IN OUR HANDS

NEW ZEALAND YOUTH SUICIDE PREVENTION STRATEGY

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SEE THE FLIPSIDE OF THIS PUBLICATION FOR *KIA PIKI TE ORA O TE TAITAMARIKI*

FOREWORD

During 1996 144 young New Zealanders died by suicide, and many more attempted to do so. The deaths, physical harm, and emotional pain of these young people, and the grief of those close to them have caused concern throughout our community. There is a strong feeling that 'something must be done'.

The causes of suicide are complex. Often there is an interweaving of experiences and behaviours that makes a young person more vulnerable to suicide. The complexity of the causes means that there is no one simple answer for reducing youth suicide.

Research has identified a range of factors that are associated with an increased risk of suicide or serious suicide attempt. To reduce youth suicide we need to work on reducing the risk factors, and where this is not possible, minimise the harmful effects on young people. This will require action at government, community, and individual levels.

This Strategy operates as a framework to assist us all to identify actions we can undertake to help reduce youth suicide. The government's work in the area of reducing youth suicide will be brought together in an implementation plan, which is being developed by the Ministry of Health. This plan will be updated annually.

Suicide has always existed in our society. Although it is unlikely that we will be able to stop all youth suicides, together we can work to reduce the number of young people harming themselves or ending their lives.

We would like to thank the many people who have helped produce this Strategy: the researchers, people working in mental health, young people, youth workers, teachers, concerned parents, bereaved families and friends, counselling and support groups, and community organisations.

Hon. Deborah Morris
Minister of Youth Affairs

Hon. Bill English
Minister of Health

Hon. Tau Henare
Minister of Māori Affairs

VISION AND MISSION

In Our Hands is inspired by a Vision of a society where ...

... young people are valued, nurtured and strengthened.

The Mission for *In Our Hands* is ...

... to help government, communities, and families/whanau and individuals act together to reduce youth suicide and suicidal behaviour.

INTRODUCTION

YOUTH SUICIDE – A CHALLENGE FOR GOVERNMENT AND COMMUNITY

The death of a young person is always a tragedy. This tragedy is often compounded when the death is the result of a suicide. In this small country, the suicide of a single young New Zealander can cause a profound and personal effect on their family, friends, and society as a whole. Over the last 20 years New Zealand has witnessed a dramatic increase in the rate of young people aged 15-24 years dying by suicide. We now have one of the highest rates in the world. Suicide is not a disease which can be cured. Rather, it is a complex problem for which there is no one cause or cure. Instead there is a range of biological, cultural, economic, social and psychological influencing factors. Most suicides can, however, be prevented.

Given the multitude of factors which contribute to suicide, the government alone cannot adequately respond to this challenge. What is required is a co-ordinated response involving all levels of the community to tackle the serious self-harming behaviours of teenagers and young adults.

THE STRATEGY

The National Youth Suicide Prevention Strategy provides a framework for understanding suicide prevention and signals the steps a range of government agencies, communities, services, hapū and iwi must take to reduce suicides in the 15-24 year old age group.

The National Strategy is made up of two parts: *In Our Hands,* which is the general population strategy; and *Kia Piki te Ora o te Taitamariki* (on the flipside of this publication), which focuses on specific Māori needs and approaches. Each has a set of broad goals and objectives which together form a comprehensive approach to reducing the rate of suicide in this country. The two parts of the Strategy are not mutually exclusive and should be read together.

In Our Hands is aimed at the general population but notes that substantive efforts must be made to make services more appropriate and responsive to the culture and ethnicity of the people they serve. The government has a duty under the Treaty of Waitangi to ensure that policies and services are developed in consultation with Māori, that they are appropriate and effective for Māori, and that they reduce disparities in outcomes. The increasing numbers of young Pacific peoples and Asians in this country mean that services also need to look at the best ways to meet the needs of these populations. As the make-up of our population changes, we need to constantly re-evaluate whether our approaches and services are still effective.

In Our Hands is based on five goals which relate to the different levels of suicide prevention. These actions range from broad initiatives which enhance the resilience of young people and reduce their vulnerability, to initiatives to provide support to people affected by a suicide.

Kia Piki te Ora o te Taitamariki takes an approach based on community development, and on encouraging services to be more responsive to the needs of Māori. This too has five goals and a range of objectives to progress this approach.

The approach taken in the National Youth Suicide Prevention Strategy is consistent with national strategies from overseas and the recommended framework of the United Nations. It has been developed with the input of a range of experts, both from New Zealand and overseas, and has been supported by a substantial consultation process.

GOVERNMENT ACTION

The National Youth Suicide Prevention Strategy has been developed by a secretariat led by the Ministry of Youth Affairs, with key input from the Ministry of Health and Te Puni Kōkiri. The Ministry of Health is co-ordinating an implementation plan with other government departments and agencies to progress the Strategy. This will include a more thorough stock-take of current government initiatives which address the prevention of youth suicide, and seek the co-operation and agreement of these government agencies to implement other priority initiatives.

Already a number of key priorities have been implemented as a result of consultation on the draft Strategy. Examples of current work by government agencies are included in Appendix A.

Two reports were commissioned to inform the approach and provide evidence on the Strategy. A Review of Evidence: In Our Hands – the New Zealand Youth Suicide Prevention Strategy *by Annette Beautrais examines the evidence behind the approaches in In Our Hands. The second report,* A Review of Evidence: Kia Piki te Ora o te Taitamariki – the New Zealand Youth Suicide Prevention Strategy for New Zealand *was written by Keri Lawson-Te Aho and provides the basis for the strategy for the prevention of Māori youth suicide. These reports are available from the Ministries of Health and Youth Affairs and Te Puni Kōkiri.*

HOW NON-GOVERNMENTAL AGENCIES AND COMMUNITIES CAN USE THIS STRATEGY

In Our Hands has been produced for government departments, health sector agencies, schools, churches, community organisations, local governments, hapū and iwi, youth workers or individuals with an interest in reducing youth suicide. They can use this Strategy to develop actions to help prevent suicides and to assess how well their community provides support for young people at risk of suicide. The examples and case studies provide models which organisations can adapt to their own situations.

Both *In Our Hands* and *Kia Piki te Ora o te Taitamariki* complement each other and should be read and applied together.

HOW ORGANISATIONS CAN USE THIS STRATEGY

1 Read both parts of the Strategy, noting in particular the sections headed 'Framework for Prevention'. These show the different 'points of intervention' at which organisations can take steps to reduce youth suicide. These points of intervention have been grouped under five main goals, ranging from programmes aimed at preventing suicide by promoting wellbeing, through to crisis support when suicide is imminent, and ways to respond to a completed suicide.

2 Identify the points of intervention which are most relevant to your organisation's work with young people. At times, of course, young people will be at varying degrees of risk, so these points of intervention will change.

3 Under each of the relevant goals, look at the specific objectives and check how well your organisation is working to meet them.

4 Discuss this Strategy with your co-workers, and talk with young people. What are their needs? How can your organisation assist in meeting those needs?

5 Please note that programmes aimed at increasing young people's awareness of youth suicide issues are <u>not</u> recommended (see Appendix C for more on this).

AN EXAMPLE – YOUTH GROUP USE OF *IN OUR HANDS*

1 Read the *In Our Hands* Strategy. Note that most of your group's work probably falls under Goal One – Promoting Wellbeing [Page 14].

2 Discuss the objectives under Goal One with your co-workers and group members to determine whether your group has a role in meeting these objectives.

- **Objective One – Support for families**

– Does your group provide support for families experiencing stress or difficulties, particularly those with teenage children?
– Can you provide more support and education for those families having difficulties, or refer them to appropriate agencies?

- **Objective Two – Initiatives to promote mental health and wellbeing**

– If your group finds that some of its members have mental health problems such as drug or alcohol abuse or depression, do you know the appropriate agencies to refer these young people to?
– Can the group run programmes to assist young people to solve their interpersonal problems, and develop problem-solving skills?

- **Objective Three – Initiatives to reduce the stigma of mental illness**

– Are the members of your group as aware of and responsive to the needs of people with mental illness as they could be?

– Can your group run programmes to increase members' understanding of mental illness and the needs of people with mental illness?

- **Objective Four – Participation of young people**

– Are young people included in your youth group's decision-making process?

– Are they represented on boards at the local, regional and national level of your organisation?

– Does your group provide youth-focused activities and services?

- **Objective Five – Development and affirmation of young people's own identity**

– Are young people encouraged to develop their own identity within your group?

– Does the group value young people from different ethnic groups, and those with differing sexual orientations?

– Are young men and young women equally valued and involved in group activities?

- **Objective Six – Addressing social inequality and discrimination**

– Does your group discuss the issues of equality and discrimination?

– Is there a role for the group to actively address these issues?

3 Discuss each of the remaining four goals and objectives with a view to:

- identifying the group's role
- identifying appropriate agencies for referral and support
- identifying problems for youth in your community, and lobbying for change.

4 Meet with other groups, organisations and agencies to discuss the roles of each agency and the wider community in supporting and valuing your young people.

If possible, develop a network to co-ordinate your community's activities, communicate ideas and provide support.

YOUTH SUICIDE – THE FACTS

Suicide is second only to vehicle accidents as the main cause of death among young New Zealanders aged 15–24. Over the last 20 years the youth suicide rate has increased. Although the rate of youth suicide appears to be increasing in many countries, New Zealand now has one of the highest rates in the world. For each completed suicide, there are a far greater number of attempted suicides[1].

There are many factors that may influence suicidal behaviour, and these are linked in complex ways. Generally, the more risk factors a young person experiences, the more vulnerable they are to becoming suicidal. A stressful or traumatic life event (such as a relationship break-up or the death of a friend) may trigger suicidal behaviour when combined with other factors, and when a young person is without good support.

