .....	14
Demonstrate sustainability and a long-term commitment .....	14
Acknowledge that everyone has a role in suicide prevention .....	14
Have a commitment to reduce inequalities .....	14
<b>Part 3: Summary of the Evidence</b> .....	<b>15</b>
Pathways to suicidal behaviour .....	15
The impact of suicidal behaviour .....	17
Mātauranga whakairo (honoured knowledge) .....	18
<b>Part 4: Issues for Population Groups</b> .....	<b>19</b>
Issues relating to age .....	19
Issues relating to gender .....	19
Issues for Māori .....	20
Issues for Pacific peoples .....	21
Issues for Asian populations .....	22
Issues relating to sexual orientation .....	22
Issues for refugees and migrants .....	22
<b>Part 5: The Seven Goals</b> .....	<b>23</b>
Implementing the seven goals .....	28
<b>References</b> .....	<b>29</b>
<b>List of Figures</b>	
Figure 1: The framework of the <i>New Zealand Suicide Prevention Strategy</i> .....	2
Figure 2: Age-specific suicide rates, 1948–2003 .....	4
Figure 3: Suicide rates by ethnicity, 2000–2003 .....	5
Figure 4: Māori and non-Māori suicide rates, 1996–2003 .....	6
Figure 5: Multisectoral approach to suicide prevention .....	7
Figure 6: How this strategy fits with other government strategies .....	12
Figure 7: Pathways to suicidal behaviour .....	16
Figure 8: Potential adverse consequences of suicidal behaviour .....	17
Figure 9: New Zealand suicide rates by age group and gender, 2003 .....	20



# The New Zealand Suicide Prevention Strategy in Summary

The *New Zealand Suicide Prevention Strategy 2006–2016* provides a framework to help us understand how all the various activities across the range of sectors fit together to prevent suicide, and will guide our efforts nationally over the next 10 years. This framework is outlined below and shown in Figure 1. The strategy builds on and replaces *The New Zealand Youth Suicide Prevention Strategy: 'In Our Hands'* and *'Kia Piki te Ora o te Taitamariki'*, and draws from an expanded knowledge base of suicide and suicide prevention.

## ■ Vision

The inspiration for this strategy is a vision of a society where all people feel they:

- are valued and nurtured
- value their own life
- are supported and strengthened if they experience difficulties
- do not want to take their lives or harm themselves.

## ■ Purposes

The overall purposes of this strategy are to:

- reduce the rate of suicide and suicidal behaviour
- reduce the harmful effect and impact associated with suicide and suicidal behaviour on families/whānau, friends and the wider community
- reduce inequalities in suicide and suicidal behaviour.

## ■ Principles

All activities undertaken as part of this strategy should be guided by the following principles:

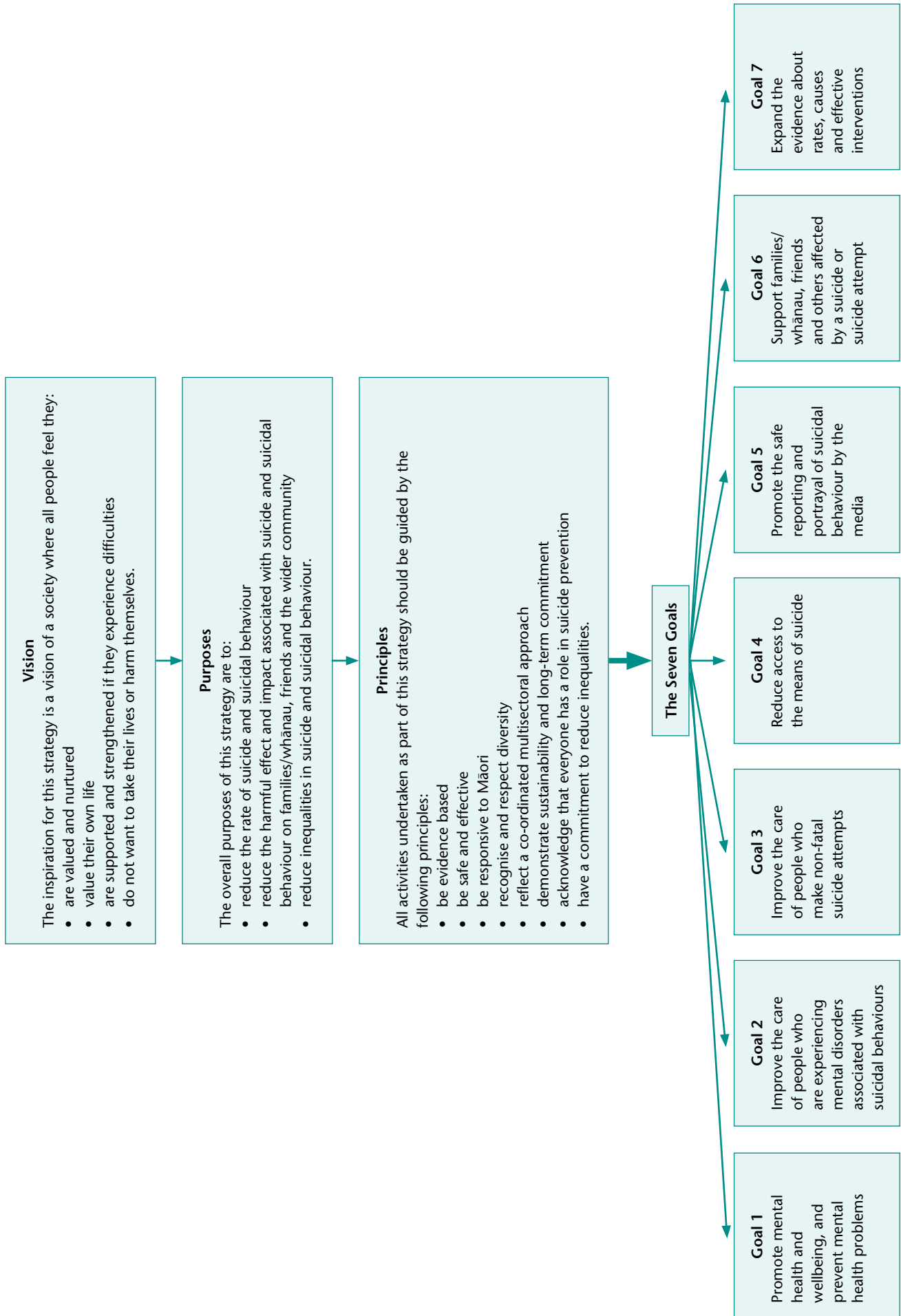
- be evidence based
- be safe and effective
- be responsive to Māori
- recognise and respect diversity
- reflect a co-ordinated multisectoral approach
- demonstrate sustainability and long-term commitment
- acknowledge that everyone has a role in suicide prevention
- have a commitment to reduce inequalities.

## ■ Goals

The seven goals of the *New Zealand Suicide Prevention Strategy* are to:

1. promote mental health and wellbeing, and prevent mental health problems
2. improve the care of people who are experiencing mental disorders associated with suicidal behaviours
3. improve the care of people who make non-fatal suicide attempts
4. reduce access to the means of suicide
5. promote the safe reporting and portrayal of suicidal behaviour by the media
6. support families/whānau, friends and others affected by a suicide or suicide attempt
7. expand the evidence about rates, causes and effective interventions.

**Figure 1: The framework of the New Zealand Suicide Prevention Strategy**





# Part 1: Introduction

## ■ The approach of this strategy

Suicide is a serious health and social issue, and represents a significant loss to our society. It is an indicator of both the mental health and social wellbeing of the population.

The Government's strategic approach to suicide prevention is intended to provide confidence to all New Zealanders that, together, we can make a real difference.

This strategy is for all New Zealanders, and has been developed to:

- provide a uniform set of directions to guide suicide prevention activities across New Zealand, no matter which agency provides them or how they are funded
- support the Government's ongoing investment in suicide prevention
- help identify where new investment is needed
- assist government and non-government service providers, individuals, researchers and communities to work more closely together and gain a common understanding of where they fit within the overall spectrum of suicide prevention.

## ■ Making it happen

This strategy sets out the broad areas for action. Five-year action plans will be developed separately to provide more detail as to how this strategy will be implemented, by when and by whom. These action plans will set out the priorities, the sector or agency that will implement each activity and the processes for managing, monitoring and reviewing implementation.

## ■ Definitions and scope

Internationally, there has been considerable debate and controversy about the terminology used to describe suicidal behaviours. This strategy uses the following definitions.

1. Suicide, which refers to the act of intentionally killing oneself. Classification of a death as suicide in New Zealand is based upon coronial verdict.
2. Attempted suicide, which covers a range of actions where people make attempts at suicide that are non-fatal.
3. Deliberate self-harm, which refers to behaviours that may or may not result in serious injury, but are not intentionally fatal.
4. Suicidal ideation, which refers to thoughts of suicide.

This strategy does not address the issue of physician-assisted suicide or euthanasia, which raises separate ethical, legal and practical issues.

## ■ Extent of the problem

Every year approximately 500 New Zealanders die by suicide; more than the number who die in road traffic crashes. Five times as many people will be hospitalised after making an attempt on their life (Ministry of Health in press).

Internationally, New Zealand's rates of suicide are high. This is particularly evident for young people aged 15–24 years, with suicide being the second most common cause of death for this age group. Furthermore, hospitalisation for suicide attempts is most prevalent in this age group. While suicide disproportionately affects young adults, approximately 80 percent of suicides now occur in the 25 years and over age group (Beautrais et al 2005). Those who live in the most deprived areas of New Zealand have higher rates of suicide and hospitalisation for suicide attempts than those living in the least deprived areas. There are also gender disparities, with more males dying by suicide than females, yet more females are hospitalised for suicide attempts than males (Ministry of Health in press).

