Suicide prevention research programme

A summary of results and their implications

November 2012
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Executive Summary

The Suicide Prevention Research Fund was managed by Te Pou between 2008 and 2012. The fund was established by the Ministry of Health in 2007 to help address gaps in New Zealand research on suicide and self-harm. The following 11 projects were completed. Details of authors, methods, key findings and recommendations can be found in the appendix to this report.

1. **Reporting of suicide in New Zealand media - a content analysis**
   A content analysis of media reporting of suicide behaviour in New Zealand was undertaken, including the type, content and quality of reporting in newspaper, broadcasting, television and internet excerpts published within a 12-month period. Five case studies were examined in depth to explore aspects of media coverage. The study found that the overall quality of reporting was above average using a scoring system developed by Pirkus et al (2001), and met the requirements of the Coroners Act 2006.

2. **Youth ’07: The Health and Wellbeing of Secondary School Students in New Zealand**
   This study compiled and analysed information about the prevalence of mental illness, suicidal thoughts and behaviours of over 9000 secondary school students from the Youth 2000 and Youth 2007 surveys. The researchers concluded that while most young people in New Zealand have good mental health, suicidal thoughts and behaviours are not uncommon, especially amongst young women, young people from low socio-economic communities, those who abuse drugs and alcohol, those with depression or mental health disorders, and those attracted to the same or both sexes.

3. **Evaluation of Phase 2 of the self-harm and suicide prevention collaborative**
   This study evaluated the process and impact of Phase Two of the NZGG Self-harm and Suicide Prevention Collaborative – Whakawhanaungatanga. The collaborative was designed to improve care for people at risk of self-harm and suicide by mental health services, including Māori health and mental health services and emergency departments. Fourteen district health boards participated in Phase 2 of the collaborative. The researchers concluded that the collaborative had worked well and good progress had been made during Phase 2 against most targets. However there was less progress on providing follow-up for people at risk of self-harm or suicide.

4. **Pilot study of Dialectical Behaviour Therapy for young people with self-harm**
   Field trials suggest that dialectical behaviour therapy (DBT) may be effective for reducing self-harm in adolescents; however no randomised controlled trials have been published on the effectiveness of DBT with this population. This small-scale pilot study sought to evaluate the acceptability of DBT treatment and of research participation by New Zealand families with adolescents experiencing self-harm. Overall the findings suggest that DBT was acceptable to the adolescents, families and clinicians involved in the treatment. Recommendations were made in relation to a future full-scale study.

5. **The role of dynamic family factors in the development and management of suicidal risk in young people**
   This project identified characteristics which differentiate families who cope well with the threat or loss of suicide from those who do not. Participants were recruited from families of people who had died by or attempted suicide, families who had a member attending a mental health clinic and families without experience of mental illness. The results suggest that social and health providers can strengthen family resilience against suicide risk by helping family members enhance their communication skills, improving access to information on mental health and suicide risk, supporting problem-solving and emphasising the importance of shared activities for families.
6. Geospatial mapping of suicide and suicide attempt clusters in New Zealand
This study used the recently developed statistical technique of geospatial mapping to estimate the extent of suicide clusters in NZ and explore whether geographic, demographic or social deprivation characteristics were associated with suicide clusters. The findings suggest that suicide clusters are not as common as thought, accounting for only 1.3 per cent of all suicides over the 18-year period covered (1990-2007). Clustering was found to affect people of all ages, with only half of those identified being under the age of 25 years. Public education needs to provide more accurate information about clusters.

7. In the balance - Pro-suicide and support material located by New Zealand-based web searches
This study extends an earlier UK-based study (Biddle, Donovan, Hawton, Kapur & Gunnell, 2008) from a New Zealand perspective. The aims were: to describe the presence of suicide method-related content revealed by NZ-based searches; to describe the balance between pro-suicide and suicide support websites accessed by the searches; and to characterise the content of suicide-related websites accessible from NZ. The authors identified that only a few of the NZ-based sites were pro-suicide, and suggested that search engine optimisation could be used to increase the likelihood that suicidal people access helpful rather than potentially harmful information.

8. Media influences on suicidal behaviour
This project investigated how the media may influence the occurrence of deliberate self-harm. Detailed information was collected on possible mechanisms of media influence on self-harm through structured interviews with 71 young people aged 12-25 years who had a history of intentional self-harm. The study found that TV, movies, the internet and music were the most common source of media portrayal of suicidal behaviours. While .27 participants had access suicide-related material from websites, few reported using the internet to meet others who self-harm. The internet and mobile phones were rare first sources of knowledge about suicidal behaviours, and were more likely to be used for information and social support.

9. Analysis of suicide methods and locations
Information on approximately 1000 suicide deaths was analysed to examine the frequency of methods (cause of death) and types of location, and determine whether common methods and locations differ across age, sex and ethnicity. The study also examined whether trends in methods used and location changed between 2005/2006 and 1997/1998. This findings support the development of policies and other strategies that reduce access to suicide means.