By understanding the risk factors that contribute to suicide, we can prepare the most effective prevention strategies.

RISK FACTORS FOR SUICIDE ATTEMPTS

Research has identified four factors distinguishing young people at increased risk of attempting suicide:

- They often come from educationally and socially disadvantaged backgrounds.
- They often have disturbed or unhappy family and childhood backgrounds.
- They almost always display some recognisable mental health problem or adjustment difficulty before the suicide attempt.
- Immediately before the suicide attempt, they may face some severe stress or life crisis, often around the breakdown of an emotional or supportive relationship.

Around 90% of young people dying by suicide or making suicide attempts are likely to have one or more recognisable psychiatric disorders at the time. The three psychiatric disorders most commonly associated with suicidal behaviours are:

- depressive disorders – present in almost three-quarters of those making suicide attempts
- alcohol, cannabis and other drug abuse – present in over one-third of young people making suicide attempts
- significant behavioural problems, such as conduct disorders and antisocial behavioural disorders – present in one-third of young people making suicide attempts.

A small number of young people will not fit any of the above risk categories. Prevention strategies therefore need to be broad and inclusive, and should be monitored and reviewed on an ongoing basis.

There is a recognised shortage of relevant, in-depth studies looking at Māori suicide, and involving significant numbers of Māori participants. *Kia Piki te Ora o te Taitamariki* has utilised the experiences of tangata whenua and indigenous people internationally in designing the Māori strategy. Cultural alienation is therefore considered to be a significant risk factor for suicide, in combination with the risk factors already noted, and this may also place young Pacific people born in New Zealand at increased risk.

THE GROWING RATE OF SUICIDE

There are many reasons suggested for the increase in New Zealand's youth suicide rate. Possible explanations include: the increasing rates of depression, alcohol and drug abuse; rising rates of violence including child abuse and sexual abuse; alienation of an individual from his or her cultural heritage; changes in the family structure; reduced influence of the Church; increased discussion and portrayal of suicide in the media; high unemployment; and trends towards a more risk-taking society.

[1] *For more detailed information on youth suicide statistics, see Appendix B (page 28).*

TEN PRINCIPLES OF YOUTH SUICIDE PREVENTION

1 The Treaty of Waitangi

The Treaty of Waitangi provides a constitutional basis to enable Māori to achieve their full social and economic potential. Suicide prevention policies and programme delivery must be accessible to, and appropriate for, Māori.

2 Collective responsibility

Suicide is complex and requires a multi-faceted approach to its prevention to be effective. No single discipline, organisation or individual is solely responsible for suicide or suicide prevention. The full range of people and organisations in contact with young people should actively participate in suicide prevention initiatives, and be empowered to act as part of a community-wide suicide prevention network.

3 Co-ordination and collaboration

Community initiatives for suicide prevention are most effective when activities are co-ordinated and integrated. This requires collaboration across sectors and across regions, between government and non-government organisations, and involving both public and private sectors.

4 Research and information

Accurate information about the nature of the problem, protective factors for suicide, and effective prevention programmes, is a fundamental basis for youth suicide prevention.

5 Cultural relevance

The design and delivery of prevention programmes must be able to meet the needs of people from diverse cultural backgrounds.

6 Responsive to a diverse youth population

The youth population is not an homogeneous group. To be effective, the design and delivery of prevention programmes must reflect the realities and needs of the young people they target. This means considering issues such as ethnicity, gender, sexual orientation and disability.

7 Focus on the family/whānau

A healthy family/whānau is central to the healthy development of children and young people. The role of the family in nurturing and healing its young people must be acknowledged and supported in all prevention activities.

8 Preventing both death by suicide, and suicide attempts

Prevention means developing a wide range of strategies which aim at reducing both the number of deaths from suicide, and the poor health and negative effects of non-fatal suicide attempts. It also means beginning many prevention efforts well before adolescence.

9 Long-term approach

Public health initiatives will require both investment and long-term evaluation before any clear trends in reducing suicide can be concluded.

10 Reducing risk

Initiatives to prevent suicide must be informed by research and best practice to ensure that these initiatives do not put people at further risk of suicide.

A FRAMEWORK FOR PREVENTION

IN OUR HANDS

KIA PIKI TE ORA
O TE TAITAMARIKI

FIVE GOALS TO HELP REDUCE YOUTH SUICIDE: A SUMMARY

GOAL ONE: PROMOTING WELLBEING

To prevent young people becoming at risk of suicide through strengthening families/whānau, young people and communities.

GOAL TWO: EARLY IDENTIFICATION AND HELP

To better identify and help young people at risk of suicide, and reduce opportunities which present suicide as an option.

GOAL THREE: CRISIS SUPPORT AND TREATMENT

To improve support and treatment for young people who have attempted suicide or who are suicidal.

GOAL FOUR: SUPPORT AFTER A SUICIDE

To give effective support to those who are bereaved or affected by a suicide, and to reduce the potential for further suicides.

GOAL FIVE: INFORMATION AND RESEARCH

To improve information about the rates and causes of suicidal behaviour in young people to inform effective prevention efforts.

GOAL ONE: PROMOTING WELLBEING

To prevent young people becoming at risk of suicide through strengthening families/whānau, young people and communities.

This goal is based on reducing the likelihood that young people will develop suicidal behaviour, by changing the ways we relate to and treat young people within families and communities. Young people at increased risk of suicidal behaviour are likely to have experienced social disadvantage, negative childhood experiences and family hardship. Through strengthening families and communities to support the positive development of young people, many of these risk factors for suicide can be overcome.

The following objectives will progress this goal:

1 Support for families/whānau to increase the wellbeing of their young people.

Examples could include:
- home visiting initiatives for at-risk families
- parenting skills courses
- youth/parent communication courses.

2 Support initiatives which promote the mental health and wellbeing of all young people and which encourage them to seek help in times of need.

In schools and other training and educational institutions, children and young people can be helped to develop skills to recognise mental health problems, and be encouraged to seek appropriate help.

Examples could include:
- school-based programmes such as Mental Health Matters
- learning opportunities which improve young people's problem-solving and interpersonal skills
- campaigns to remove the stigma of mental illness
- peer support training for students
- health promotion messages targeted to young people with positive messages on how to avoid drug and alcohol related harm, and supporting personal choice over peer pressure.

3 Support initiatives to reduce the stigma of mental illness.

Unlike most physical illnesses, mental illness attracts stigma and discrimination. Negative attitudes to mental illness can cause shame and isolation, and make people reluctant to seek help when they need it. By educating people about mental health and mental illness, attitudes can be improved, making a real difference in encouraging young people to seek help and stay well.

Examples can include:
- Mental Health Awareness Week activities
- increasing awareness about mental health and mental illness, through school curricula
- information resources for young people to learn about mental health problems and how to support a friend who has a mental illness.

4 Encourage the participation of young people in all aspects of community life and in decisions which impact upon them.

If young people can actively participate in their communities, they are more likely to have a sense of self-worth and purpose in life, and take responsibility for their actions. Involving young people in issues that affect them is important to help ensure that services aimed at meeting their needs are effective.

Examples could include:

- participation of young men and women, eg. as student representatives on school boards of trustees
- processes that actively involve young people in designing youth-oriented services.

5 Promote opportunities to enable young people to develop and affirm their own identity.

There are many aspects to an individual's identity, including gender, cultural and ethnic identity, and sexual orientation. Feeling good about all these aspects is important for every individual's mental health and wellbeing.

Examples could include:

- youth studies to explore what 'being' male and 'being' female means
- initiatives which foster pride in one's culture
- school environments that support gay and lesbian students
- promotion of kapa haka groups in communities
- promotion of Pasifika cultural festivals and sports tournaments for young people.

6 Support initiatives which address social inequality, discrimination and abuse where they impact on young people.

Improvements in social equity may have a positive effect on suicide prevention by reducing the risks of childhood and adolescent adjustment difficulties and mental health problems.

Examples could include:

- anti-bullying programmes in schools
- employment strategies targeting assistance to under- or unemployed young people
- strategies to reduce discrimination against Māori and Pacific peoples and other ethnic minorities, gay, lesbian and bisexual young people.

GOAL TWO: EARLY IDENTIFICATION AND HELP

To better identify and help young people at risk of suicide, and reduce opportunities which present suicide as an option.

The strongest risk factor for suicidal behaviour is mental health problems, particularly depression, substance use disorders, and anti-social behaviours. Young people experiencing emotional stress and mental health problems need to be encouraged or assisted to seek help from others, and need access to health services.

In addition, it is important that vulnerable young people have as little exposure as possible to influences which may unintentionally suggest suicide as an option for dealing with their distress. They should also not have ready access to easy opportunities to harm themselves.

The following objectives will progress this goal:

1 Improve the capacity of those who work with young people, to identify and respond effectively to behaviours associated with suicide.

It is important that those who work with young people are able to identify and respond to behaviours that put young people at a greater risk of suicide, such as depression, and drug and alcohol abuse.

Examples could include:

- providing appropriate education and training programmes for teachers, school counsellors, youth and social workers, church and religious leaders, health care workers, general practitioners and associated

health professionals, and workers in the justice system to improve the recognition, treatment and management of a range of mental health disorders and suicidal behaviour and identify skill limits and the need for referral
- providing seminars for community and youth workers on depression in young people.

2 Ensure that information is available to those in contact with young people to help them identify and respond to young people who may be at risk of suicide.

Examples could include:
- publishing 'user-friendly' pamphlets for parents, caregivers, kaumātua and community elders, explaining possible warning signs that indicate a young person is in distress, eg. alcohol and drug abuse, depression
- publicising contact and access details of appropriate agencies to provide help.