All suicidal behaviours, regardless of medical severity, are indications of severe emotional distress, unhappiness and/or mental illness (Beautrais et al 2005). Furthermore, every suicidal behaviour can have an enormous impact on others. In a small country like New Zealand, the suicide of just one person can have a long lasting and profound effect on their family/whānau, friends and the wider community. For Māori, the grief and impact is often felt beyond the whānau to the hapū and iwi, viewed not only as a tragedy, but also as a loss to the continuation of whakapapa which is the founding stone of hapū and iwi.

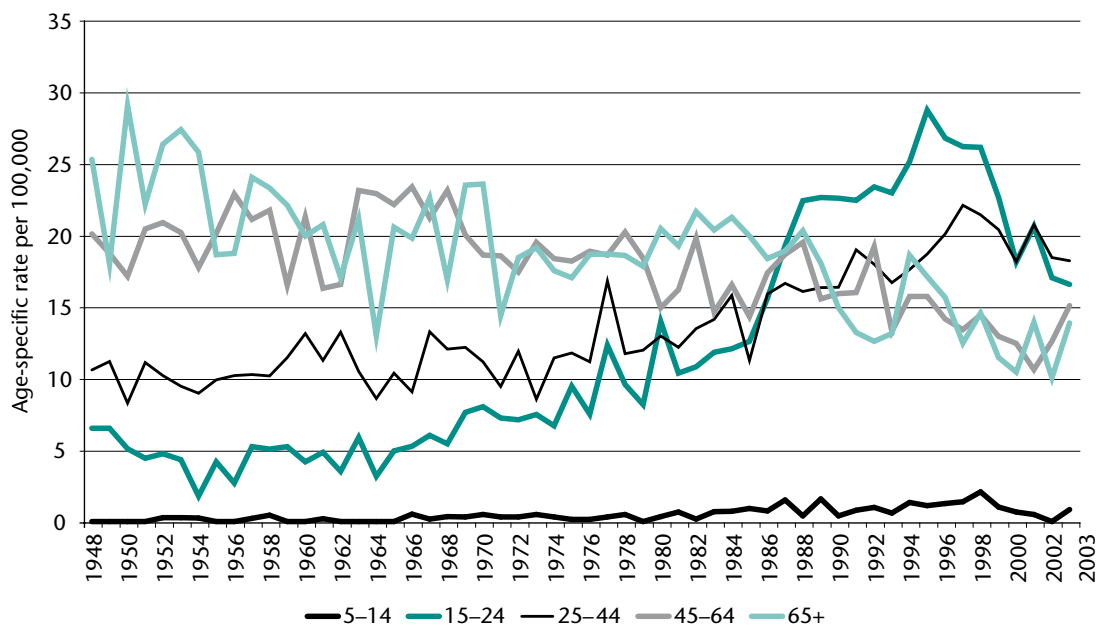
The costs of suicide to society are high. There are not only the 'intangible costs'; the grief and bereavement of family, whānau and friends, and the lost potential of lives cut short, but also the direct economic costs of suicide. The annual economic cost of suicidal behaviour to New Zealand society is estimated to total \$1,381,492,000 – nearly \$1.4 billion (O’Dea and Tucker 2005).

## ■ Trends over time

In New Zealand, suicide rates were relatively stable from 1948 to the mid-1980s and then increased from the mid-1980s to the late 1990s (see Figure 2). Most recently, they have begun to decline from a 50-year peak of 14.3 deaths per 100,000 in 1998 to 11.5 per 100,000 in 2003. This reduction is paralleled by similar decreases in other countries (eg, Australia).

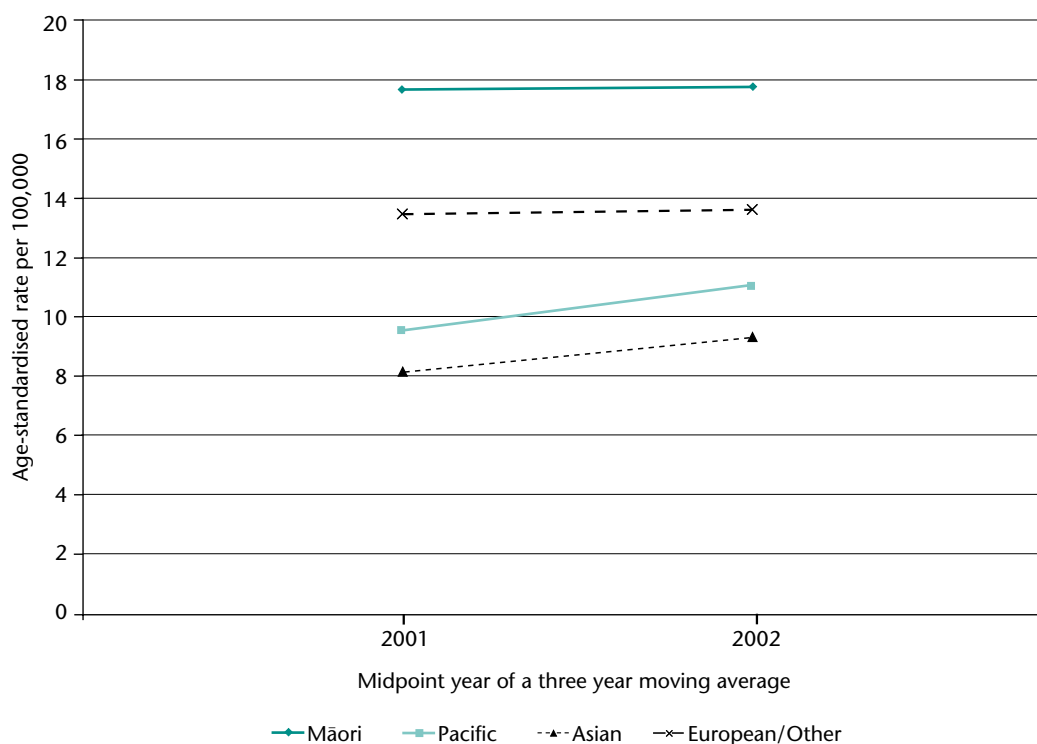
From the mid-1980s the rate of youth suicide (15–24 year age group) grew dramatically, reaching a peak in 1996. The youth rate since then has declined by 25 percent. The 25–44 year age group now has the highest suicide rate. The rate of suicide in the over-65 year age group has been declining since the 1950s. The rate amongst those under 15 years of age is very low, however, the fact that there are any suicides in this age group is of concern. Furthermore, suicide rates increased more notably among Māori than non-Māori throughout the 1980s and 1990s (Ajwani et al 2003).

**Figure 2: Age-specific suicide rates, 1948–2003**



Note: 2003 data are provisional; rates are age-standardised.  
Source: New Zealand Health Information Service.

**Figure 3: Suicide rates by ethnicity, 2000–2003**



Note: 2003 data are provisional; rates are age-standardised.  
 Source: New Zealand Health Information Service.

**Māori suicide trends**

Figure 3 shows that between 2000 and 2003, the three-year moving averages of the age-standardised suicide rates were consistently higher in Māori (followed by European/Other) than in other ethnic groups.

Māori suicide is characterised by a significant pattern of suicide occurring in the under-35 year age group, with it being much less prevalent in those aged over 45 years. Similar to the general population, Māori rates of hospitalisation for suicide attempts are highest in the 15–24 year age group (Ministry of Health in press).

Māori males have a higher rate of suicide and hospitalisation for suicide attempts compared with non-Māori males (see Figure 4). In contrast, there is little difference between Māori female and non-Māori female suicide rates. However, Māori females have a significantly higher rate of hospitalisation for suicide attempts than non-Māori females. In fact, Māori females have a much higher rate of hospitalisation than any other group (Ministry of Health in press).

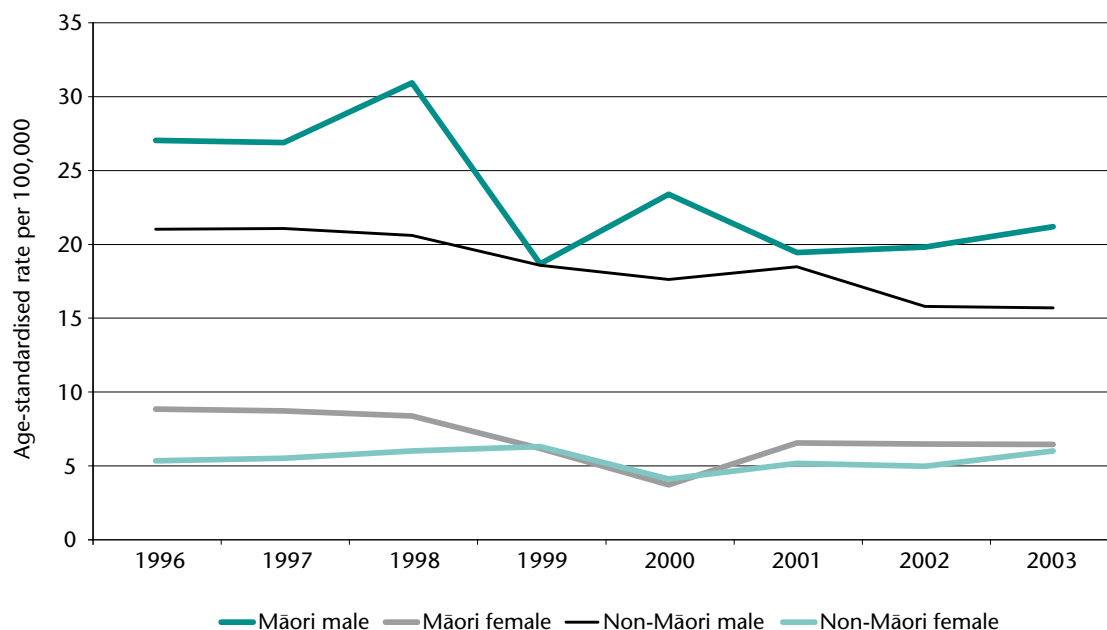
**Pacific suicide trends**

Pacific peoples are ranked third compared to other ethnic groups for rates of suicide (see Figure 3) and also rates of hospitalisation for suicide attempt. Trends according to specific populations groups (eg, age groups) can not be accurately reported due to small numbers.