10. Report to inform the provision of mental health promotion and prevention services to gay, lesbian, bisexual, transgender and intersex populations in New Zealand
This needs assessment on mental health promotion and prevention services for gay, lesbian, bisexual, transgender and intersex (GLBTL) populations in NZ includes a review of evidence, a description of existing services and programmes and identification of gaps in service provision. There is convincing international evidence that GLBTL individuals experience higher levels of mental health distress than their hetero-sexual counterparts. Few specialist services were found, and mainstream mental health services need to be more acceptable to GLBTL. Poor access to counselling services was a major concern.

11. Review and update of suicide prevention guidelines for schools
Existing suicide prevention guidelines for schools were reviewed and updated. The guidelines update was informed by stakeholder consultation, a literature review, and consultation with teachers on the updated (draft) guidelines. The researchers produced a guideline which is being completed by the Ministry of Education, and a literature review aimed at school stakeholder audiences.
Introduction

The Suicide Prevention Research Fund was established by the Ministry of Health in 2007 to help address gaps in New Zealand research on suicide and self-harm, and inform ongoing development of the Ministry’s 2006 Suicide Prevention Strategy and the related Action Plan (2007). The suicide prevention research programme was identified as part of suicide prevention funding in Budget 2007.

The suicide prevention research funding aligned with one of the New Zealand Health Strategy’s objectives of reducing suicide, and also with *Te Tāhuhu – Improving Mental Health 2005-2015: The Second New Zealand Mental Health and Addiction Plan* (Ministry of Health, 2005).

One-off funding of $1.5 million was allocated to the fund covering the period 2008–2010, and this was managed by Te Pou under contract to the Ministry. The funds were used for 11 research and feasibility studies on the causes, correlations and nature of suicidal behaviours, and the implementation and effectiveness of suicide prevention interventions.

Individual research projects were contracted via a Request for Proposal (RFP) process and selections were made by independent panels. The research fund targeted small scale evaluation and research and feasibility studies, to ensure suicide prevention approaches were based on the best available research and relevant to the New Zealand context.
The research programme implications

The research summarised below can be accessed on the Te Pou website, with the exception of the school guidelines, which are with the Ministry of Education for completion, and the school guideline evidence review which is awaiting final peer review.

1. Reporting of suicide in New Zealand media - a content analysis

*Brian McKenna, Katey Thom, Gareth Edwards, Raymond Nairn, Anthony O’Brien, Ingrid Leary.*

This study investigated media reporting of suicide behaviour in New Zealand. The researchers produced a description of the type, content and quality of reporting in newspaper, broadcasting, television and internet excerpts published in a 12-month period. Five case studies were examined in further depth.

**Implications for policy, future research and service delivery**

Findings of the study had implications for the review of the Ministry of Health’s media guideline *Suicide and the Media* (Ministry of Health, 1999). The 1999 guidelines were seen to be very general and highly subjective in places, and there were instances where the project team had difficulty understanding exactly what a reporter should or should not report when considering a suicide event. To enhance the quality of reporting on suicide, it was recommended that media guidelines take into account both the requirements of different media and the practicality of the guidelines in the daily practices of journalists. This was especially important in attempts to have media perform an educative and health promoting role. Media items could be easily modified to include basic contact information and help-seeking advice. Better interaction between the media and mental health professionals was needed to increase mental health literacy and links to support services in the reporting of suicide. Such interaction must recognise the professional and commercial culture that shapes media performance.

2. Youth '07: The Health and Wellbeing of Secondary School Students in New Zealand

*Simon Denny, Terry Fleming, Peter Watson, Shanthi Ameratunga, Elizabeth Robinson, Jennifer Utter, Terryann Clark, Robyn Dixon, Sue Crengle, Sally Merry, David Schaaf.*

This study compiled and analysed information about the prevalence of mental illness, suicidal thoughts and behaviours of over 9000 secondary school students from the Youth 2000 and Youth 2007 surveys. Prevalence rates were calculated for emotional well-being, depression and anxiety symptoms, behavioural problems, mental health services access, deliberate self-harm, suicidal thoughts and behaviours, and incidence of death from suicide by a friend or family member for the group of young people who participated in the survey.

**Implications for policy, future research and service delivery**

The report itself provides a good summary of information about the mental health status of young New Zealanders which will inform policy, future research and service delivery in many ways. The report also provides
a good summary of the issues that need to be taken into account for planning and delivering youth services and informing suicide prevention policy for young people, and makes a number of recommendations:

**For schools, communities and families:**

- Provide safe and supportive environments for all young people and especially those from at-risk groups.
- Take any threat of suicide seriously and get professional advice for any young person considering suicide. However, be aware that it may be difficult for them to be seen by mental health services. It may be necessary to seek advice from a school guidance counsellor or a GP in the first instance.
- Ensure that young people who are down or depressed receive the support they need to deal with their difficulties and concerns.
- Schools and community organisations should have a policy for following up incidents involving suicide or suicide behaviour.