Please note that these initiatives must be balanced against the potential dangers of normalising the idea of suicide among young people.

3 Support initiatives to reduce young people's risk-taking behaviour where this has a negative consequence on their or others' health and wellbeing.

Adolescence is a normal time to test boundaries and take risks. Sometimes risk-taking can put adolescents themselves, or others, in danger. Excessive risk-taking, such as bingeing on alcohol or having unsafe sex, can also be an indication of more serious problems or emotional distress.

Examples can include:
- health promotion campaigns for young people on how to avoid alcohol and drug related harm
- culturally appropriate sexual health services that allow young people a choice other than the mainstream provider
- one-stop health shops for young people which include sexual health, counselling, and alcohol and drug services.

4 Ensure that primary health, mental health, and drug and alcohol services are responsive to the culture, gender and sexual orientation of young people.

The strong link between mental health problems and suicidal behaviour means that effective mental health services are key players in preventing suicide. For mental health services to be effective to Māori, it is imperative that services acknowledge that the cultural (spiritual, physical, intellectual and familial) needs of taitamariki Māori are an inherent part of their identity, that those needs can only be met by Māori experts, and ensure that such expertise is available.

It is also vital that these services work in a way that takes account of the specific developmental needs of young women and young men; that they are accessible and youth-friendly; and that they meet the particular needs of Pacific peoples, other ethnic groups, and gay and lesbian young people.

Examples could include:
- cultural assessment undertaken by Māori at point of entry and at all stages of care
- specialist training in adolescent mental health issues and service delivery
- mental health programmes that target young men
- one-stop youth health shops
- 'by Māori, for Māori' services
- mainstream services with the capacity to meet the needs of Pacific peoples and other ethnic groups.

5 Reduce the opportunities for self-harm and suicide.

Reducing access to the means of suicide is a key opportunity for suicide prevention. Research has shown that the more accessible a particular method is, the more likely that it will be a method of choice for a suicidal person.

Examples could include:
- restricting access to firearms
- restricting access to toxic and lethal drugs
- ensuring safety in seclusion areas (ie. in police cells and prisons).

6 Reduce messages in the media that suggest suicide as an acceptable problem-solving option.

Experts suggest that young people are increasingly seeing suicide as a rational option for dealing with an emotional crisis. Research has demonstrated that fictional and non-fictional portrayal of suicide in the media can unintentionally suggest to young people in crisis that suicide is an acceptable problem-solving option. Young people may be particularly vulnerable to the way suicide is reported and portrayed, which can provoke 'copy-cat' and cluster suicides.

Examples could include:
- encouraging the media to report and depict suicide in safer ways
- advising commentators (eg. police, coroners) on safe ways of discussing suicide publicly.

GOAL THREE: CRISIS SUPPORT AND TREATMENT

To improve support and treatment for young people who have attempted suicide or who are suicidal.

One of the most significant risk factors for suicidal behaviour is a history of prior attempts. It is therefore vital that young people who have attempted suicide receive effective and appropriate treatment and support.

The following objectives will progress this goal:

1 Ensure that crisis support services are available, accessible and effective for young people who are suicidal or who have attempted suicide.

Examples could include:
- ensuring that services such as telephone crisis services and psychiatric emergency services are well advertised, trained, acceptable and accessible to young people
- campaigns to increase awareness of who to contact in a suicide emergency.

2 Ensure that all hospitals and emergency health services respond effectively and appropriately to young people who have attempted suicide.

Accident and Emergency departments in hospitals often begin the physical healing for young people who have attempted suicide. This can also provide an opportunity to begin to deal with the underlying emotional distress. It is essential that those who have made a suicide attempt receive a mental health assessment and appropriate follow-up treatment.

Examples could include:
- clear protocols for assessment, treatment and assertive follow-up of those who present at emergency departments for suicidal behaviour

- ensuring that all protocols address Māori needs, eg. cultural assessment undertaken by Māori
- training for emergency department staff on how to work with young people.

3 Ensure that young people who have attempted suicide have access to follow-up services which are appropriate and effective.

Improved treatment and management strategies for young people with suicidal behaviour may reduce the risks of a subsequent suicide. Experts consider that this may be one of the most effective approaches to reduce the level of suicide amongst young people.

Examples could include:

- developing and evaluating treatment models which encourage participation by young people
- developing and disseminating best practice initiatives throughout mental health services
- availability of Māori services for Māori clients
- developing and evaluating treatment models that encourage participation by young Pacific peoples and their families.

4 Encourage opportunities for families/whānau to be involved in the care and support of their young people.

Families can play a vital part in the support and recovery of a young person who has attempted suicide. Services can encourage, assist and empower families/whānau to be part of this recovery process.

Examples can include:

- support groups for parents and caregivers/whānau of young people who have attempted suicide
- information for families/whānau on understanding suicide and recognising its warning signs
- protocols and best practice models in health and social services for involving families/whānau in counselling after a suicide attempt.

5 Encourage co-ordination and collaboration between service providers to ensure that young people receive an effective and seamless service.

Following an incident as serious as a suicide attempt, it is important that young people receive the best follow-up treatment and support. This means services have to know about each other, and have clear processes for referral, case management and follow-up.

Examples can include:

- mainstream health services working closely with kaupapa Māori health services to ensure that taitamariki receive a service which is culturally appropriate
- inter-agency protocols for referral and assertive follow-up after a suicide attempt
- joint training opportunities between different services such as school counsellors, GPs and mental health services
- establishing networking of community organisations for youth suicide prevention.

GOAL FOUR: SUPPORT AFTER A SUICIDE

To give effective support to those who are bereaved or affected by a suicide, and to reduce the potential for further suicides.

Suicide of a young person can result in a great deal of distress and intense emotions. People affected may include family, friends, colleagues, school friends, teachers, police, and health professionals. People who have witnessed a suicide, or who were close to someone who had died by suicide, are themselves at a greater risk of suicide.

Post-suicide strategies aim to limit the continuing impact and effects of the death, including further suicides.

The following objectives will progress this goal:

1 Ensure that responsive and culturally appropriate support and grief counselling are available to those bereaved by suicide.

Family members and those close to the suicide victim are a high-risk group for subsequent suicide. Appropriate support services for a period after the death can help prevent further fatalities and assist in the grief process.

Examples could include:
- culturally appropriate information to bereaved families
- support groups for people who have lost someone through suicide.

2 Ensure that those who have a key role following a suicide are informed about appropriate behaviour and approaches that will minimise the likelihood of further suicides.

Suicides, particularly youth suicides, bring the danger of imitative behaviour. Those who have a key role at or following a funeral should avoid glorifying the deceased or sensationalising their death. To do so runs the risk of increasing the likelihood that someone who identifies strongly with the deceased or who is having suicidal thoughts may also attempt suicide to receive similar attention. People in key roles can play a major part in discouraging suicide as an option for people in distress, but this must be done in a way that is sensitive to the feelings of those grieving.

Examples could include:
- awareness guidelines for those who officiate at funerals and memorial services
- information to assist funeral directors in meeting the needs of bereaved families.

3 Encourage communities and organisations to become informed about behaviour and approaches that will minimise the likelihood of further suicides.

Young people who are close to or identify with someone who has died by suicide may be at increased risk of attempting suicide. The organisations and communities in which the deceased participated can play a valuable role in reducing the likelihood of imitative suicide. Groups such as schools and cultural groups can help by identifying and providing support to those at high risk, such as good friends, brothers and sisters, and those with a history of mental illness, and providing accessible and appropriate counselling.

Developing post-suicide plans in advance is an important step to preventing potential suicide clusters.

Examples could include:
- guidelines for communities to help prevent a cluster of youth suicides
- a system to access expert assistance soon after a suicide
- each community developing post-suicide plans which identify and co-ordinate support processes.

4 Ensure that the media are aware of the risks in reporting, discussing and depicting suicide, to minimalise normalisation of suicide and imitative suicides.

There is consistent evidence suggesting that publicity about suicide issues may provoke imitative behaviour in vulnerable individuals. Post-suicide plans need to include advice for those who may be called upon to make comment.

Examples could include:

- guidelines on safer reporting practices for news media organisations
- a resource list of informed people able to provide media comment
- dissemination of research to media organisations which demonstrates the link between media coverage and a subsequent increase in suicides.

GOAL FIVE: INFORMATION AND RESEARCH

To improve information about the rates and causes of suicidal behaviour in young people to inform effective prevention efforts.

The success of any prevention initiative is largely determined by the level of understanding of the problem and knowledge of ways to address it. Any contribution to our knowledge and understanding is crucial to improving our capacity to reduce the level of suicidal behaviour and suicide.

The following objectives will progress this goal:

1 Promote research into the design and evaluation of suicide prevention and intervention initiatives.

There is a lack of information about the effectiveness of various suicide prevention programmes. In particular, further research could cover the following areas:

- evaluation of school-based mental health awareness and suicide awareness programmes
- identifying ways to improve young people's attendance and participation in treatment services, for example, determining how to make services appropriate for young men
- evaluation of treatment studies for young people at especially high risk of suicide, including those with schizophrenia, those who have made previous suicide attempts, and those recently discharged from psychiatric inpatient units
- design and evaluation of early intervention and family support programmes
- evaluation of culturally-specific suicide prevention programmes
- evaluation of the effectiveness of mainstream programmes for people from minority cultures.

2 Promote and prioritise research into suicidal behaviour among young people, including Māori, and Pacific peoples, and sexual orientation-focused research and protective factors.