**Asian suicide trends**

Asian populations have the lowest rates of suicide (see Figure 3) and hospitalisation for suicide attempt compared to Māori, European/Other and Pacific ethnic groups.

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



Note: 2003 data are provisional.

Source: New Zealand Health Information Service.

## ■ A plan for prevention

Suicidal behaviour is complex and the contributing factors are many and varied. There is consensus that effective prevention of suicide requires a multisectoral approach that integrates both individual and population level programmes to reduce the factors that are associated with suicidal behaviour (Beautrais et al 2005). Consequently, there is a range of potential interventions that can be pursued to impact on suicide. The role of a national strategy is to provide a map for how all these activities can fit together, provide opportunities for co-ordination and collaboration, and mobilise efforts in ways that can make the most difference.

## ■ Addressing inequalities in the broader determinants of health

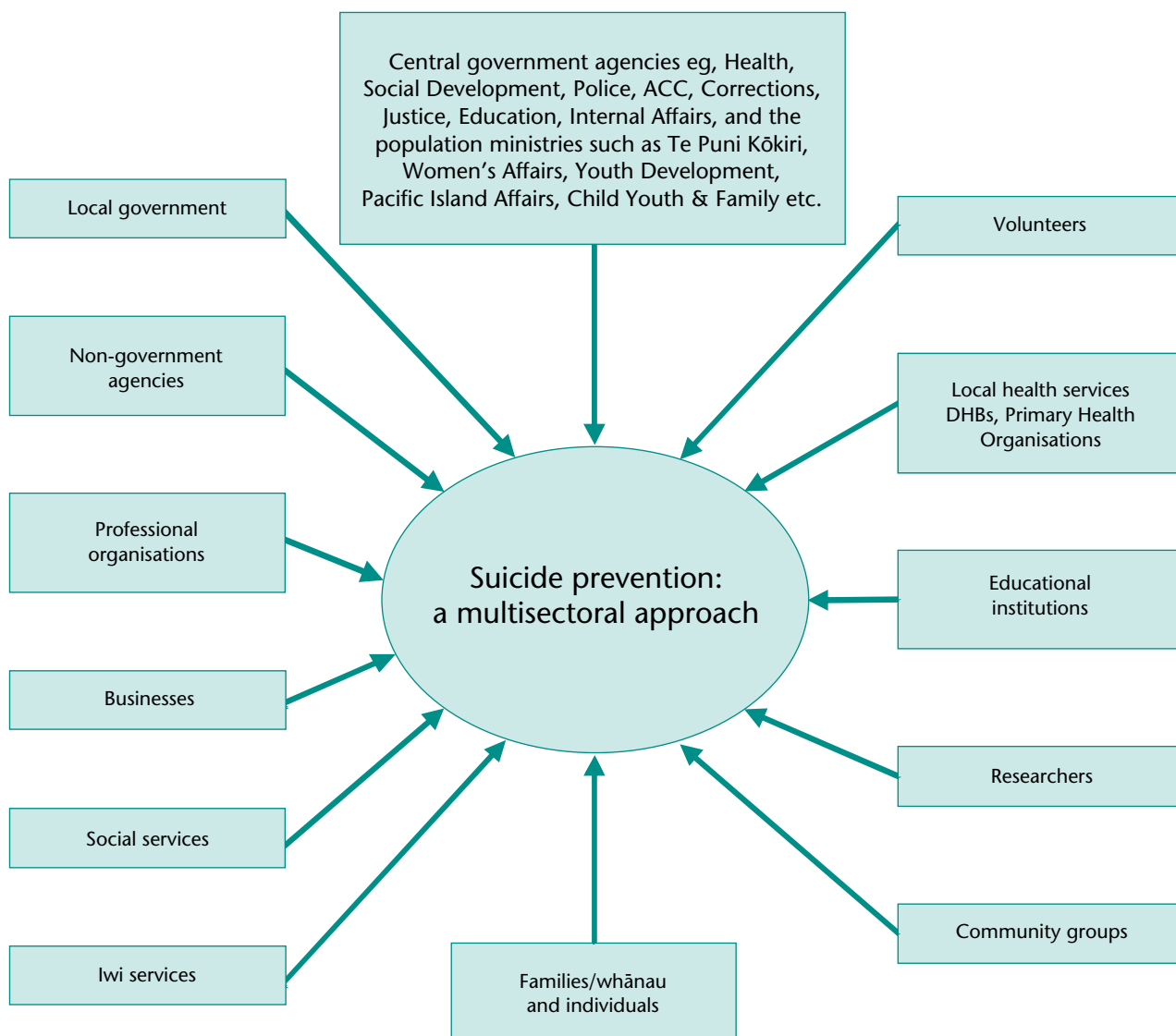
New Zealand’s suicide rates reflect patterns of inequalities in the broader determinants of health, such as socioeconomic status, ethnicity, gender, age and geographical region. Reducing health inequalities between these different population groups is a key principle of the *New Zealand Health Strategy* (Minister of Health 2000), and District Health Boards (DHBs) have a statutory responsibility for reducing health inequalities under the New Zealand Public Health and Disability Act 2000.

Within the context of other health strategies, this strategy endeavours to address inequalities in the suicide rates of different populations. All related activities that fall out of the strategy will focus on reducing these inequalities as well as reducing suicide rates overall. At the very least, the actions should not make inequalities worse.

## ■ A multisectoral approach

Suicide most often results from an accumulation of risk factors. The complex nature of suicide indicates that there is a need to develop a collaborative approach to suicide prevention, co-ordinated across government agencies and integrated across the public and private sectors. This is illustrated in Figure 5.

**Figure 5: Multisectoral approach to suicide prevention**



## ■ Leadership and implementation of this strategy

### ■ National

The Ministry of Health has led the development of this strategy, and will continue to lead and co-ordinate the multisectoral implementation.

A key feature of *The New Zealand Youth Suicide Prevention Strategy* was the demonstration of leadership and co-ordination at the Government level. This included the formation in 1999 of the Ministerial Committee on Youth Suicide Prevention and the Inter-Agency Committee on Youth Suicide Prevention. These committees have played a key role in the development of this strategy and will continue to do so throughout its implementation. The names of both these committees have been changed ('Youth' has been deleted) to reflect the broadening out to an all-age focus.

To translate this strategy into tangible and monitorable actions the Ministry of Health will co-ordinate the development of an action plan, which will be updated every five years. These action plans will specify the type of activities to be undertaken, identify which government agency will lead each action, and contain specific outcomes and timeframes. They will also identify those actions that can be undertaken within existing resources and where additional resources will be needed.

## ■ Local

The active involvement of communities is essential if implementation of this strategy is to have maximum effect. A community-wide approach to suicide aims to encourage community ownership of suicide prevention activities and to facilitate community members in playing an active role in the planning, development and implementation of such activities (Commonwealth of Australia 2005). To date, there are a number of New Zealand communities that have developed community-wide suicide prevention plans. These are most effective when they:

- base their approach on safe suicide prevention interventions
- have an identified group responsible for leadership and co-ordination
- utilise existing community structures and initiatives
- utilise specialist advice where needed
- have a shared vision
- have a planned approach to build capacity and readiness.

## ■ Monitoring and evaluating progress

### ■ Monitoring

A monitoring framework will be developed to measure progress in implementing the strategy. Monitoring will also allow individual stakeholders to track their performance with respect to the actions they are involved in, and will be the basis for modifying actions to improve their effectiveness.

Progress on the implementation of this strategy will be monitored in various ways, including:

- Routine data collection and analysis by the Ministry of Health, using the ICD-10 (AM) coding system (codes X60–X84), will track overall progress towards achieving the purposes of this strategy. Trends over time will be measured by three-year moving average data on both deaths by suicide and hospital admissions for suicide attempts. Monitoring will require improvements in the use, efficiency and scope of national coronial data collection and reporting. Trends in suicide data will be reported through the annual *Suicide Facts*, and five-year *Suicide Trends* publications.
- The Ministerial Committee on Suicide Prevention (MCSP) will meet at least twice yearly to review progress and decide what new initiatives should be implemented.
- The Inter-Agency Committee on Suicide Prevention (IACSP) will meet monthly to discuss progress on the implementation of this strategy and ensure that policies and programmes throughout government are consistent and mutually supportive. The IACSP will co-ordinate reports from government agencies and make recommendations to the MCSP for future directions.

### ■ Review and evaluation

While it is important to monitor overall strategy progress, it is also important to evaluate its component parts. This includes the implementation of a number of specific policies that span: a) improvements in clinical management; b) public health initiatives; c) community level actions; d) development of culturally specific initiatives.

Evaluating these approaches will require the use of a range of research methods depending on the specific policy and the context within which it is developed. These methods will span the use of: randomised trials for clinical interventions; quasi-experimental designs for population interventions; qualitative studies of policy implementation and process; periodic population surveys to monitor mental health and related issues; time series analyses of macro-economic and macro-social changes; and culturally appropriate research designs to examine the impacts of policy in different cultural contexts.



Evaluation is particularly important in the area of suicidal behaviour where relatively little is known about the policies and strategies that lead to beneficial results (Mann et al 2005). It is essential that any new interventions for which there is little evidence will be designed and funded to include an evaluation component.