**For health services that provide care for young people:**

- Ensure services are accessible to young people.
- Ensure providers have the necessary knowledge and skills to engage with young people and make good assessments of their emotional health.
- Ensure service has plans and procedures to effectively manage young people who disclose suicidal behaviours.

**For mental health services and providers of suicide prevention services:**

- Ensure the service is accessible for young people, particularly those at higher risk of suicide.
- Ensure that everyone approaching the service with concerns about the safety of young people get help or helpful information, even if the case is not of sufficiently high risk to be seen by the team.

**For policy-makers:**

- Ensure that clear evidence-based guidelines are available to guide suicide prevention activities.
- Ensure that communities are able to access advice or help for young people who are distressed or suicidal, either from mental health services if they meet their criteria, or if not, from other agencies.

One of the most important factors which support the healthy emotional development of young people is having at least one parent who cares a lot about them. Young people need the support of adults in their families and government policies should be family-friendly across all areas of government activity.

### 3. Evaluation of Phase 2 of the self-harm and suicide prevention collaborative

*Julian King, Kataraina Pipi, Gareth Edwards, Michelle Moss*

This study evaluated the process and impact of Phase Two of the NZGG Self-harm and Suicide Prevention Collaborative – Whakawhanaungatanga. The collaborative was designed to improve care for people at risk of
Implications for policy, future research and service delivery

The NZGG Self-harm and Suicide Prevention Collaborative – Whakawhanaungatanga was established to improve crisis care in emergency departments, Māori health, Māori mental health and mental health services in a way that recognised local situations, people and resources, and built on the 2003 guideline *The Assessment and Management of People at Risk of Suicide* (NZGG and Ministry of Health, 2003). This evaluation demonstrated that the collaborative had made significant progress in improving the quality of services for people at risk of suicide in these settings.

However Ministry of Health funding for the collaborative was not continued after March 2011. A certain amount of organisational change was described in the report as having “become part of standard practice” in the way emergency departments and other agencies managed self-harm and suicide risk. However the report indicated that the target relating to follow-up was not as well supported by DHBs. Without support from the NZGG implementation team, this change was unlikely to be sustained. Without any further evaluation it would not be possible to see whether the changes that did appear to be sustainable will in fact continue to be in place. Without national support, service quality is likely to become more varied between DHBs, relying on individual ‘champions’ at a local level. This will have a particular relevance to young people, who have higher rates than other age groups to be presenting at emergency departments following self-harm or a suicide attempt¹. In 2008, 15-19 year olds had the highest rate of hospitalisations for self-harm (118.1 per 100,000) of any age group, followed by 20-24 year olds at a rate of 106.3 (Ministry of Health, 2010). Individuals who have been hospitalised for self-harm are at very high risk for suicide. Effective care and follow-up support for this group is essential in preventing suicides and further hospitalisations for suicide attempts.

A follow-up evaluation is advisable, to establish whether changes brought about by the collaboration project to improve the quality of care and health outcomes of people at risk of self-harm and suicide, have been sustained.

4. Pilot study of Dialectical Behaviour Therapy for young people with self-harm

*Emily Cooney, Kirsten Davis, Pania Thompson, Joanna Stewart.*

Field trials suggest that dialectical behaviour therapy (DBT) may be effective for reducing self-harm in adolescents; however no randomised controlled trials had been published on the effectiveness of DBT with this population. This small-scale pilot study sought to evaluate the acceptability of DBT treatment and of research participation by New Zealand families with adolescents experiencing self-harm. Overall the study findings suggest that DBT was acceptable to the adolescents, families and clinicians involved in the treatment.

Implications for policy, future research and service delivery

The following comments were not made in the report itself, but have been drawn from the findings.

¹ Self-harm hospitalisations are a proxy for suicide attempt in New Zealand.
Psychological interventions are recommended as a first-line treatment for depression in children and young people (NICE 2010, NZGG 2008). There is strong evidence for effectiveness with cognitive behaviour therapy (CBT), interpersonal therapy, and shorter-term family therapy and these are recommended by NICE for moderate to severe depression. New Zealand guidelines also recommend structured problem-solving therapy (PST) for young people with depression, and PST is mentioned in the NICE guideline on managing self-harm in secondary care (Guideline 133, NICE 2011). There is less evidence or discussion in the literature for the use of dialectical behavioural therapy (DBT).

DBT has been used in Auckland at the Kari Centre (ADHB child and adolescent mental health service) for the previous five years, and is relatively well-established in New Zealand. This study does not attempt to assess the effectiveness of DBT as a treatment for young people assessed at risk of suicide, but rather its acceptability to the young people, their families, and the clinicians. A primary aim of the research was to undertake preliminary work to inform a more comprehensive evaluation of DBT. However the study does show that DBT was at least as acceptable as other forms of treatment, which indicates that it was found to be helpful. The study identifies research that shows DBT has promise as a treatment for high-risk adolescents, while noting that there is a paucity of research on treatment for suicidal and self-harm behaviours in adolescents generally. Small numbers (self-harm is statistically rare) and difficulties with control conditions have hampered research efforts to date.