In order to target prevention, the research base needs to examine in further detail various genetic, medical, psychiatric, behavioural, and social characteristics of suicidal young people and their families/whānau.

Further research could include examination of:

- cultural alienation
- suicide amongst Māori, Pacific peoples, and other ethnic groups
- gender differences
- suicide clusters and contagion
- the effect of media on suicidal behaviour
- access to means of suicide
- sexual orientation issues
- societal changes
- the effect of contact with police, courts, prisons or other aspects of the justice system.

3 Promote the co-ordination, collection and dissemination of research, information and best practice findings to all involved in suicide prevention.

It is important that all those who are involved in suicide prevention initiatives are aware of the latest national and international data, research findings and evidence about prevention strategies. It is also important that those working in suicide prevention co-ordinate and collaborate on prevention opportunities.

Examples could include:

- the establishment of an information resource centre to collect, co-ordinate, and distribute research information and best practice findings about suicide prevention
- the formation of networks amongst those working in suicide prevention
- the establishment of a website for suicide prevention information.

4 Improve statistical information about the trends and rates of suicidal behaviours among young people.

Planners and researchers need accurate, timely, and systematic data collection on the rates and trends of suicide and attempted suicide.

Three areas in which data could be improved are:

- faster provision of annual suicide data
- consistency in the approach of coroners to reaching a suicide verdict
- accuracy in recording ethnicity data in suicides.

APPENDIX A

EXAMPLES OF GOVERNMENT INITIATIVES

Below are some of the government initiatives to support the reduction of suicidal behaviour and suicide in young people. Many of these initiatives have been developed in response to the draft version of this Strategy.

The Ministry of Health is developing an implementation plan for government departments and agencies which will include a stock-take of current government initiatives.

MENTAL AND GENERAL HEALTH

- The Ministry of Health has set a target for reducing youth suicide in its *1997 Progress on Health Outcome Targets* report:
  – To reduce the suicide rate among all New Zealand males aged 15–24 years to 30 per 100,000 or fewer by the year 2005, and
  – To reduce the suicide rate among all New Zealand females aged 15–24 years to five per 100,000 or fewer by the year 2005.
- The Health Funding Authority is expanding mental health services for children and young people around the country. Approximately $11 million extra, making a total of $32 million, are being spent in this area during the 1997/98 financial year. New services purchased or currently in negotiation or development include:
  – early intervention services for youth with serious mental illness
  – specialist youth assessment and treatment services
  – supported accommodation for youth with serious mental illness
  – Māori-provided services for Māori youth
  – pilot programmes for Māori youth with alcohol and drug dependency problems
  – additional adolescent acute inpatient psychiatric beds.
- The Health Funding Authority is running a national programme to counter stigma and discrimination associated with mental illness.
- The Health Funding Authority is developing a five year purchasing plan which will include details on how child and youth mental health services can be increased and improved. This will be finalised by 1 July 1998.
- The Ministry of Health is developing a strategic framework for specialist services to be provided for children and young people with severe mental health problems. This will be completed in June 1998.
- The Ministry of Health is developing a National Child Health Strategy which will outline key strategies for improving child health outcomes. This will be complete by June 1998, and will feed into the Health Funding Authority's prioritisation process for funding health services.
- The Ministry of Health and the Health Funding Authority are jointly developing guidelines for the clinical assessment of risk for mental health services. These will include a component on suicide risk assessment.
- The Ministry of Youth Affairs is working with primary health care providers and other stakeholders to develop guidelines for primary health care providers (eg. general practitioners, practice nurses, school nurses) on the recognition and management of young people considered to be at risk of suicide.
- The National Health Committee has published *Guidelines on the Treatment and Management of Depression in Primary Health Care*. These guidelines are primarily intended for general medical practitioners to improve the recognition and treatment of depression at a primary health care level.

- A number of one-stop health shops, which provide integrated primary health care for young people, have recently been established around the country to provide youth-friendly and youth-appropriate services. Eight were in operation during 1997, with more being planned.

FAMILY, YOUTH AND SCHOOL

- Strengthening Families is an intersectoral initiative involving health, welfare, education and other social sectors. It has a significant work programme which aims to improve life outcomes for children at risk of poor outcomes, including improved health, better educational achievements, and a reduced incidence of persistent offending or abuse and neglect.
- The Ministry of Education has developed and released a draft curriculum on health and physical education. It will contribute to the positive mental wellbeing of students by helping them to develop the skills to: express their feelings; identify their emotions; and support themselves and others during times of stress, disappointment and loss. The curriculum requires schools to provide learning opportunities which: strengthen students' personal identity and self-worth; promote tolerance, inclusiveness and non-discriminatory practices; enhance relationships; and help students recognise and respond to situations of abuse and harassment.
- Guidelines on the recognition and management of young people at risk of suicide are being published by the Ministry of Education and the National Health Committee. The next phase, training for guidance counsellors and teachers, will begin in June 1998.
- The Health Funding Authority has purchased training for teachers on Mental Health Matters, a mental health awareness curriculum for secondary schools which began implementation in May 1997 and will cover 250 schools by the end of 1998.
- The Mental Health Foundation has published *Young People and Depression* (funded by the Health Funding Authority), a resource for people who work with youth (such as school guidance counsellors, teachers, youth workers, and TOPS tutors). Training on this resource will begin shortly.
- The Ministry of Health has published *Healthy Schools – Kura Waiora, Health Promotion Guidelines for Schools*, which includes guidelines on mental health, and has been distributed to all schools.
- The Specialist Education Services provide assistance to educational facilities (early childhood, schools, and tertiary) with the management of traumatic incidents. This can involve:
  – immediate assistance with student and staff management issues
  – immediate assistance with postvention (and prevention of further suicides)
  – analysis of organisational and personal risk
  – development of a management plan on which the partnership for recovery can be based
  – immediate assistance with issues of organisational continuance (where a staff member has been involved).
- Police and Telecom have recognised that bullying can be a significant contributing factor in youth suicide and launched a national campaign in July 1997, providing practical advice and resources for young people and caregivers. This includes a website, 0800 helpline, leaflets, a free video and community workshops.
- By giving children the skills to protect themselves and be confident in getting help, Police education programmes such as DARE and Keeping Ourselves Safe help young people deal with stress and other precursors of suicide. An important outcome of these programmes is positive family interaction and support for young people.

- The Ministry of Youth Affairs is producing information for parents, caregivers, and young people on the identification of, appropriate response to, and referral of, young people considered to be at risk of suicide.

STAFF AND TRAINING

- The New Zealand Children, Young Persons and their Families Service (CYPFS) has:
  – issued guidelines to staff on the recognition of suicidal behaviour and identification
  – issued guidelines to staff on the recognition of depression in young people
  – other ongoing work in the development of strategies to address the needs of young people displaying suicidal behaviour. For example a screening tool for assessing suicide risk is being developed by the Risk Estimation System project.
- Training for staff on suicide assessment and the recognition of depression has been developed by CYPFS Training Units. CYPFS Training Units have also developed a debriefing training package for staff involved in critical incidents, such as the death (including suicide) of a child or young person known to the Service.
- The Ministry of Youth Affairs and the Department of Internal Affairs are working together to look at skills of community-based youth workers with young people with suicide risk.

CUSTODIAL SAFETY

- Police have implemented a custodial suicide prevention training package for all staff. This includes a 'Prisoner Management Assessment Form' that ensures all persons in custody, including young people, are assessed for risk of suicide. Following a major review of cell environments, modifications were made to cells in some stations and a suicide-resistant cell installed in all 24-hour stations. Districts have also been reviewed to ensure they have sufficient suicide-resistant cells.
- The Department of Corrections trains prison officers in the identification and management of suicidal inmates and has procedures for identifying and monitoring at-risk inmates, including 'safe' cell designs to minimise opportunities for self-harm.
- The Department of Corrections has established a project to implement recommendations arising from its joint work with Te Puni Kōkiri on Māori suicide.
- The Public Prisons Service has circulated a training module on 'Cultural Aspects of Whakamomori (Suicide)', prepared by the Cultural Development Advisor at Auckland Prison. The module touches on the background of suicide in Māoridom, symptoms of suicide among Māori, reasons for suicide and managing 'at-risk' inmates, and provides information on finding cultural assistance to deal with 'at-risk' Māori inmates.
- 'Post incident support teams' are being provided in all prison institutions and include the provision of support to other inmates in the event of a suicide.

MEDIA

- The Ministries of Health and Youth Affairs are working with key media groups on the ways they report or depict suicide, to reduce the potential for imitation. A guide for reporters and commentators, *Preventing Suicide – guidelines for the media on the reporting of suicide*, has been published and distributed.

RESEARCH

- The Ministry of Health is identifying current gaps in research on youth suicide.

RECORDING OF SUICIDE

- Te Puni Kōkiri and the Ministries of Health and Pacific Island Affairs will report to Ministers on mechanisms to improve accuracy of ethnicity data on suicide.
- The New Zealand Health Information Service has improved the timeliness of the collation of annual youth suicide data, to make it available earlier.