## ■ Context

### ■ Building on past initiatives

Until recently, New Zealand's national strategic response to suicide prevention focused on reducing the rate of suicidal behaviour amongst young people aged 15–24 years. This was largely because of a groundswell of concern about New Zealand's high rate of youth suicide compared with other countries. Moves at a national level began in 1992 with a workshop convened by the Ministry of Health. This was followed by the establishment of a steering group in 1993, and the subsequent publication of a report in 1994 titled *The Report and Recommendations of Steering Group on Youth Mental Health and Suicide Prevention* (Ministry of Health 1994). This report identified a number of areas where government agencies could work together to reduce youth suicide. In 1998, this was superseded by *The New Zealand Youth Suicide Prevention Strategy* developed by the Ministries of Youth Affairs, Health and Te Puni Kōkiri. Consisting of two parts, 'In Our Hands' (which focused on all youth) and 'Kia Piki te Ora o te Taitamariki' (which used a Māori framework to address suicidal behaviour amongst Māori), it was one of the first multisectoral government strategies addressing a single issue.

In recent years, there has been growing recognition of the need for a broader all-ages response to suicidal behaviour. This strategy is a response to this, and builds on the significant achievements of the earlier youth-focused strategy by refining and extending its goals to New Zealanders of all ages.

Other key developments have included recognition of the importance of suicide prevention as a national priority in other key government strategies such as the *New Zealand Health Strategy* (Minister of Health 2000) and the *New Zealand Injury Prevention Strategy* (Minister for ACC 2003).

The move to an all-age approach does not, however, preclude services taking a targeted approach to address specific needs or high-risk groups. For example, given that young people continue to have high rates of suicidal behaviour, a targeted approach for many types of intervention is still required.

### ■ International developments

New Zealand's suicide prevention activities have been taking place in an international context of growing concern about suicide. In 1996, the United Nations published guidelines emphasising the importance of countries developing their own national suicide prevention strategies using a clear conceptual framework (United Nations 1996). New Zealand was one of the first countries to develop a comprehensive national suicide prevention strategy. The Ministry of Health maintains close links with the World Health Organization (WHO), the International Association for Suicide Prevention and other member nations in monitoring international developments in suicide prevention research, policy and practice.

### ■ Suicide prevention and Māori

This strategy has been developed to reduce the rate of suicide for all New Zealanders, including Māori. This requires actions that:

- reduce the differences in suicide rates between Māori and non-Māori
- are consistent with Māori needs and expectations
- use Māori concepts of hauora and whānau ora
- enable the dual goals of Māori development and improving Māori health and wellbeing.

## ■ Health inequalities for Māori

This strategy acknowledges that in New Zealand, as elsewhere, there are health inequalities between socioeconomic groups, different ethnic groups and males and females. The inequalities in health are not random. In countries like New Zealand, indigenous peoples have poorer health even when socioeconomic position is considered.

The broader determinants that have been shown to have the greatest influence in promoting and protecting health are income, employment, occupation, education and housing. In the health and disability sector, the focus is to remove barriers that inhibit the effective use of, and increase access to, health and disability services by population groups in need. The distribution of resources in relation to those other factors can best be achieved by working with other sectors (such as housing, education, income support and justice) to ameliorate or change approaches that can impact on the wider determinants of health.

Suicide rates have declined since 1998 for all groups, however, evidence shows that the improvements over this period have not eliminated the difference between Māori and non-Māori suicide rates. Action to tackle these differences for Māori needs to take a multi-faceted approach ranging from intersectoral action, health promotion and public health interventions, primary health care delivery and specialised clinical care. Other factors that may impact on Māori wellbeing also need consideration.

## ■ Responsiveness to Māori

Government agencies and community groups will have different strategic frameworks for, and responses to, how they work with Māori to address Māori needs and ensure interventions are accessible, effective and appropriate for Māori.

The guiding framework used in the health sector for responding to Māori health issues is outlined in *He Korowai Oranga: The Māori Health Strategy* (Minister of Health, Associate Minister of Health 2002) and *Te Puāwaitanga: The Māori Mental Health National Strategic Framework* (Ministry of Health 2002a). The *He Korowai Oranga* framework uses the concept of whānau ora (Māori families are supported to achieve their maximum health and wellbeing). *He Korowai Oranga* identifies four pathways to achieving better Māori health outcomes in the context of suicide prevention, which are described below.

### ***Hauora and whānau ora***

In addressing suicidal behaviour amongst Māori, it is essential to recognise that Māori social structure is such that suicide not only impacts on whānau, but also hapū and iwi. This strategy acknowledges the importance of using Māori concepts of hauora and whānau ora to address Māori disparities in the rates of suicidal behaviour. The use of cultural frameworks to address suicide prevention issues affecting Māori was recognised in *Kia Piki te Ora o te Taitamariki* (the Māori-specific component of *The New Zealand Youth Suicide Prevention Strategy*) (Ministry of Youth Affairs, Ministry of Health, Te Puni Kōkiri 1998).

The steps to achieve whānau ora are clearly set out in *He Korowai Oranga*. The concept of whānau ora within this strategy identifies four pathways to achieving better Māori health outcomes. This is a valuable framework for addressing the spectrum of approaches required for Māori suicide prevention. The four pathways are:

#### 1. Whānau, hapū, iwi and community development

This pathway focuses on promoting wider community development and participation, led by Māori, to provide a strong base for Māori whānau. Where whānau can manage their own health,

the whānau is strengthened, as is their ability to participate in their own communities. Services need to be organised around the needs of whānau rather than individuals. Physical, financial and cultural barriers also need to be removed.

## 2. Māori participation

This focuses on supporting Māori participation in all levels of the health and disability sector. It is about effective partnerships with iwi and Māori communities; for example, strengthening the capacity and scope of Māori providers, and developing the Māori workforce with new types of service-worker training and accreditation. Māori providers and workers are uniquely placed to work with whānau and hapū in holistic ways.

## 3. Effective service delivery

This focuses on reducing inequalities for Māori in health by ensuring mainstream services accept increased responsibility for Māori health, and deliver services in ways that are culturally appropriate and of the highest quality. Effective service delivery includes high-quality research and information to inform government and assist whānau to determine and provide for their own needs.

## 4. Working across sectors

This focuses on government sectors working together to address the wider issues affecting Māori health, including economic, social and cultural frameworks. It is also about sharing a common interest, and achieving improved co-ordination and service integration.

### ■ Links with other activities

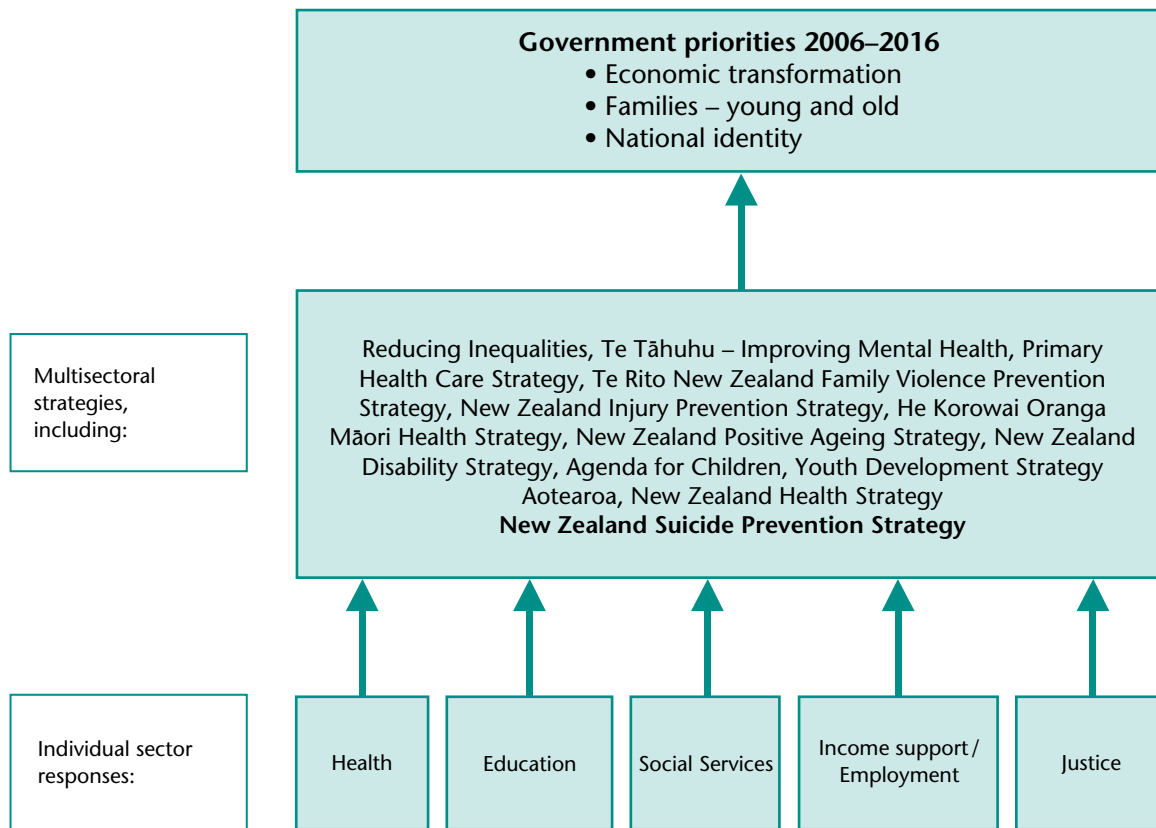
It is important to acknowledge that reducing New Zealand's rates of suicide cannot solely rely on the effective implementation of this strategy. There are many other policies, programmes and services that will contribute, directly or indirectly, to suicide prevention. Key areas include policies and programmes to address:

- mental health and mental illness
- alcohol and drug abuse and dependence
- interpersonal violence
- child abuse and neglect
- family support
- aged care
- Māori development
- Pacific development
- stigma and discrimination
- refugee and migrant support
- unemployment
- offending
- problem gambling
- low income
- low educational attainment
- availability and quality of generic health and social services.