The study provides six recommendations for a full-scale randomised study of DBT for self-harming adolescents.

5. The role of dynamic family factors in the development and management of suicidal risk in young people

John Fitzgerald, Karma Gayler, Phillipa Thomas and Gavin Whiu.

This project identified characteristics which differentiate families who cope well with the threat or loss of suicide from those who do not. Participants were recruited from families of people who had died by or attempted suicide, families who had a member attending a mental health clinic and families without experience of mental illness.

The study found that family relationships were defined in terms of how people felt about each other, and the responsibilities they had to each other, rather than biological or legal ties. Effective communication is a critical component of effective coping, particularly in supporting conflict resolution and joint problem-solving. Problem-solving resources and courses may assist families make the minor adjustments that are often required.

Families at risk, or those that are in a chronic state of challenge and stress, may require more extensive family support. This may include support to identify and use their strengths in a flexible way, explore barriers to compromise, accept diversity or change, and avoid common (and less common) problem-solving dead ends.

Families wanted more information about depression, suicide and trauma. They believed they would have been able to mitigate risk more effectively if they had known what to look out for, including the signs and symptoms of depression, the most common warning signs of suicidal thought and behaviour, and how to recognise a trauma response.
Implications for service delivery

The results of this study suggest that social and health providers can strengthen family resilience against suicide risk by helping family members enhance their communication skills, improving access to information on mental health and suicide risk, supporting problem-solving and emphasising the importance of shared activities for families.

6. Geospatial mapping of suicide and suicide attempt clusters in New Zealand

Annette Beautrais, Gregory Larkin.

International research suggests that suicide clusters may be more common in certain groups. This study used the recently developed statistical technique of geospatial mapping to estimate the extent of suicide clusters and explore whether geographic, demographic or social deprivation characteristics were associated with suicide clusters.

The data challenges the common assumption that suicide clusters exclusively or predominantly involve teenagers or young people (under the age of 25). Although young people accounted for about half of cluster membership, the remaining half of the cluster decedents were aged 25 years and older. It is likely that framing suicide clusters as a phenomenon only of youth has resulted in under-counting both the number of clusters and the number of people involved in clusters. Far from being a homogeneous group of vulnerable and impressionable young people, those at risk of copycat suicide likely represent a number of distinctly different groups which have yet to be well-defined.

GIS modeling identified 15 distinct suicide clusters from 1990 to 2007 in NZ. The 122 decedents included accounted for 1.3 per cent of all suicides during the 18-year study period.

Implications for policy, future research and service delivery

The researchers found that accurate information was needed to counter public misperceptions about the age of cluster participants, and to inform professional and community efforts to interrupt and intervene in ongoing suicide clusters, particularly to identify and assist vulnerable individuals.

The findings suggest that suicide clusters occur rarely and account for only a small minority of total suicides. Suicide clusters tend to grab media headlines which may lead to the incorrect conclusion that clusters are more common than, in fact, they are. In turn, this misperception may influence vulnerable individuals who may view suicide as a reasonable option when circumstances dictate. Education about suicide clusters for the public, press and health professionals should convey accurate information, specifically, that suicide clusters are rare and account for a small minority of all the suicides that occur.

There are concerns that suicide clusters may be increasing, partly because of the changing nature of modern communications technology, dominated increasingly by social media. These findings suggest there is a strong need to invest further in research exploring the social relationships and contexts that surround not only the decedents in clusters, but the communities in which clusters occur. Further studies of suicide clusters should include resources for media monitoring in order to examine relationships between intensity of media reporting of suicide and cluster size and location.
The extent to which echo clusters represent distinct events which are temporally but not spatially demarcated, or whether they are linked in some way by some personal and/or community relationship of elevated suicide risk which are manifested as repeated suicide clusters, is another question identified for further research. Echo cluster sites may be targets for development of community suicide prevention plans.

Further GIS research was needed to conduct ‘sensitivity’ analyses to examine the extent to which cluster solutions vary with the stringency of cutting point criteria, and explore the application and utility of geospatial mapping of suicides at the regional or small local area level, in order to detect emerging suicide clusters.

New Zealand is possibly the only country which has developed a national postvention support service to respond to suicide clusters. More research was needed to explore the extent to which this service may be able to use geospatial mapping techniques to objectively identify emerging suicide clusters in time to intervene and interrupt clusters.

The coronial database, in its current form, was seen to provide a limited resource for the research opportunities that follow from these studies. A need was identified to develop a new system and structure for coronial data collection that includes comprehensive demographic, psychiatric, social and media information.