EXAMPLES OF GOVERNMENT ACTIONS: LINKAGE WITH THE STRATEGY

GOALS	ONE Promoting Wellbeing						TWO Early Identification and Help						THREE Crisis Support and Treatment					FOUR Support after a Suicide				FIVE Information and Research			
Objectives	1	2	3	4	5	6	1	2	3	4	5	6	1	2	3	4	5	1	2	3	4	1	2	3	4
Expansion of mental health services										●			●	●	●	●	●	●							
Mental health service guidelines for clinical assessment of patient risk													●	●	●	●	●								
Strengthening Families	●																								
Depression guidelines		●	●				●	●	●																
Young People and Depression, resource		●	●				●	●	●																
One-stop shops		●	●							●			●												
Campaign to counter discrimination against mental illness		●	●																						
Primary health care provider guidelines		●	●				●	●	●	●			●	●	●										
Draft health and physical education curriculum		●	●		●	●		●	●																
School guidelines		●					●	●	●				●		●										
Specialist Education Services traumatic incident intervention																		●	●	●					
Mental Health Matters, curriculum		●	●				●	●	●																
Healthy Schools	●	●	●	●	●	●			●																
Anti-bullying campaign		●	●	●		●																			
DARE		●		●	●																				
Keeping Ourselves Safe		●		●		●																			

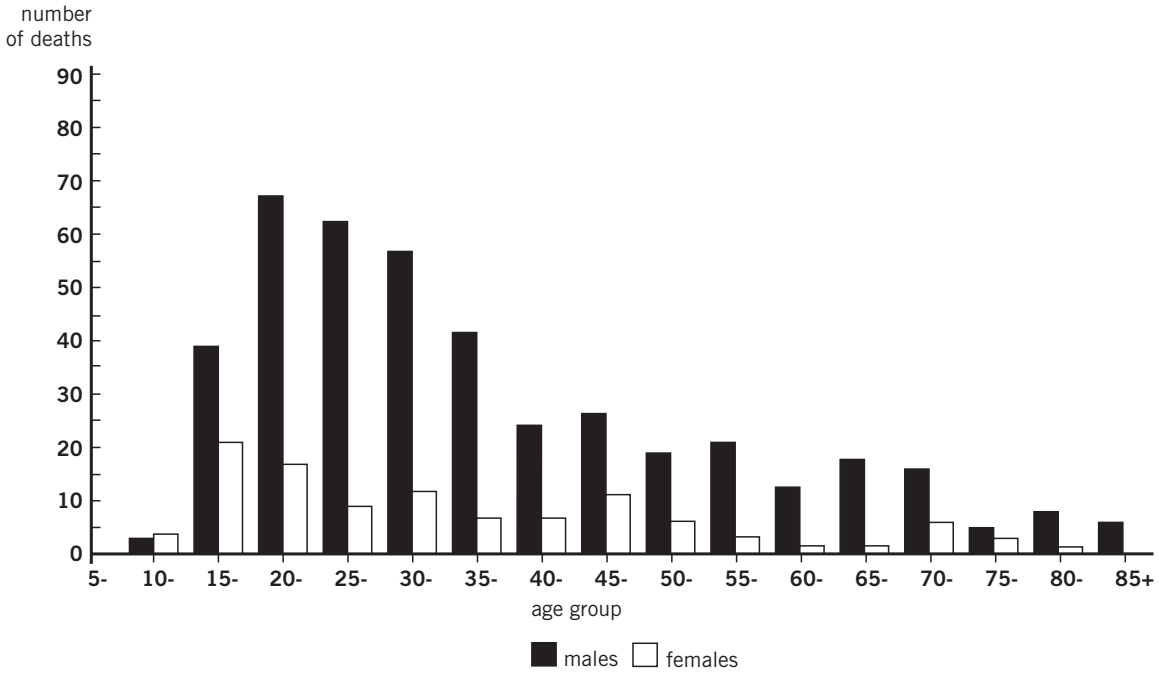
GOALS	ONE Promoting Wellbeing						TWO Early Identification and Help						THREE Crisis Support and Treatment					FOUR Support after Suicide				FIVE Information and Research			
Objectives	1	2	3	4	5	6	1	2	3	4	5	6	1	2	3	4	5	1	2	3	4	1	2	3	4
Information for parents and caregivers on suicide prevention	●	●						●			●														
Information for young people on suicide prevention		●	●					●																	
CYPFS staff guidelines on suicide risk identification							●	●			●						●	●	●						
CYPFS staff guidelines on depression identification							●	●		●															
CYPFS screening tool for assessing suicide risk							●	●																	
Community youth worker training	●	●	●	●	●	●	●	●	●									●	●	●					
Police custodial suicide prevention staff training package							●	●			●						●		●						
Police cell modification											●														
Prison officer training in identification and management of suicidal inmates							●	●			●						●		●						
Prison cell modification											●														
Post-incident support for inmates																		●	●						
Special programmes and training to prevent Māori inmate suicides							●	●			●								●						
Media guidelines on safe reporting												●									●				
Identification of gaps in research																						●	●	●	●
Improvement of reporting ethnicity data																									●

APPENDIX B

YOUTH SUICIDE STATISTICS: A SUMMARY

In New Zealand, youth[1] are over-represented in the suicide statistics compared to all other age groups. In 1996, youth suicide deaths (ages 15–24 years) represented 27% of total suicide deaths, while this group made up only 15% of the total population. Of the 541 individuals who died from suicide in 1996, 144 were aged 15–24 years. Figure 1 shows that the peak in male suicide deaths was 20–24 years, closely followed by the age group 25–29 years. The peak in female suicide deaths in 1996 was 15–19 years, compared to 20–24 years in 1995.

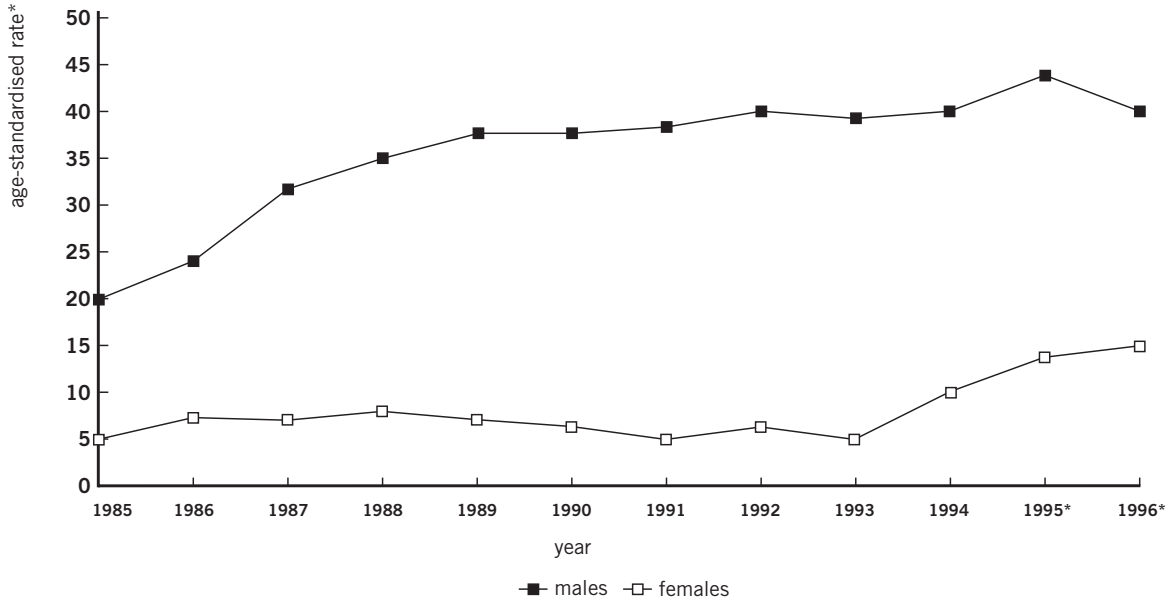
FIGURE 1: AGE OF SUICIDE DEATHS, TOTAL POPULATION, 1996



[NB: 1996 data provisional.]

[1] *'Youth' is defined in these statistics as persons aged 15–24 years. This is consistent with the definition used by the World Health Organization.*

FIGURE 2: YOUTH SUICIDE DEATHS, 1985-96

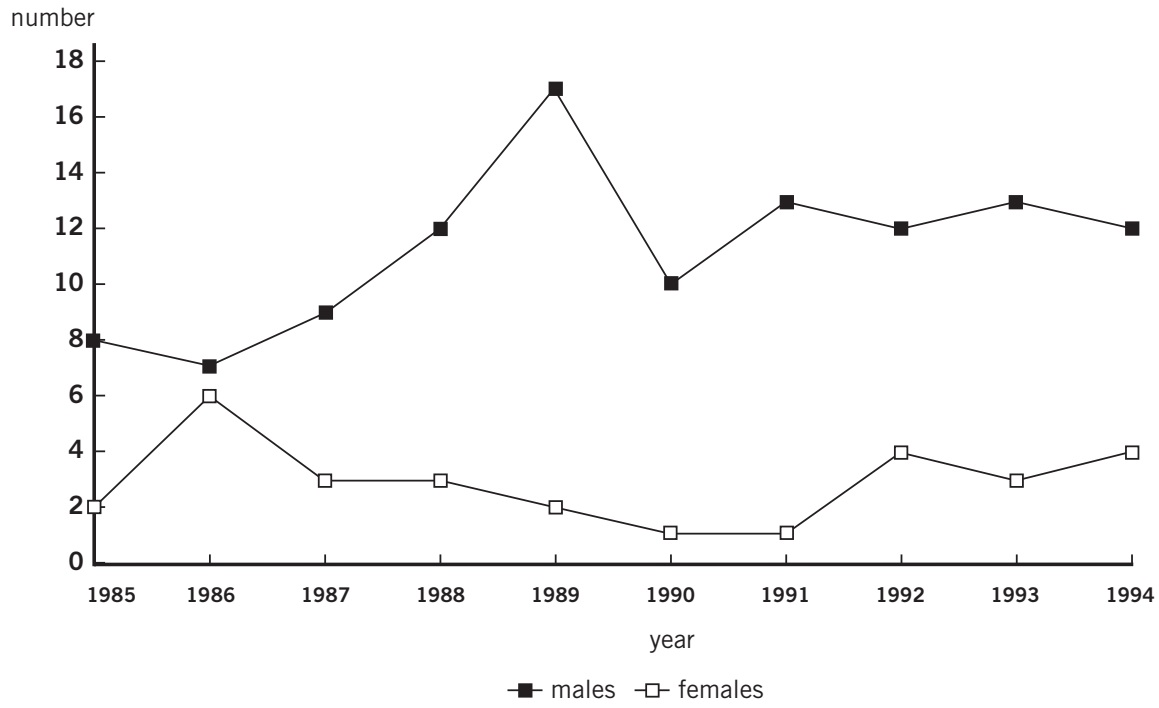


[NB: 1995 and 1996 data provisional.]