## ■ Links with other government strategies

One challenge when implementing this strategy is to identify alignment with other government strategies, policies and programmes and, where necessary, assist them to enhance the effectiveness of their services with regard to suicide prevention. Figure 6 illustrates how this strategy fits with other government strategies.

**Figure 6:** How this strategy fits with other government strategies



## Part 2: Framework of this Strategy

### ■ Vision

The inspiration for this strategy is a vision of a society where all people feel they:

- are valued and nurtured
- value their own life
- are supported and strengthened if they experience difficulties
- do not want to take their lives or harm themselves.

### ■ Purposes

The overall purposes of this strategy are to:

- reduce the rate of suicide and suicidal behaviour
- reduce the harmful effect and impact associated with suicide and suicidal behaviour on families/whānau, friends and the wider community
- reduce inequalities in suicide and suicidal behaviour.

### ■ Principles

All activities undertaken as part of this strategy should be guided by the following principles:

- be evidence based
- be safe and effective
- be responsive to Māori
- recognise and respect diversity
- reflect a co-ordinated multisectoral approach
- demonstrate sustainability and long-term commitment
- acknowledge that everyone has a role in suicide prevention
- have a commitment to reduce inequalities.

#### ■ Be evidence based

Where possible, all suicide prevention activities should be based on sound scientific research and supported by the experiences and knowledge of those working in suicide prevention. In areas where robust scientific evidence is lacking, a plan to build the evidence base that includes evaluations using methods appropriate to the question and context needs to be incorporated into the approach.

#### ■ Be safe and effective

Although it is important that services are responsive to the needs of their community, it is vital that interventions are informed by research and agreed best practice. Some suicide prevention initiatives, though well meaning, have been shown to place vulnerable people at an increased risk of suicide. It is imperative therefore that all initiatives are carefully developed, informed by evidence and best practice, assessed for safety issues and are comprehensively evaluated to ensure that they make a positive difference and do not have unintended outcomes.

## ■ Be responsive to Māori

Government agencies and community groups will all have different strategic frameworks and responses that provide guidance on how they will work with Māori to address the need to reduce Māori suicide rates. In acknowledging the range of approaches, it is important to ensure that interventions are accessible, effective and appropriately reflect realities and priorities for Māori. Responsiveness to Māori requires measures that reach the structure, strategies, systems, management, staff and culture of the organisation in such a way that it will account for the needs and aspirations of Māori in all its activities, in particular, its core business.

## ■ Recognise and respect diversity

To be effective, the design and delivery of prevention programmes and services must reflect the realities and needs of the population they target. This means being responsive to, and respectful of, issues such as ethnicity, culture, gender, sexual orientation and age, and can be undertaken by:

- delivering services to people in a way that affirms, values and respects their self-identity and community identity, particularly isolated minority individuals and groups
- encouraging communication across and between diverse communities
- recognising and supporting people through life changes that may significantly impact on their wellbeing, such as ageing.

## ■ Reflect a co-ordinated multisectoral approach

Services will be most effective when they are co-ordinated, integrated, and where people clearly understand each other's role. This requires collaboration across sectors and communities, and between government and non-government organisations.

## ■ Demonstrate sustainability and long-term commitment

Suicide is not a 'quick fix' issue and no one approach is likely to, on its own, make a significant difference. Like most complex health issues where there are multiple contributing factors, suicide prevention requires sustained action at a range of levels, and a commitment to investment over a long period of time.

## ■ Acknowledge that everyone has a role in suicide prevention

The full spectrum of suicide prevention is a shared responsibility for the whole of New Zealand society, including community groups, friends, colleagues, whānau, hapū, iwi, families, professional groups, all levels of government, business, and non-governmental organisations. These efforts will be most effective when everyone is clear about their specific role, is participating within the parameters of evidence and safety and working towards a common goal.

## ■ Have a commitment to reduce inequalities

Reducing social and economic inequalities among different groups of New Zealanders has been identified as a key priority for the Government. It is evident in our data for suicide and hospitalisation for suicide attempt that some groups of New Zealanders do better than others. For example, young Māori men have higher rates of suicide than non-Māori men of the same age, Māori females have the highest rates of hospitalisation for suicide attempts, men die by suicide at approximately three times the rate of women, women are hospitalised for suicide attempts at approximately one and a half times the rate of men, and the most deprived geographic areas of New Zealand have much higher rates of suicide compared with the least deprived areas. Because there is a complex web of causality for health inequalities, the approach to reducing them needs to be also necessarily multi-faceted. It is important that all approaches to suicide prevention focus on reducing these inequalities and do not exacerbate them.



## Part 3: Summary of the Evidence

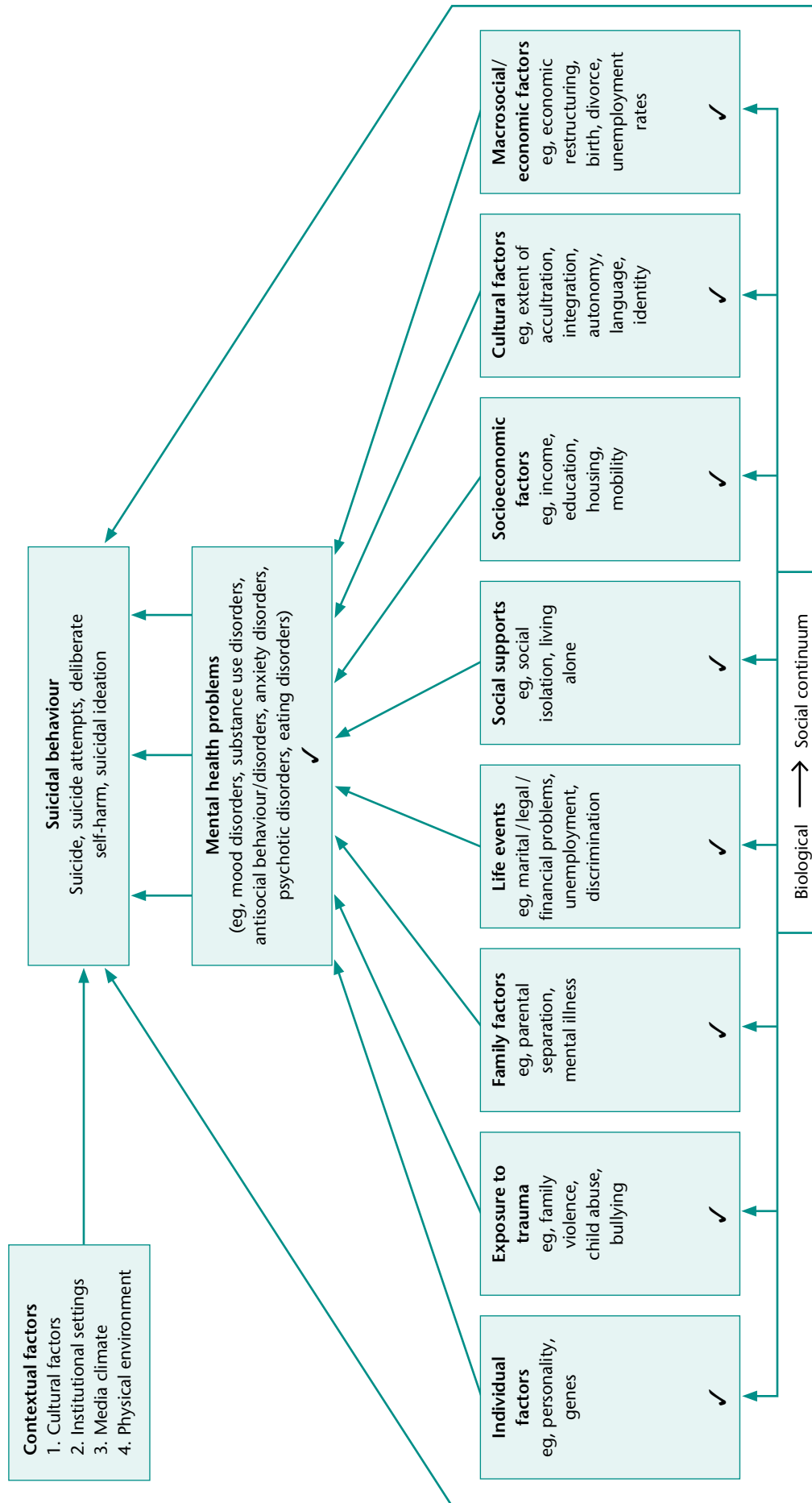
### ■ Pathways to suicidal behaviour

There are a number of factors involved in the development of suicidal behaviours. This is summarised in two reports commissioned by the Ministry of Health which helped inform the development of this strategy (Beautrais et al 2005; Collings and Beautrais 2005). These factors, and how they work together, are illustrated in the model depicted in Figure 7. This model shows that:

1. Factors that contribute to suicidal behaviours are wide ranging, from individual factors (eg, genes, personality) to macro-social factors (eg, unemployment rates).
2. These factors can contribute to suicidal behaviours directly, but can also contribute indirectly by influencing individual susceptibility to mental health problems. Consistent evidence shows that:
  - a. the majority of those dying by suicide or making suicide attempts have a recognisable mental health problem
  - b. mental health disorders (including, in particular, mood disorders, substance use disorders, psychotic disorders and antisocial disorders) account for up to 70 percent of suicides and suicide attempts (Beautrais et al 2005).
3. Contextual factors may also influence the extent to which exposure to the factors reported above contribute to suicidal behaviours. Contextual factors include:
  - a. cultural factors that may modify the effects of risk and protective factors of suicidal behaviours
  - b. institutional settings such as schools, universities, workplaces, hospitals and prisons whose climate, organisation and practices may influence the extent to which exposure to risk factors is translated into suicidal behaviours
  - c. media climates that may influence the extent and expression of suicidal tendencies
  - d. physical environments that may influence the availability of methods of suicide.