7. In the balance - Pro-suicide and support material located by New Zealand-based web searches

Sunny Collings, Sarah Fortune and Keith Hawton.

This study extended an earlier UK-based study (Biddle, Donovan, Hawton, Kapur & Gunnell, 2008) from a New Zealand perspective. The aims were: to describe the presence of suicide method-related content revealed by New Zealand-based searches; to describe the balance between pro-suicide and suicide support websites accessed by the searches; and to characterise the content of suicide-related websites accessible from NZ.

Implications for policy and service delivery

The report documents strong evidence that some styles of media reporting may foster suicide among vulnerable people, through contagion effects and by normalising suicide as a possible response to adversity. Given that at least 78 per cent of New Zealanders use the internet, suicide prevention activities focusing on the safe portrayal of suicidal behaviour must acknowledge not only the reporting by New Zealand’s news media, but also the content and quality of websites created and hosted around the world.

The role of the internet in suicide and suicidal behaviours is not well understood. Some believe the internet facilitates and promotes suicide by offering dangerous information to vulnerable people, while an alternative view is that the internet can make helpful resources readily accessible. Online mental health services are becoming increasingly common, and online counselling and e-therapy is now commonly offered to adolescents and adults. Some see the internet as a particularly important resource for adolescents, as this age group prefers to seek help from informal sources. The report suggests that investment in well-designed, interactive, targeted,
search-engine-optimised support sites such as thelowdown help mitigate the visibility and effects of dedicated pro-suicide sites. The findings validate the approach being taken in NZ to web design and promotion, which argues for continued funding.

8. Media influences on suicidal behaviour

Sunny Collings, Sarah Fortune and Keith Hawton.

This project investigated how the media may influence the occurrence of deliberate self-harm. Detailed information was collected concerning media influence on self-harm, through structured interviews with people aged between 12 and 25 years who had a history of intentional self-harm. The results can be used to inform the development of policies and interventions to limit negative, and support positive effects of web-based media, and inform the development of media guidelines on reporting suicide.

Implications for policy, future research and service delivery

The results of this study have particular implications for media guidelines. Participants strongly felt that media had a key role to play in self-harm prevention, and identified a number of ways that media could help. They asked for clearer warnings on TV programmes and movies that contained disturbing materials and those who found that the images and media acted as triggers for their self-harm behaviour preferred that these were censored before being broadcast.

There was also a strong call for toning down the graphic nature of portrayals of suicide and self-harming in media. Participants also asked for safer reporting of suicides, including reducing the glorified ways celebrity self-harm and suicides were portrayed. They asked for better awareness and support campaigns so that young people were aware of different avenues for seeking help. Some asked for media to show the effects of self-harm and suicides on families; others wanted to see stories of people in recovery who had overcome self-harming. Those who create fictional material should be encouraged to consider the potential consequences for vulnerable young people.

The finding that young men plan self-harm more than young women, suggests the suicidal process differed between genders in the clinical sample. If this study was replicated it would present an opportunity for consideration of gender-specific interventions and approaches.

People have ready access to a wider range of media content on suicide and self-harm than ever before. Much of the content is not monitored or regulated. However, there are still opportunities for prevention through policies and programmes that support education and skill development among young people, so that they become better equipped to manage their use of and responses to such material and to seek help for themselves and their peers when appropriate. The media itself is also a relatively untapped source of potential suicide prevention activity. Young people prize their ready access to information and to diverse ways of social participation. Their level of engagement with media provides opportunities to develop innovative approaches to suicide prevention.

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2 Search engine optimization requires payment to ensure that when someone searches for ‘suicide’ or similar, the support website comes up as first choice. This approach has been in place for NDI websites since their establishment.
Participants saw their use of interactive-media-related technologies, such as mobile phones and the internet, as supports for themselves and others. Interactive technologies provide young people with opportunities for checking, gaining further information or feedback, or participating in a community, all of which are aspects that are clearly valued by young people, and which have great potential for prevention.

9. Analysis of suicide methods and locations
Sunny Collings, Barry Taylor.
This project investigated the frequency of different methods and locations in previous New Zealand suicides. Information on approximately 1000 suicide deaths was analysed to examine the frequency of methods (cause of death) and types of location, and determine whether common methods and locations differ across age, sex and ethnicity.

Implications for policy, future research and service delivery
It was noted that the Ministry of Health had completed a feasibility study looking at the possibility of establishing a suicide mortality review committee. Consideration should be given to how this could overlap with the functions of existing mortality review groups. The combination of existing mortality review groups, including the Child and Youth Mortality Review Committee, does not cover suicide over the lifespan.

As most suicides occur in people over the age of 25, and (in 2007) rates were highest among those 30-39 years of age, the report recommended the early development of an approach to all-ages suicide review and monitoring. A significant number of those who died, especially men, had experienced recent significant losses or life stressors, with the most common theme being relationship breakups, domestic violence and financial failure. High levels of emotional distress and impulsivity coupled with alcohol use appeared to be relevant in many of these.