Figure 2 illustrates youth suicide trends from 1985 to 1996. Over this period the annual rate of suicide has increased from 12.6 deaths per 100,000 population in 1985, to 26.9 deaths per 100,000 population in 1996. Male and female suicide death rates have more than doubled from 1985 to 1996. Male suicide deaths have increased from a rate of 19.6 per 100,000 population in 1985 to 39.5 per 100,000 population in 1996. Female suicide deaths have increased from 5.1 per 100,000 population in 1985 to 14.3 per 100,000 population in 1996.

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

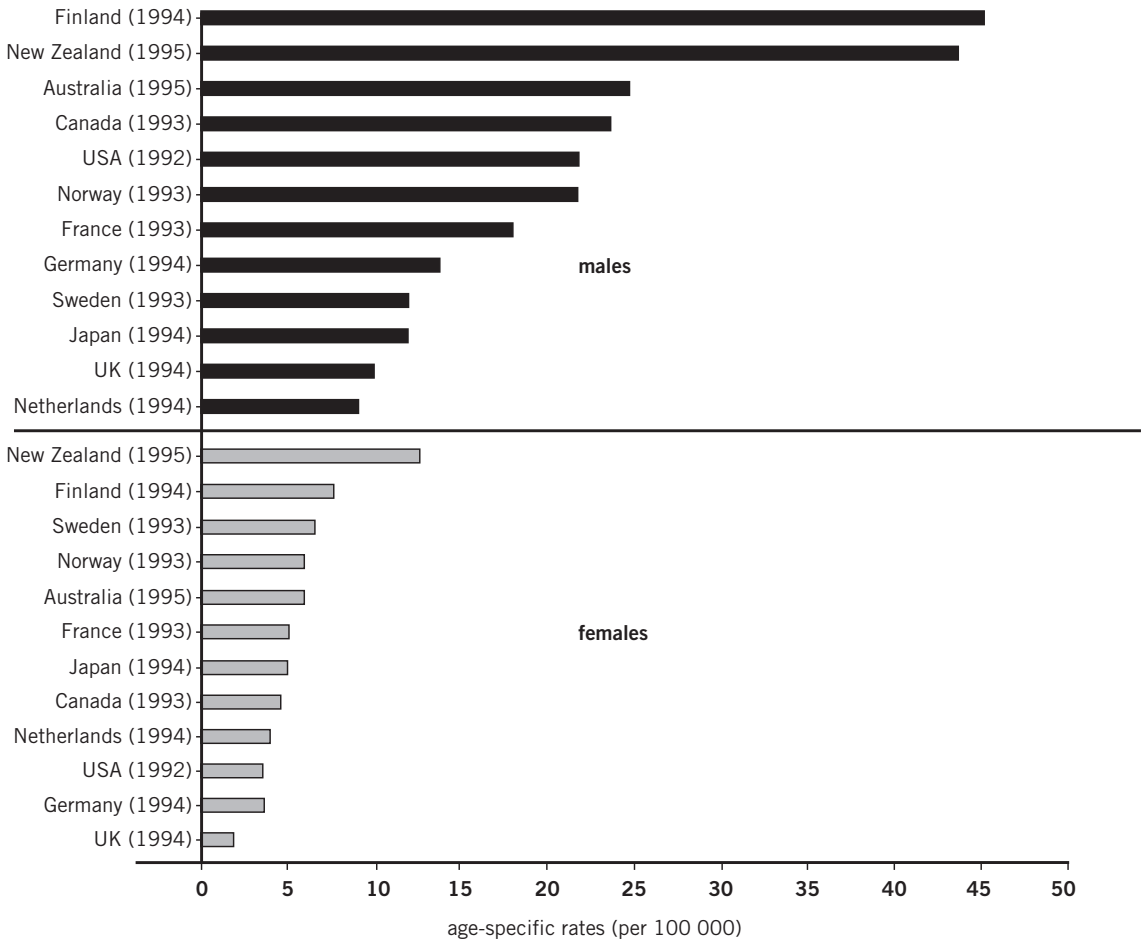
FIGURE 3: MĀORI YOUTH SUICIDE, 1985-94



Māori data for 1995 and 1996 is not presented on this graph as it is not comparable to earlier years. In September 1995, the recording of ethnicity was changed from a system based on the biological concept (50% or more ancestry) to one of self-identification. Because of this change, 1995 data is not comparable to any other year, and a new time series begins in 1996.

In 1996 a total of 38 Māori aged 15-24 years died by suicide. Of this number nine were females and 29 were males. The overall rate for young Māori was 38.4 per 100,000. The rate for Māori females in the age group was 17.8, and for Māori males was 59.6. It should be noted that the figures for 1996 cannot be accurately compared with the figures for previous years.

FIGURE 4: YOUTH SUICIDE RATES (AGES 15-24) COMPARISON WITH SELECTED OECD COUNTRIES



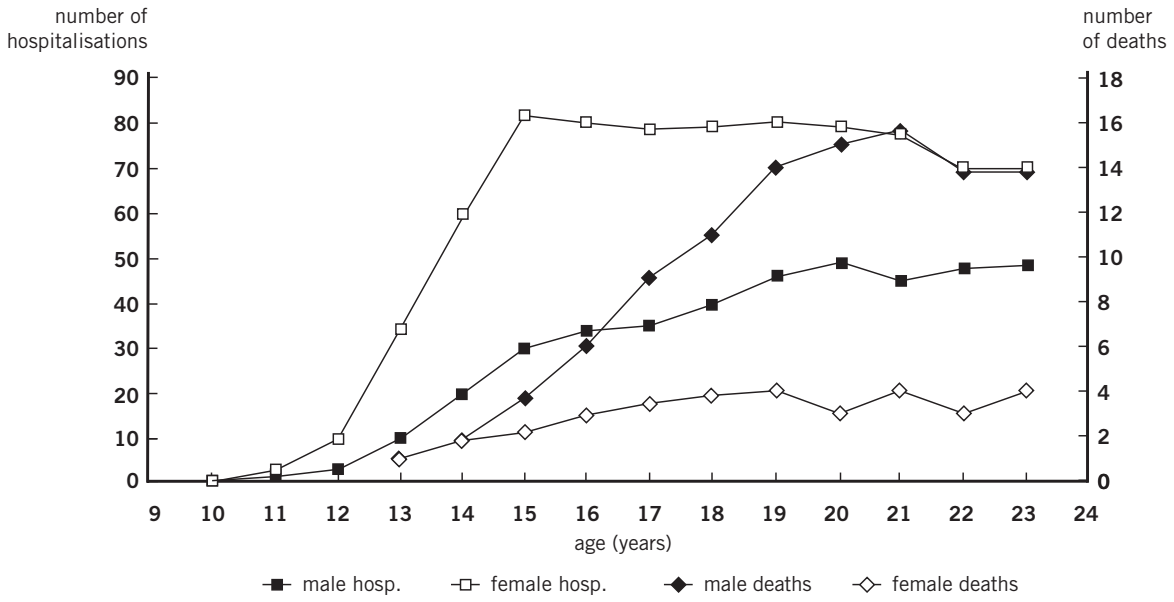
[NB: 1996 data not available.]

Figure 4 compares the youth suicide rates of selected OECD countries. In New Zealand, the male youth suicide rate in 1995 was 44.1 per 100,000 and the rate for female youth suicide was 12.8 per 100,000. Data is not available from many countries for 1995 so direct comparison is difficult. However, on the basis of the available data, New Zealand's ranking in 1995 may be the highest.

Comparing international rates of suicide is inherently problematic given that different methods are used to classify suicide and that the classification of suicide is, to some degree, culturally determined. Evidence used by coroners to help them decide whether or not a death is due to a suicide may also vary, leading to classification differences[2].

[2] *Barwick H. Youth Suicide Prevention Project: Workshop Report and Literature Review, Wellington. Ministry of Health.*

FIGURE 5: YOUTH SUICIDE HOSPITALISATIONS AND DEATHS, 1995 AND 1996, MOVING AVERAGE



[NB: 1995 and 1996 data provisional.]

Males have a higher rate of completed suicide, increasing at 18-19 years, with a peak at 22 years. However females have a much higher rate of hospitalisation for self-inflicted injury for all ages from 15-24 years. Figure 5 illustrates this trend. Research has shown that a sizeable proportion of young people may contemplate suicide, and about 5% of young people attempt suicide. Most attempts are relatively minor, neither requiring hospital treatment nor resulting in death.

** Hospitalisations in this graph refer to public hospital day patient and inpatient treatments only. Outpatient (accident and emergency) treatments are not included.*

TABLE 1: PACIFIC ISLAND YOUTH SUICIDE DEATHS

Year	Females	Males	Total
1985	0	1	1
1986	0	0	0
1987	1	2	3
1988	0	3	3
1989	0	2	2
1990	0	2	2
1991	0	6	6
1992	1	2	3
1993	0	2	2
1994	0	5	5

Pacific Island data for 1995 and 1996 is not presented on this graph as it is not comparable to earlier years. In September 1995, the recording of ethnicity was changed from a system based on the biological concept (50% or more ancestry) to one of self-identification with up to three ethnic groups. Because of this change, 1995 data is not comparable to any other year. A new time series for recording ethnic data begins in 1996. A total of four 15–24 year old male Pacific young people, and no females, died by suicide during 1996. The numbers of Pacific youth suicides are very small in statistical terms. Extreme caution should be exercised in drawing conclusions from the trend comparisons.