Because there are multiple factors and different pathways that lead to suicidal behaviours, there is a need for a broad multisectoral approach to suicide prevention.

**Figure 7: Pathways to suicidal behaviour**

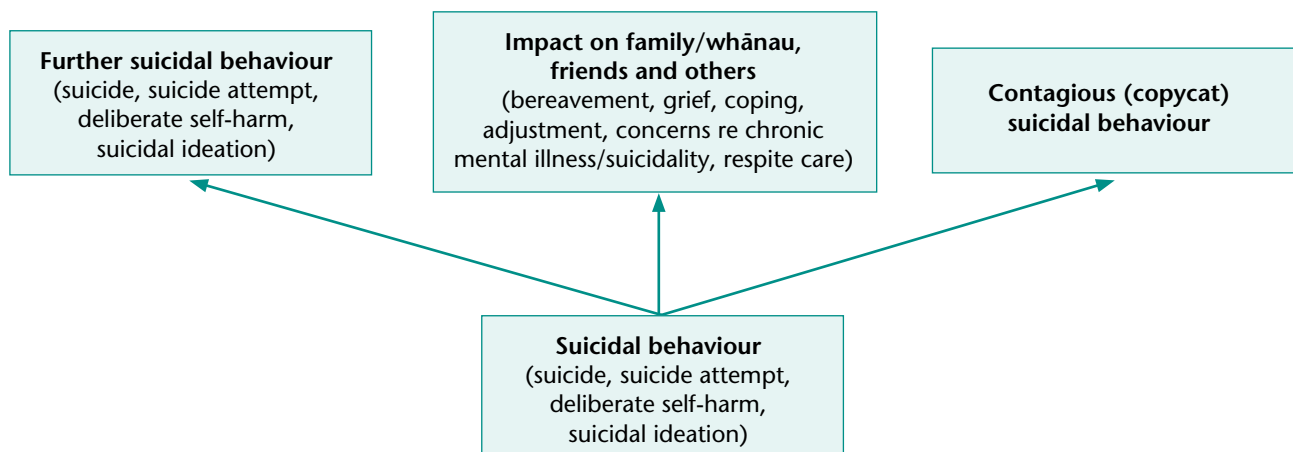


## ■ The impact of suicidal behaviour

Suicidal behaviour can have major adverse consequences for the individual and those who care about them. While Figure 7 explored the pathways that lead to suicidal behaviour, Figure 8 depicts the effect of these behaviours on the individual, family/whānau, friends and others. This model shows that:

1. Further suicidal behaviour can occur. Those individuals who have displayed suicidal behaviours that did not result in death are markedly more at risk of a later suicide attempt and suicide. Amongst those New Zealanders who make a serious suicide attempt, almost half will make at least one further attempt and one in 12 will die as a result of suicide within five years (Beautrais 2003, 2004b; Gibb et al 2005).
2. Suicidal behaviour can impact considerably on family/whānau, friends and others. These people are faced with either issues regarding the wellbeing, safety and quality of life of the individual who survived, or coming to terms with the death of their loved one. The available research suggests that bereavement after a suicide death may raise a wide range of issues for significant others that span: needs for cultural and religious rituals to be observed; needs for information about suicide and the mental disorders with which suicide is associated; needs for social, emotional, spiritual and professional support; access to counselling or psychotherapy; assistance with a police investigation, coronial inquest and other official procedures, and help and advice about practical matters following the death (Beautrais 2004a).
3. Contagion can occur. A suicide by one individual within a group may lead to further suicides within that group. The reasons for contagion are unclear, but a number of factors have been suggested (eg, Gould et al 2003). These include grief (and, in particular, prolonged or unresolved grief), imitation, glorification of the suicide victim and sensationalisation of their death. People at risk of making imitative suicide attempts are those that already have some of the factors that contribute to suicidal behaviour (as shown in Figure 7).

**Figure 8: Potential adverse consequences of suicidal behaviour**



## ■ Mātauranga whakairo (honoured knowledge)

It is important to strengthen the evidence base in order to inform practice and policy. Given the high overall Māori rate of suicide and the need to reduce inequalities, it is essential that research and intervention approaches are designed to be effective for Māori. A consensus about effectiveness needs to result from a convergence in interpretation of evidence of different kinds, from different places, generated by different researchers (WHO 2004).

There is an urgent need to increase and build on existing evidence based research relating to Māori suicidal behaviour, and the inclusion of other forms of evidence is seen as critical by Māori. These might include:

- research that helps inform on both the risk and protective factors of Māori suicidal behaviour
- qualitative studies and evaluations using Māori research frameworks
- comparative research from other indigenous populations
- accounts of the impacts of suicidal behaviour on whānau, hapū and iwi
- acknowledging the importance to whānau, hapū and iwi, of the historical and cultural knowledge of suicidal behaviour captured through appropriate and relevant mediums of communication, for example, kōrero (stories), whaikōrero (formal oratory), waiata mōteatea (traditional songs), karakia (spiritual dedications), whakapapa (geneology)
- building on and strengthening the gains made from *Kia Piki te Ora o te Taitamariki*, the Māori specific component of *The New Zealand Youth Suicide Prevention Strategy*.

The ongoing need to develop appropriate programmes and services to reduce Māori rates of suicide and suicide attempts remains a high priority for this strategy.

## Part 4: Issues for Population Groups

The previous sections set out a series of general principles to guide the development of this strategy, and described what we know about the factors that contribute to suicidal behaviour in New Zealand. In this section, issues for a range of population groups in New Zealand are identified. These are issues relating to:

- age
- gender
- Māori
- Pacific peoples
- Asian populations
- sexual orientation
- refugees and migrants.

### ■ Issues relating to age

Until recently, the major focus of New Zealand's suicide prevention efforts was on reducing suicidal behaviour amongst young people aged 15–24 (Ministry of Youth Affairs, Ministry of Health, Te Puni Kōkiri 1998). While youth remain an important focus given their high suicide rates in New Zealand, it is important to note that 80 percent of suicides occur in individuals aged 25 and over (Beautrais et al 2005).

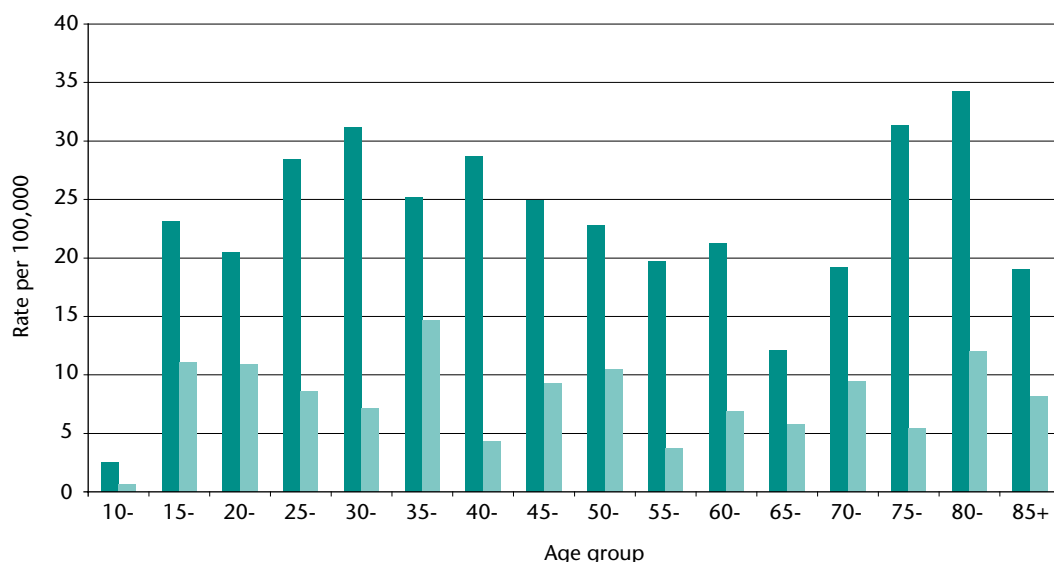
There is also evidence indicating that the risk factors for suicide may vary with age. In particular, although poor mental health is the major risk factor for suicidal behaviour at any age, factors relating to family, trauma and related issues appear to play a stronger role in the aetiology of youth suicide than they do in older populations (Beautrais et al 2005). These considerations suggest the need for the implementation of this strategy to recognise age and developmentally related differences in the risk factors for suicidal behaviour.

While suicide rates in the elderly have been declining over time, they remain relatively high, and the risk is often overlooked in this population. This is a concern because elderly who attempt suicide usually have a strong intent to die and are more likely to make attempts that are fatal; elderly people who attempt suicide usually choose more lethal means and more often live alone, which decreases their chances of being discovered. Because of their physical frailty, an elderly person may be less able to survive or recover from a physically serious suicide attempt (Blumenthal and Kupfer 1990). Furthermore, it is uncommon for an older person to seek assistance after deliberately self-harming (Rifai et al 1994).

### ■ Issues relating to gender

Males die by suicide at a higher rate than females (see Figure 9). These findings have led to a number of speculations about the reasons for this. There have been suggestions that males may have a greater tendency to suicide than females because of gender differences in the prevalence of mental health problems (including schizophrenia, drug and alcohol abuse, externalising behaviours and propensity to violence), cultural acceptability of male (as opposed to female) suicide, and psychosocial differences (including the protective role of children for females and male reluctance to seek help for emotional problems). These arguments linking gender with suicidality may be without foundation. In particular, studies in New Zealand and around the world have consistently shown that females are more prone to suicidal behaviour and make more suicide attempts than males.