In retrospect, early intervention to provide social support may have had the potential to avert some of these deaths. Because most people in these situations do not die by suicide, formulating advice for family/whānau was identified as a challenge, and likely to remain at the level of general community advice to actively support one another in times of distress, and to avoid alcohol as a strategy for coping with distressing feelings.
Family/whānau should be advised to take any mention of suicide or self-harm/suicide attempt seriously and seek appropriate help for the person. Where suicide risk is felt to be present (rather than general emotional distress), family/whānau can be advised to take more specific measures such as considering the safe storage of car keys, not keeping the car filled with petrol, removing ropes and/or keeping garages and sheds locked, and securely storing LPG bottles.

More consideration needs to be given to the most common method of suicide in New Zealand, hanging. Hanging in private dwellings is a major challenge of increasing importance for suicide prevention given that the proportion of deaths by hanging has increased.
10. Report to inform the provision of mental health promotion and prevention services to gay, lesbian, bisexual, transgender and intersex populations in New Zealand

Jeffery Adams, Pauline Dickinson, Lanuola Asiaiga, Tim McCreanor, Helen Moewaka Barnes.

This project resulted in a report on mental health promotion and prevention services for gay, lesbian, bisexual, transgender and intersex (GLBTI) populations in New Zealand. The report includes a review of the evidence, a description of existing services and programmes and identification of gaps in service provision. The literature review found strong evidence in both international and NZ studies that non-heterosexual populations are more at risk of suicide and mental health problems than the heterosexual population.

Implications for policy, future research and service delivery

There are implications for both policy and service development arising from this needs assessment. It is recognised that groups of protective and risk factors can be enhanced and reduced by interventions. Promising mental health promotion programmes are those that:

- Strengthen individual’s self-esteem, self-efficacy, life and coping skills, relationship and social connections
- Strengthen organisations to ensure environments are inclusive, safe and supportive
- Strengthen communities to increase social cohesion, social participation and inclusion
- Strengthen whole societies through interventions designed to counter stigma and discrimination and reduce inequalities.

Access to mental health services and the competency of mental health services were the two overarching issues for informants and respondents. Health service training and staff development relating to working with GLBTI people, especially within mental health services, is clearly a priority given the higher risk of suicidal behaviour within these populations.

11. Review and update of suicide prevention guidelines for schools and evidence review

Sunny Collings

Existing suicide prevention guidelines for schools were reviewed and updated. New evidence and services had emerged since the original guidelines were developed over 10 years ago. The guidelines update was informed by stakeholder consultation, a literature review, and consultation with teachers on the updated (draft) guidelines. A full guideline was finalised by the Ministry of Education based on the draft provided, and the evidence review which was aimed at school stakeholder audiences. The evidence review suggests a number of key aspects to successful suicide prevention, recognition and management of risk, and postvention in schools (see p. 36). The evidence also suggests that certain interventions are not generally recommended. These include:

- the use of screening instruments for the identification of young people at risk of suicide
- the use of peer support programmes focusing on suicide.
Appendix One: Te Pou suicide prevention research programme: a summary of results

Reporting of suicide in New Zealand media - a content analysis

Brian McKenna, Katey Thom, Gareth Edwards, Raymond Nairn, Anthony O’Brien, Ingrid Leary. June 2010

<table>
<thead>
<tr>
<th>Aims and methods</th>
<th>Results/key findings/recommendations</th>
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<tbody>
<tr>
<td>This study design was shaped significantly by the Media Monitoring Project undertaken by Pirkis et al (2001) for the Department of Health and Aged Care in Australia. Both quantitative and qualitative research methods were used to review radio, television, newspaper and internet mainstream news coverage of suicide. The quantitative arm of the study involved the undertaking of content analysis which aimed to:</td>
<td>The report provides the first comprehensive baseline picture of the extent and nature of the reporting of suicide by the New Zealand media. It also identifies differences between the professional culture of journalism and the health sector.</td>
</tr>
<tr>
<td>• Provide a descriptive account of the nature and extent of reporting of suicide by the New Zealand news media</td>
<td>The quantitative analysis found that the NZ news media report extensively on suicide, with a total of 3483 items extracted from a sample of print and broadcast media over the 12-month period. Overall the quality of reporting was above average using the scoring system developed in the Australian Media Monitoring Project (Pirkis et al., 2001). This paints a very different picture than much of the international literature that suggests most reporting on suicide is sensationalist (Gould, 2001; Gould &amp; Romer, 2003; Hawton &amp; William, 2001; Martin, 2004; Stack, 2000).</td>
</tr>
<tr>
<td>• Assess the alignment of news media items with the best practice standards for reporting set out in Ministry of Health guidelines (1999) and by the Coroners Act 2006</td>
<td>The nature of media reporting varied across media type and specific variables (content, demographic groups, methods of suicide etc). This was particularly noticeable in internet items, which were more likely to focus on events that took place in the United States, murder-suicides and the use of firearms as suicide methods. Some media items reflected the ‘official reality’ provided by NZ statistics on suicide. Males in the 25-44 age group are far more likely to complete suicide and these demographics featured prominently in the media items. However many items did not reflect the facts. For example, Māori are more likely than non-Māori to complete suicide, and this was not reflected in media items. The items also focussed on completed suicides when statistics indicate that the rates of attempted suicide and suicide ideation are higher. Most items portrayed suicide in a manner consistent with Ministry of Health guidelines. Few items were reported in such a way as to normalise suicide and few of the items</td>
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which focus on the reporting of suicide.