REFERENCES:

[1] *New Zealand Health Information Service (1997). Youth Suicide Statistics for the Period 1991-95.*

[2] *New Zealand Health Information Service (1997). Suicide Trends in New Zealand 1974-94.*

3 New Zealand Health Information Service (1997) unpublished mortality data for 1996.

APPENDIX C

SUICIDE PREVENTION: THE RESEARCH EVIDENCE

As part of the development of the National Youth Suicide Prevention Strategy, Dr Annette Beautrais, Principal Investigator of the Canterbury Suicide Project, was contracted to provide a review of the evidence of the suicide prevention initiatives in *In Our Hands.* This included an examination of both New Zealand and international research.

She concluded that, "...these (*In Our Hands*) policies are well founded on the available research evidence, are theoretically justified, and are consistent with expert opinion contained within major reviews of youthful suicidal behaviour, and with international approaches to suicide prevention."

Below is a summarised extract from her review paper *A Review of Evidence – the National Youth Suicide Prevention Strategy*, which highlights the major approaches of suicide prevention. The full paper is available from the Ministry of Health.

1 IMPROVEMENTS IN MENTAL HEALTH EDUCATION AND AWARENESS, TREATMENT AND MANAGEMENT

Research has found that one of the strongest indicators of suicidal behaviour is psychiatric disorder, and particularly depressive disorder and substance use disorder. Effective policies in the area of youth suicide prevention therefore need to focus upon the prevention, treatment and management of psychiatric disorder in young people.

- Research evidence strongly suggests that the majority of young people who make serious suicide attempts or who die by suicide have at least one mental disorder at the time of their attempt, while a significant proportion have more than one disorder.
- Most commonly, these are depressive disorders, substance use disorders (including alcohol, cannabis and other drug abuse or dependency) and anti-social behaviours (including conduct disorder and offending behaviours).
- Improved mental health education, services and care for young people with mental disorders may reduce the population of young people with disorders with which suicidal behaviour is associated.
- There is strong agreement on the need to provide education and training programmes for professionals who have contact with young people, to enable them to better identify, refer, treat and manage young people at risk of a range of mental health disorders and of suicidal behaviour.
- Strong support generally exists for education programmes about youth suicide prevention for teachers, allied school professionals, and parents. However the provision of school-based suicide prevention programmes specifically for students is contentious. There are suggestions that these programmes may have harmful effects among young people by normalising the concept of suicide. Given these reservations, most reviews recommend incorporating general mental health issues into school curricula, rather than teaching suicide-specific programmes to students.
- Young people who have made suicide attempts, those recently discharged from a psychiatric hospital, and young people with psychotic disorders are at high risk of suicide. These groups may be relatively easily identified and targeted with suicide prevention initiatives developed especially for their needs.

Within the broad area of improvements in mental health education and services, a range of strategies may be proposed. These include:

- promotion of positive mental health among young people
- professional mental health education and community mental health awareness programmes
- the development of mental health services appropriate for young people
- the provision of crisis services and best practice models of mental health services for suicidal young people
- the development of postvention guidelines and bereavement and support services following a suicide.

While there are few well-evaluated models of mental health education training programmes for professionals, positive mental health programmes for young people, postvention procedures, mental health care delivery programmes or crisis services for young people, there is strong theoretical argument for developing programmes in these areas, as significant suicide prevention initiatives.

2 FAMILY SUPPORT AND EARLY INTERVENTION PROGRAMMES

Research evidence consistently suggests that young people with suicidal behaviour frequently come from socially disadvantaged and dysfunctional family environments. This suggests there is a need for a family support policy which aims to provide long-term support to high-risk families in which children might be at risk of developing a range of adjustment problems.

- The aims of early intervention with high-risk families are not confined to suicide prevention, but span a broad series of goals relating to improving the health, social wellbeing and life opportunities for children in these families.
- Early intervention with high-risk families may reduce the number of children exposed to dysfunctional and compromised childhood environments, with a consequent reduction in the number of young people at risk of adolescent mental health problems and suicidal behaviour.
- This proposal involves implementation of a long-term strategy whose benefits could not be evaluated for a period of two to three decades.
- Early intervention is a promising approach which is theoretically well supported but, as yet, not proven.

3 MAJOR SOCIAL CHANGES, INCLUDING SOCIAL EQUITY, AND PUBLICITY ISSUES ABOUT SUICIDE

i) Development of policies to reduce social inequities

Research evidence suggests that young people with suicidal behaviour are frequently characterised by social, educational and economic disadvantage. Policies which aim to provide more equitable opportunities for education and employment may reduce the risk of childhood and adolescent adjustment difficulties and mental health problems which are associated with suicidal behaviour in young people. While there is no research evidence to demonstrate that changes in social equity, by themselves, will reduce youth suicide rates, such changes may provide a social context in which the potential benefits of other, more targeted approaches to suicide prevention might have the best opportunity to succeed.

ii) Publicity and media issues

The aim of this policy is to provide support for the careful, prudent and muted reporting of suicide issues in the media. There is consistent evidence that vulnerable individuals may imitate suicidal behaviour after

fictional, documentary or news reports of suicidal behaviour. Frequent publicity about suicide may also increase risk of suicide by 'normalising' the concept of suicide in the population, so that the taboo which has previously surrounded suicide may be lessened, and suicide may be more widely perceived as a socially acceptable option for people under stress.

- Publicity about suicide may contribute to suicide contagion and the development of suicide clusters among young people.
- Preventing Suicide – guidelines for the media on the reporting of suicide, which deals with more cautious reporting of suicide, has been published by the Ministry of Health.
- A negotiated, co-operative approach between suicide researchers, prevention agencies and journalists is most likely to be successful in achieving more careful reporting of suicide issues.
- The cautions which apply to reporting non-fictional suicide issues also apply to the fictional or dramatic portrayal of suicide in television, plays or movies.

To be effective, major social programmes, including improved social equity and reduced publicity about suicide, would need to be applied to large populations for a long duration. It is likely that their contribution to reducing suicide rates would only be assessed after several decades, since they would be in place at the same time as a range of other, more specific, interventions. However, the lack of opportunity for evaluation should not discourage the implementation of policies which appear theoretically justified and which remain desirable social goals.

4 RESTRICTION OF ACCESS TO MEANS OF SUICIDE

There are frequent suggestions that restricting access to particular means of suicide should result in a reduction in suicide rates. However there is no clear evidence that restricting access to particular means of suicide will result in a reduction in the rate of suicide by that method, and in the overall suicide rate.

- Potentially useful limitations to means of suicide include: restricting access to firearms; limiting the quantities of medicine which may be purchased or dispensed at one time; modifying car exhaust systems.
- The value of restricting access to various methods of suicide may vary across cultures and countries, depending upon the availability of particular methods.
- As methods of suicide may change over time, intervention strategies may need to be reviewed.

5 IMPROVED STATISTICAL INFORMATION AND RESEARCH ABOUT SUICIDE ISSUES

There is a need for continued and further research into a range of issues related to suicidal behaviour and suicide prevention, and for the dissemination of research findings.

- There is a well-acknowledged need for accurate, timely, systematic data collection for suicide and attempted suicide.
- While an extensive research base now exists about risk factors for suicidal behaviour, there is a need for continuing research. Some areas which merit further research include: further exploration of risk factors for suicidal behaviour in both Māori and non-Māori youth; research into suicide clusters and contagion; and research into the impact of population-wide changes including, for example, legislative changes, health services reorganisation and the restriction of access to means of suicide.

- The need for all intervention and prevention programmes to be systematically and appropriately evaluated is consistently emphasised as a research priority.
- There is an ongoing need for reviews of risk factors for suicidal behaviour, and of approaches to suicide prevention, which are regularly updated.
- Consideration should be given to the formation of an expert committee at a national level to oversee research priorities, evaluation of preventative approaches, and the development of best practice guidelines.

APPENDIX D
HISTORY AND DEVELOPMENT

The National Youth Suicide Prevention Strategy has been developed by a secretariat led by the Ministry of Youth Affairs, with key input from the Ministry of Health and Te Puni Kōkiri. This is supported by a Māori Reference Group, an expert group and a steering group made up of officials from relevant government agencies.

Two reports were commissioned to inform the approach and provide evidence on the Strategy. *A Review of Evidence: In Our Hands – the New Zealand Youth Suicide Prevention Strategy* by Annette Beautrais examines the evidence behind the approaches in *In Our Hands*. This report is available from the Ministry of Health. The second report, *A Review of Evidence: Kia Piki te Ora o te Taitamariki – the New Zealand Youth Suicide Prevention Strategy for New Zealand,* was written by Keri Lawson-Te Aho and provides the basis for the strategy for the prevention of Māori youth suicide. This report is available from Te Puni Kōkiri.

In September 1997 a discussion paper was distributed to seek feedback on the development of the National Strategy. Over 3000 copies of this paper, titled *An Approach for Action – Part Two in the development of a National Strategy to help prevent youth suicide* were sent to community groups, health services and individuals. Consultation meetings, discussion groups and hui were held around New Zealand to seek feedback, and 134 written submissions were received. (A list of those who made submissions is found in Appendix E.)