**Figure 9: Suicide rates by age group and gender, 2003**



Note: 2003 data are provisional.

Source: New Zealand Health Information Service.



The explanation for the higher rate of death by suicide for males may not lie with gender-related differences in tendencies to suicidal behaviour but, rather, with gender-related differences in the choice of method used, with females more likely to use overdosing and males more likely to use firearms, carbon monoxide poisoning and hanging. Furthermore, there is evidence in New Zealand that gender differences in suicide rates are reducing. The male to female sex ratio reached a peak in 1990–1992 (4.2 male deaths for every female death), then decreased to a ratio of 3.2 male deaths for every female death in 2001–2003 (Ministry of Health in press). This decline was largely explained by an increasing rate of hanging in younger women. These considerations suggest that it would be misleading to represent suicide as a ‘gender issue’. Rather, policies need to recognise that suicidal behaviour is an important issue for both genders and is expressed in gender-specific ways, with women making more suicide attempts and males more often dying by suicide.

## ■ Issues for Māori

Suicide is a complex issue and, as such, requires a multi-faceted and diverse range of responses. Such responses must also take account of the heterogeneity of Māori. For Māori, a strong cultural base is a central source of identity (Durie 1998; Hirini and Collings 2005). Having a positive attitude about identity is important for Māori towards achieving cultural and spiritual wellbeing. Culture influences expressions of health. It also influences how health workers and whānau understand and respond (Lawson-Te Aho 1998). To address the loss suffered by Māori, it is important to acknowledge the past, confront the present and strengthen the future to protect the continuation of whakapapa, hapū and iwi structures.

According to ancient Māori beliefs, the union between Tāne and Hineahuone symbolises the unique beginning of physical human life and the ultimate origins of whānau, hapū and iwi. For Māori, it is important that this knowledge lives on through their stories and whakapapa. Whakapapa provides the links between whānau, hapū and iwi. The added dimension beyond the loss of a precious life is the loss of that whānau member’s unique contribution and continuation of whakapapa. Whānau, hapū and iwi are dependant upon each member for their continued existence. Support of both structures and expressions of culture through concepts of tātau tātau (togetherness), manākitanga (care and hospitality), wairuatanga (spirituality), whanaungatanga (relationships), kawa (process) and tikanga (principles) are significantly threatened with the high rates of suicide experienced across some age groups of Māori.



### ***Whakamomori (Māori suicide)***

Whakamomori is a term often used in relation to Māori suicide. It is not universal to all iwi. Northern iwi for example use the term “tārona” (strangulation) (Coupe 2005). Nevertheless, whakamomori is the most widely acknowledged term for Māori suicide. Whakamomori has been defined by Williams (1971) as “commit(ing) suicide or any other act of desperation”. It has also been interpreted as a “deep seated underlying sadness”, “in built tribal suffering”, “grieving without a death” and a “psychological, spiritual and cultural or collective state of being that may or may not result in death” (Lawson-Te Aho 1998). Consequently, it is important to acknowledge the use of the term whakamomori and the differences in interpretation and meaning within a given context.

Suicidal behaviour in Māori, as well as non-Māori, is closely linked to mental health status. However, when set against the historical context, many other factors have been suggested as intensifying the risk factors for Māori. Suicidal behaviour among Māori today are extremely complex; however, ethnic and cultural differences and their effects on behaviour are important considerations in reducing Māori suicide (Lawson-Te Aho 1998).

### **■ Issues for Pacific peoples**

Pacific peoples living in New Zealand represent 22 different cultures and speak an even greater number of languages (Ministry of Pacific Island Affairs 1999). The Pacific population is predominantly a young population with a high percentage of children under the age of 15 years. Pacific peoples comprise 6.5 percent of New Zealand’s population (Statistics New Zealand 2006) and this is projected to increase to 13 percent by 2031 (Gray 2001).

The socio-cultural fabric of the Pacific populace is culturally diverse. Differences exist between and amongst ethnic nation groups, including island-born, New Zealand-born and New Zealand-raised, regarding languages, values, cultural norms, customs and newly acquired lifestyles. Contrary to common belief, Pacific peoples do not necessarily share a common migration and acculturation history because of their different constitutional relationships with New Zealand (Ministry of Pacific Island Affairs 1999).

While there are many differences within the Pacific populace, there are some areas of commonality. Pacific peoples tend to be geographically clustered within low socioeconomic areas, often living in overcrowded conditions and having low family or household incomes. The increased number of Pacific peoples accessing mental health services is an indication that unemployment, low income, poor housing, extended family breakdowns, cultural fragmentation and increased social problems are having an increasing impact on their mental health and, therefore, suicidal tendencies of Pacific peoples (Tiatia and Coggan 2001; Tiatia 2003).

Pacific peoples often have a strong sense of belonging to their families, their church and the Pacific community. An individual’s identity and wellbeing are traditionally dependent on family heritage, family connections, roles and responsibilities. Although the closeness of mutual family obligations is weakening because of socioeconomic factors and acculturation to New Zealand society, the extended family structure is still at the centre of Pacific cultures, behaviours and beliefs (Finau 1982; Ministry of Health 1997). The social organisations of family and church provide significant and meaningful relationships, which protect members against suicide (Finau 1994; Skegg 1997).

Mainstream approaches to suicide prevention for Pacific peoples are unlikely to be effective on their own, and community development in isolation does not necessarily deal with reducing mental health problems or suicidal behaviours (Disley 1997). Consequently, suicide prevention policies, programmes and services aimed at Pacific peoples require consideration of their cultural contexts and their beliefs about issues such as mental health, which may differ from mainstream culture (Beautrais et al 2005).

## ■ Issues for Asian populations

The Asian population is the fastest growing ethnic community in New Zealand and makes up almost seven percent of the population (Statistics New Zealand 2006). Like Pacific peoples, Asian groups are culturally diverse and have varying degrees of acculturation to New Zealand society (New Zealand Guidelines Group and Ministry of Health 2003). Consequently, suicide prevention policies, programmes and services need to account for this diversity.

Over 40 percent of the total Asian population in New Zealand identify as Chinese, making this the single largest Asian group (Statistics New Zealand 2006). There is a strong stigma attached to suicide for many Chinese, with it often seen as shameful to both the individual and the collective esteem of the family. They often regard mental health problems, including depression and suicidal behaviours, to be caused by social factors, such as failure to fulfil family and societal expectations. In addition, they may be more reluctant to seek professional help for mental health problems unless they experience substantive physical symptoms at the same time (New Zealand Guidelines Group and Ministry of Health 2003).

## ■ Issues relating to sexual orientation

An issue that has been an ongoing source of debate has concerned the extent to which people of gay, lesbian and bisexual (GLB) sexual orientation are at increased risk of suicidal behaviour. Although this view was subject to considerable doubt in the scientific literature of the 1990s, recent research evidence strongly suggests that non-heterosexual orientation is a risk factor for suicidal behaviour.

New Zealand has made an important contribution to this research with findings from both the Christchurch and Dunedin longitudinal studies suggesting that young people of GLB orientation are at significantly increased risk of suicidal thoughts and suicide attempts (Fergusson et al 2005; Skegg et al 2003).

The higher risk of suicidal behaviour amongst GLB young people may reflect a series of factors that together increase the occurrence of mental health problems and thereby suicidal behaviour in this population. Some research suggests that social prejudices, homophobic attitudes, victimisation and harassment increase the vulnerability of GLB young people to mental health problems (D'Augelli 1996; McDaniel et al 2001). It also suggests that the effects of non-heterosexual status on suicide risks are greater for males than for females.

Because it is not recorded in coroner's records or in hospital admission information, sexual orientation as a risk factor does not show up in the official Ministry of Health suicide statistics. Given the high rates of suicidal behaviour in GLB people found by the Christchurch and Dunedin studies, it is important that research continues into both the extent of this risk and the factors that contribute to it.

All of these considerations suggest the need for this strategy to recognise the increased risks faced by GLB young people and to devise policies addressed to meet the needs of this group.

## ■ Issues for refugees and migrants

Refugee and migrant populations may have experienced a number of losses in moving to New Zealand, such as family, home, identity, role, language, cultural context, sense of self and trust in others. Further to this, many refugees have endured or witnessed physical or psychological trauma, with 40 percent estimated to have experienced severe trauma prior to arriving in New Zealand. Consequently, refugees are particularly at increased risk of physical and psychological difficulties, including suicidal behaviour (Ministry of Health 2001). Suicide prevention approaches and policies must recognise the unique issues that are evident for both these populations.

## Part 5: The Seven Goals

The conceptual models developed in Figures 7 and 8 provide the foundation for the following seven goals, which outline the spectrum of suicide prevention and the directions for a New Zealand-wide approach for the next 10 years. These goals and the rationale for each are described below.

1. Promote mental health and wellbeing, and prevent mental health problems.
2. Improve the care of people who are experiencing mental disorders associated with suicidal behaviour.
3. Improve the care of people who make non-fatal suicide attempts.
4. Reduce access to the means of suicide.
5. Promote the safe reporting and portrayal of suicidal behaviour by the media.
6. Support families/whānau, friends and others affected by a suicide or suicide attempt.
7. Expand the evidence about rates, causes and effective interventions.

### Goal 1: Promote mental health and wellbeing, and prevent mental health problems

To develop policies, services and strategies that: a) reduce population exposure to the range of social, familial, and individual risk factors that contribute to mental health problems and suicidal behaviour; and b) promote resilience following exposure to adversity.

**Rationale:** A substantial body of research evidence has shown that social, familial, individual and related factors contribute both to the development of suicidal behaviour and to the development of mental disorders.