**Method**

Data comprised news media items collected over a 12-month period beginning 1 August 2008. A content analysis aimed at generating descriptive statistical data on the nature and extent of media reports of suicide.

A further analysis of a random sample of 10% of the applicable items was then conducted in order to measure the alignment of news media items against the Ministry of Health’s guidelines for reporting of suicide based on evidence-based standards of best practice reporting of suicide. Case studies were selected on the basis of available data, the degree of homogeneity/ heterogeneity, prominence of suicide in the items, the presence of illuminating examples and consideration to main focus stories and side stories. Framing analysis was used to provide more extensive descriptions of NZ media reporting of suicide and the factors that shape news selection and presentation.

referred the fact that a person who completed suicide was a celebrity or described the methods used to complete suicide in detail. Further, most items were located appropriately, did not use the word ‘suicide’ in the headline and did not include inappropriate footage of the suicide scene or methods. However the media did not appear to provide educational or help-seeking information when reporting suicide.

**Qualitative analysis** - common to all five case studies was the identification of one or more factors that enabled the media to construct a story out of an event that would not otherwise be newsworthy. Those additional factors framed the story, providing readers with an accessible interpretation of events that would otherwise remain inexplicable or uninteresting. Celebrities’ movements are closely followed by media, and in several stories their suicidal ideation resulted in news coverage. In some of the suicide-related online stories, the primary focus was technology, but suicide added a sense of threat to an otherwise mundane story.

The theme of preventability was used in different ways across the case studies. In the suicide online case study, preventability related to the management of the internet both technologically and behaviourally; whereas in the mental health services case study, preventable service failure was held responsible for suicides. Reports of the online stories minimised the role of the individuals’ mental health, in favour of an emphasis on technology, even though those individuals had previously been in contact with mental health clinicians. In contrast, the stories of service failure were written in ways that made the individual’s mental health central.

In general, the requirements of the Coroners Act 2006 were followed, though there were instances where a death was referred to as suicide in advance of a coroner’s inquiry.

Where experts were used as sources of opinion, they were usually cited in support of an existing framing of the story.
## Youth '07: The Health and Wellbeing of Secondary School Students in New Zealand

*Simon Denny, Terry Fleming, Peter Watson, Shanthi Ameratunga, Elizabeth Robinson, Jennifer Utter, Terryann Clark, Robyn Dixon, Sue Crengle, Sally Merry, David Schauf. June 2010*

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| This study analysed information about the prevalence of mental illness, suicidal thoughts and behaviours of a random sample of over 9000 secondary school students from the Youth 2000 and Youth 2007 surveys. The surveys were representative of young people attending mainstream secondary schools, but not necessarily all young people in New Zealand. Prevalence rates were calculated for emotional well-being, depression and anxiety symptoms, behavioural problems, mental health services access, deliberate self-harm, suicidal thoughts and behaviours and incidence of death from suicide by a friend or family member for the group of young people who participated in the survey. Prevalence rates were then analysed according to age, sex, ethnicity, socio-economic status, rural/urban location and 2001/2007 data. | In 2007 the students’ reports indicated that within the previous 12 months:  
- 26.0% of female students and 6.1% of male students had deliberately hurt themselves or done something they knew may have harmed or even killed them.  
- 19.4% of female students and 9.4% of male students had suicidal thoughts.  
- 11.5% of female students and 6.1% of male students made suicide plans.  
- 6.7% of female students and 2.9% of male students had attempted suicide.  
- Many young people who make a suicide attempt do so without spending much time thinking about it.  
- Of the students who reported a suicide attempt, 21.5% did not report having serious suicidal thoughts. |

### Gender differences
- Suicide behaviours, self-harm, depression and mental health difficulties were all higher in females than males.

### Ethnic differences
- Māori students were more likely than NZ European students to report suicidal thoughts (17.4% vs. 12.4%), suicide plans (11.1% vs. 7.4%) and suicide attempts (6.9% vs. 3.6%).
- Pacific students were more likely than NZ European students to report a suicide plan (10.8% vs. 7.4%) and suicide attempts (8.2% vs. 3.6%).
- Depressive symptoms were more common in Asian students (13.5%) than NZ European students (9.3%).