This process identified priority areas to address and confirmed the general approach taken in the discussion document. It also highlighted the need for government and non-government sectors to work together in a co-ordinated way.

The Strategy builds upon the 1994 *Report and Recommendations of the Steering Group on Youth Mental Health and Suicide Prevention* which made recommendations to 13 government agencies to reduce the rate of youth suicide. This report had a lifespan of three years and is now superseded by the National Youth Suicide Prevention Strategy, and annual implementation plans for the Strategy.

Maori Reference Group members:

Keri Lawson-Te Aho
Maire Kipa
Adrian Te Patu
Dr Erihana Ryan
Grant Berghan
Wiki Walker
Maehe-Cherie Tipene
Phyllis Tangitu
Arawhetu Peretini

APPENDIX E

SUBMISSIONS, COMMUNITY MEETINGS AND HUI ON

An Approach for Action: Part Two in the development of a national strategy to help prevent youth suicide

Submission No.	Name of Organisation / Respondent
1	Youthline Wellington Inc, Wellington
2	COOL (Collective of Older Lesbians), Christchurch
3	Nga Kaimahi O Te Po, Sexual Health Education Services, Wellington
4	Brian Sweeney, Mental Health Unit, Whangarei Area Hospital, Whangarei
5	GLEE (Gays and Lesbians Everywhere in Education), Wellington
6	National Health Committee, National Advisory Committee on Health and Disability, Wellington
7	Manawatu District Safer Community Council, Feilding
8	Robin and Paul Grimstone, Bereaved by Suicide Support Group, Palmerston North
9	Samaritans of Wellington Inc, Wellington
10	National President, The Boys Brigade New Zealand, Whangarei
11	Mr A. J. Lisle, Levin
12	Ascent, Dunedin
13	Mrs Zella F. Vile, Blenheim
14	YWCA of Aotearoa-New Zealand, Wellington
15	Maree Hudson (sent by Email)
16	Paul A. van Eybergen, Whangarei
17	Cher Hunt, New Plymouth
18	Māori Mental Health Development, Central Health, a Division of the Transitional Health Authority, Wellington
19	The Hillary Commission for Sport, Fitness and Leisure, Wellington
20	Robert Maunsell, Greenmeadows Medical and Health, Napier
21	Sue Hickey, Waikato Students' Union, Hamilton
22	Dr Tom Flewett, Wellington
23	New Zealand School of Meditation, Auckland
24	Health Cities Co-ordinator, City Environment Group, Hutt City Council, Lower Hutt
25	Mrs Zella F. Vile, Blenheim (second submission, see 13)
26	Polytechnic Marlborough, Blenheim
27	Whitianga Community Resource Centre, Whitianga
28	Graeme Jackson, Project Hope Hawkes Bay, Hastings
29	Dr N. J. Pritchard, Napier
30	Community and Social Policy Division, Hutt City Council, Lower Hutt
31	Counties/Manukau Health Council, Manukau City Council, Manukau City
32	Kevin Baston, Feilding
33	Rape Crisis National Office, Wellington
34	Youth Resource Centre, Hamilton
35	New Zealand Association for Adolescent Health & Development, Nelson
36	Mental Health Division, North Health, a Division of the Transitional Health Authority, Auckland
37	Wellington Gay Welfare Group, Wellington

Submission No.	Name of Organisation / Respondent
38	Cathy McGachie, Palmerston North
39	New Zealand AIDS Foundation, Auckland
40	Otago Youth Wellness Trust, Dunedin
41	Graham McEwen, Cheviot
42	Sylvia Huitson, New Plymouth
43	David Barr Thompson, Auckland
44	Taranaki Pride Alliance, New Plymouth
45	Women's Christian Temperance Union, Blenheim
46	Injury Prevention Research Centre, Department of Community Health, Faculty of Medicine and Health Science, University of Auckland, Auckland
47	The Royal New Zealand College of General Practitioners, Wellington
48	error (no submission)
49	Simon Wilson, Wellington
50	Māori Health Promotion, Public Health Service, Healthcare Otago, Dunedin
51	Mental Health Foundation of New Zealand, Auckland
52	Public Health Service, Healthcare Otago, Dunedin
53	Family Planning Association, Wellington
54	Allen Cookson, Oxford
55	Specialist Education Services, Wellington
56	Whenua Iti Outdoor Pursuits Centre, Upper Moutere
57	Education Department, University of Canterbury
58	Glenn Ashworth and Marianne Gray, Nelson
59	Healthy City Committee, Waitakere City Council, Waitakere City
60	Jenny Campbell, Mossburn
61	Emmanuel Productions, Auckland
62	Crown Public Health, Christchurch
63	Child Advocacy Trust (The Children's Agenda), Auckland
64	Dannevirke Community Groups
65	error (no submission)
66	Scripture Union of NZ, Wellington
67	Making Waves, Public Health Service, Porirua
68	Loto Fale, Pacific Islands Services, Mental Health, Auckland Healthcare Services, Auckland
69	Public Health Nurse (Adolescent Team), Healthcare Otago, Wakari Hospital, Dunedin
70	Bisexual, Lesbian and Gay Group, Canterbury University Students' Association, Christchurch
71	Caring Support Trust (CST/SCATT), Auckland
72	Presbyterian Support Services (Central), Wellington
73	Palmerston North Women's Health Collective, Palmerston North
74	Department of Corrections, Wellington
75	National Ambulance Officers' Training School, Health Studies Faculty, Auckland Institute of Technology
76	The Salvation Army, Whangarei Corps, Whangarei
77	Clive Aspin, Research Fellow, Māori Health, Department of Public Health, Wellington School of Medicine, Wellington
78	Project K Trust, Auckland

79	Specialist Youth Service, Mental Health Services, Manukau City
80	Youth Public Health Nurses, Double One Public Health, MidCentral Health, Palmerston North
81	Central Health, a Division of the Transitional Health Authority, Wellington
82	Community Child, Adolescent and Family Services, Mental Health Services, Auckland Healthcare Services, Auckland
83	The Parent Link Project, The Parent Link Trust, Christchurch
84	Social Policy Agency, Department of Social Welfare, Wellington
85	Association of Proprietors of Integrated Schools, Wellington
86	Group Manager, Māori, Ministry of Education, Wellington
87	National Council of Women of New Zealand, Wellington
88	Child Development Foundation of New Zealand, Auckland
89	Te Korowai Hauora O Hauraki, Thames
90	Dr Lloyd Hudson, Napier
91	Youthline, Auckland
92	Midland Health, a Division of the Transitional Health Authority
93	Brainteaser Publications, Hamilton
94	John Connell, Rotorua
95	Urban Vision, Wellington
96	Paul and Annette Smolenski, Katikati
97	EDEN (Eating Difficulties Education Network), Auckland
98	Keith Newman, Neil Hannan, Jacqui FitzGerald, Waitakere City
99	Community Health, Health Care Hawkes Bay, Napier
100	Manukau - The Healthy City, Manukau City Council, Manukau
101	The Salvation Army, Territorial Headquarters, Wellington
102	Naenae College, Lower Hutt
103	Mrs Fran Wilhelm, Invercargill
104	ATET, Riwaka
105	Te Ngako Community Mental Health Centre, Lakeland Health Services Rotorua
106	Local Government and Community Policy, Department of Internal Affairs, Wellington
107	Ros McCrealie, Dunedin
108	I.J. Benseman, Tauranga
109	Injury Prevention Research Unit, Department of Preventative and Social Medicine, Dunedin School of Medicine, University of Otago, Dunedin
110	Sylvia Turner, Child, Adolescent and Family Mental Health Service, Healthcare Otago, Dunedin
111	Dr Louis S. Leyland, Jr, Department of Psychology, University of Otago, Dunedin
112	Child and Adolescent Health Community Team, Taranaki Healthcare Ltd, New Plymouth
113	Children, Young Persons and their Families Service, Department of Social Welfare, Wellington
114	Gerald Moonen, Lower Hutt
115	Befrienders International, Wellington
116	Derek Cone, JP, Roxburgh
117	Leigh Miller, Auckland
118	Commonwealth Press Union, New Zealand Section, Wellington

Submission No.	Name of Organisation / Respondent
119	Aotearoa Legalise Cannabis Party, Wellington Branch, Wellington
120	Mr Robin Duff, Christchurch
121	Public Health Students of PUBH 702, Department of Preventative & Social Medicine, Otago Medical School, University of Otago, Dunedin
122	Alcohol Healthwatch, Auckland
123	National Council of YMCAs of New Zealand, Wellington
124	Galaxies (The Lesbian, Gay and Bisexual Christian Community of Wellington) Inc., Wellington
125	Legal and Parliamentary Director, The Women's Christian Temperance Union (Inc.), Levin
126	The Salvation Army, Whangarei (second submission)
127	The New Zealand Association of Counsellors, Hamilton
128	Kevin Hague, Waiheke Island
129	Manukau - The Healthy City, Manukau City Council, Manukau (second submission, see 100)
130	Institute for Child Protection Studies, Hamilton
131	UniQ, Victoria University, Wellington
132	Ministry of Education, Wellington
133	Michael Wallmannsberger and Damian McLeod, Auckland
134 - 136	error (no submissions)
137	Rick Stevenson, Auckland
138	New Zealand Organisation for Moral Education, Tauranga
139	The Phobic Trust of New Zealand Inc. 1983, Auckland

<u>Community forums were held in:</u>

Palmerston North	Manukau
Auckland	Whangārei
Gisborne	Nelson
Christchurch	Invercargill

<u>Pacific Islands forums were held in:</u>

Otahuhu
Christchurch

<u>Hui were held in:</u>

Whangārei
Auckland
Whakatāne
Whanganui
Christchurch

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