**Strategic directions:** This goal is extremely broad and will span a range of population wide and targeted initiatives to improve mental health and wellbeing overall. These will encourage resilience and reduce population exposure to the variety of psychosocial factors that contribute to mental disorders and suicidal behaviour (see Figure 7). Actions under this goal include primary prevention, and need to be aligned with, and build upon, the strategic directions outlined in *Te Tāhuhu – Improving Mental Health 2005–2015: The Second New Zealand Mental Health and Addiction Plan* (Minister of Health 2005), *He Korowai Oranga: The Māori Health Strategy* (Minister of Health, Associate Minister of Health 2002), and *Building on Strengths – A new approach to promoting mental health in New Zealand* (Ministry of Health 2002b).

**Broad areas for action include, but are not limited to:**

- promoting initiatives to support the mental health, wellbeing and resilience of families/whānau and individuals
- promoting initiatives to encourage people to be more responsive to emotional distress and the early symptoms of mental health problems
- supporting initiatives to reduce the stigma of mental illness
- supporting initiatives that address social inequality, violence, discrimination and abuse
- promoting policies and practices in a range of settings to promote mental health and wellbeing, including: schools, universities, marae, churches and other faith-based organisations, prisons and workplaces
- increasing, where appropriate, the role of cultural development as a protective factor for Māori.

## Goal 2: Improve the care of people who are experiencing mental disorders associated with suicidal behaviour

To develop policies, strategies and services that lead to better recognition, treatment and management of people who are experiencing mental disorders (eg, mood, substance use, psychotic, anxiety, antisocial, eating and personality disorders) that contribute to the development of suicidal behaviour.

**Rationale:** Research evidence has shown that mental disorders are the major contributor to the development of suicidal behaviour. Estimates have suggested that up to 70 percent of suicide attempts can be attributed to mental disorders.

**Strategic direction:** Improving the care of people who are experiencing mental disorders will require the use of both population-level public health policies and changes in clinical practice aimed at improving identification, treatment and management of mental disorders. The improvement in care for Māori who are experiencing mental disorders may require further acknowledgement and application of Māori holistic approaches to wellbeing. Actions under this goal need to be aligned with, and build upon, the strategic directions outlined in *Te Tāhuhu – Improving Mental Health 2005–2015: The Second New Zealand Mental Health and Addiction Plan* (Minister of Health 2005).

### **Broad areas for action include, but are not limited to:**

- supporting the public to recognise and be more responsive to people experiencing symptoms of mental disorder, including how to seek appropriate help
- increasing awareness of effective interventions (treatment and management) including self-help strategies
- improving the capability of health professionals and other key personnel to respond appropriately to people experiencing symptoms of mental disorders
- improving the quality of care for people experiencing mental disorders
- improving access to primary and secondary mental health services
- increasing awareness and application of Māori models of health.

### Goal 3: Improve the care of people who make non-fatal suicide attempts

To develop policies, strategies and services that lead to better treatment, management, and after-care support of those making non-fatal suicide attempts.

**Rationale:** Research evidence has shown that amongst those making non-fatal suicide attempts approximately 50 percent will make at least one further suicide attempt with one in 10 ultimately dying by suicide.

**Strategic directions:** Improving the care of those who make suicide attempts will involve clinicians, consumers, families/whānau and community agencies, including hapū, iwi and Māori providers, developing and evaluating more effective methods of after-care and support.

**Broad areas for action include, but are not limited to:**

- improving methods of treatment, management, after-care and support
- improving quality, continuity and accessibility of care
- supporting families/whānau to care for someone who has made a suicide attempt
- developing better after-care and support systems for Māori who have made a suicide attempt.

### Goal 4: Reduce access to the means of suicide

To develop policies, strategies and regulations to reduce access to, and lethality of, the means of suicide.

**Rationale:** Research evidence has shown that, under some circumstances, controlling access to means of suicide may reduce risks of suicidal behaviour. For example, in New Zealand the introduction of the amendment to the Arms Act in 1992 was associated with a dramatic reduction in firearm-related suicides.

**Strategic directions:** Reducing access involves monitoring trends of means of suicide and investigating ways to minimise the risk.

**Broad areas for action include, but are not limited to:**

- promoting compliance with firearms control regulations
- investigating ways to reduce the lethality of motor vehicle emissions
- encouraging the adoption of safer dispensing of medications and other lethal chemicals commonly used in suicide and suicide attempts
- promoting the adoption by local government and other agencies of safe urban design, eg, jump sites
- promoting safe building design for residential institutions that are housing people with a high risk of suicide, such as psychiatric inpatient units and corrections facilities
- promoting vigilance amongst families/whānau and friends of people who have made suicide attempts to limit access to means of suicide.

## Goal 5: Promote the safe reporting and portrayal of suicidal behaviour by the media

To promote good practice in the portrayal and reporting of suicidal behaviour by the media (including print, television, film, radio, drama and the internet) to minimise the potential for imitation.

**Rationale:** Research evidence has shown that some styles of media reporting and portrayal of suicide and suicidal behaviour may, under some circumstances, increase suicide rates through encouragement of 'copycat' suicide and through the normalisation of suicide as an acceptable response to adversity.

**Strategic directions:** The implementation of this goal will require joint strategies with the media to build an informed consensus upon which to develop resources, and agreed-upon codes of practice and policies for the safe and informative media reporting and portrayal of suicide.

**Broad areas for action include, but are not limited to:**

- working with the media to promote safe reporting and encourage consistent practice
- monitoring media coverage of suicide
- providing accessible and up-to-date information on suicidal behaviour to the media
- providing guidance to potential media spokespeople on the importance of informed and safe reporting.



## Goal 6: Support families/whānau, friends and others affected by a suicide or suicide attempt

To develop policies, strategies and services to meet the needs of family/whānau, friends and others following a suicide or suicide attempt, and to reduce the potential for suicide contagion.

**Rationale:** Research evidence has shown that being exposed to a family/whānau member who has died by suicide is often associated with feelings of grief, guilt and shame amongst the surviving family/whānau members. In turn, these reactions may lead to increased risks of mental health problems and suicidal behaviour in the surviving family/whānau members. In some circumstances clusters of suicides can occur which suggest imitation or ‘copycatting’ has occurred. Similar reactions may follow serious, but non-fatal, suicide attempts. There is a clear need for services, policies and strategies that address the needs of family/whānau, friends and others following a suicide or serious suicide attempt.

**Strategic directions:** The implementation of this goal will require the development of policies and services designed to meet the personal and mental health needs of families/whānau bereaved by suicide or of families/whānau with members with suicidal behaviour. The contagious nature of suicidal behaviour also makes it important to put in place postvention strategies to reduce the risk of imitative suicidal behaviours and the development of suicide clusters. This objective will require the development of partnerships between government, health professionals and community agencies, hapū, iwi, Māori providers and communities to devise effective approaches for managing the aftermath of a suicide and suicide attempt.

### **Broad areas for action include, but are not limited to:**

- developing and promoting guidance for key personnel who have contact with people affected by a suicide or suicide attempt, eg, funeral directors, teachers, doctors, police, counsellors and front-line medical personnel
- providing advice and guidance to communities, agencies and organisations in other key settings on postvention responses
- supporting people who have lost someone close to them by suicide, or who are affected by a suicide attempt
- establishing partnerships with hapū, iwi, Māori providers and communities to assist mainstream services in their responsiveness to Māori.

## Goal 7: Expand the evidence about rates, causes and effective interventions

To expand current knowledge about the rates of suicidal behaviour, contributing factors and effective interventions to inform and guide prevention efforts.

**Rationale:** The success of any prevention initiative is largely determined by the level of understanding of the problem and how best to address it. Having good data is vital and improvements are needed in the consistency and timeliness of national data for suicide and suicidal behaviour. Despite an increasingly large body of New Zealand and international research into suicide, particularly around individual risk factors in the whole population, evidence is limited on the risk and protective factors for suicidal behaviour in Māori and some other population groups, for example, Pacific peoples. National and international evidence is also limited regarding the effectiveness of suicide prevention interventions, thus necessitating an increased focus on careful programme design and evaluation.

**Strategic directions:** This goal requires: progressing a research programme to address evidence gaps on the contributing factors to suicide and effective interventions; promoting the importance of evaluation and promoting mechanisms to improve the quality and use of data and research in policy and practice.

### **Broad areas for action include, but are not limited to:**

- promoting and supporting research to expand the evidence base on suicide prevention
- promoting and supporting evaluation of suicide prevention initiatives
- promoting and supporting evaluation of issues/events that may influence, or impact on, suicidal behaviour
- promoting and supporting research to expand the evidence base for Māori suicide prevention
- promoting and supporting research to expand the evidence base for other population groups
- promoting mechanisms to improve the use of research findings
- improving the timeliness, quality and use of national data collection systems
- establishing an evaluation and monitoring framework to measure the effectiveness of the *New Zealand Suicide Prevention Strategy*.

## ■ Implementing the seven goals

This strategy marks a new period in the prevention of suicide in New Zealand which expands and extends the achievements made by the *New Zealand Youth Suicide Prevention Strategy* (Ministry of Youth Affairs, Ministry of Health, Te Puni Kōkiri 1998). The seven goals provide a clear direction for suicide prevention efforts over the next 10 years. How these goals will actually be achieved, by when and by whom will be described in the action plans that will accompany the strategy.

Everyone can help prevent suicide. If you are interested in finding out more about suicide prevention initiatives and how you can be involved, contact Suicide Prevention Information New Zealand (SPINZ) ([www.spinz.org.nz](http://www.spinz.org.nz)) or visit the Ministry of Health's suicide prevention webpage ([www.moh.govt.nz/suicideprevention](http://www.moh.govt.nz/suicideprevention)). It is people working together with a shared vision that will make the difference.

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