### Socio-economic differences
- The proportion who reported exposure to suicide behaviour was higher among students from low socio-economic neighbourhoods (17.9%) than students from high socio-economic neighbourhoods (12.3%).
- The proportion who reported suicide attempts was higher among students from low socio-economic neighbourhoods...
(6.8%) than among students from high socio-economic neighbourhoods (3.6%).

**Suicide behaviours - changes from 2001 to 2007**

- Suicide behaviours among secondary school students in New Zealand appear to have reduced. In 2001, of those students who had suicidal thoughts in the last 12 months, 4.7% of males and 10.5% of females reported making a suicide attempt; while in 2007, of all students, 2.9% of males and 6.7% of females reported making a suicide attempt in the last 12 months.
- Mental health of students appears to have improved. The proportion of male students reporting significant symptoms of depression decreased from 9.3% in 2001 to 6.9% in 2007 (females remained unchanged at around 15%).

**Mental health**

- 11.2% of female students and 7.6% of male students showed indications of an underlying mental health issue.
- 14.7% of female students and 6.9% of male students reported significant symptoms of depression.

**Psychological wellbeing**

- 50% of students had very good or excellent mental and emotional wellbeing, based on their scores on the WHO-5 Wellbeing Index.

**Other issues associated with mental health**

A number of risk and protective factors in the lives and circumstances of young people are known to be associated with mental health issues and suicide behaviours. This report looks at the prevalence of some of these factors from the 2007 survey:

- **Positive relationship with family:** 90.3% of students reported that at least one parent cared a lot about them.
- **Feeling safe at school:** 83.5% of students reported feeling safe at school all or most of the time.
- **Sexual abuse:** More than one in ten students (12.1%) reported some level of sexual abuse, with more female students (19.9%) than male students (5.4%) reporting sexual abuse.
- **High consumption of alcohol:** More than a third of students (34.3%) reported an episode of binge drinking in the previous month, with this proportion increasing dramatically with age.
- **Exposure to suicide:** 14.7% of students reported that someone among their friends or family had made a suicide attempt in the past 12 months.
• Being bullied regularly: 6.1% of students reported being bullied weekly or more often. Of these students, 8.8% of males and 21.5% of females reported making a suicide attempt in the last year - three times the reported rates among students who reported no bullying or infrequent bullying (2.5% of males and 5.9% of females).

Taken together, the results show that most young people in New Zealand have good mental health and wellbeing, and do not think about suicide or engage in any form of suicidal behaviour. However, these behaviours are not uncommon, especially among certain groups at particular risk.

Suicide behaviours are influenced by many factors – both the ‘risk factors’ that increase the likelihood that a young person will think about, plan or attempt suicide, and the ‘protective factors’ that decrease the likelihood of suicide behaviours. Given the many factors involved, suicide prevention requires a range of different approaches to reduce risk factors, enhance protective factors, provide clinical services for young people suffering from depression and distress, and reduce access to means of suicide.

Groups at particular risk are: young women, young people from low socio-economic communities, young people who abuse drugs and alcohol, young people with depression or mental health disorders, and young people attracted to the same or both sexes.

In the 2007 survey nearly a quarter of those students who reported a suicide attempt in 2007 did not report serious suicide thoughts. In light of this finding, suicide prevention strategies such as enhancing problem-solving skills among young people and reducing access to means of suicide are important.

Risk factors include: Mental health disorders – including high alcohol consumption, bullying, sexual abuse, family dysfunction and distress, and exposure to suicide attempts among friends and family.

Protective factors include: Mental and emotional wellbeing, good social skills, problem-solving abilities, positive engagement with school, family cohesiveness.
### Evaluation of Phase 2 of the self-harm and suicide prevention collaborative

**Julian King, Kataraina Pipi, Gareth Edwards, Michelle Moss, Russell Holmes. August 2010**

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<td>This study evaluated the process and impact of Phase Two of the NZGG Self-harm and Suicide Prevention Collaborative – Whakawhanaungatanga. The collaborative was designed to improve care for people at risk of self-harm and suicide by mental health services, including Māori health and mental health services and emergency departments. Fourteen district health boards participated in Phase 2 of the collaborative, including sustainability of changes, implementation quality and stakeholder satisfaction. It also outlines recommendations for how to improve and build on this work. The evaluation objectives were:</td>
<td>• By the end of Phase 2, project co-ordinators and their teams were positive about being part of the collaborative, and about the guidance, support and encouragement they were receiving from the NZGG team. • The collaborative was implemented in accordance with the NZGG’s intended methodology. • DHB project teams had made substantial progress towards achieving all four Phase 2 targets. 1. Almost all DHBs had implemented changes to meet the <strong>Access Target</strong> (to reduce emergency department waiting times for people at risk of self-harm or suicide). Initial mental health assessment was conducted with more confidence and consistency. 2. All DHBs were addressing the <strong>Assessment Target</strong> (aimed at ensuring psychosocial assessment, mental illness and risk screening, and cultural assessment are carried out for patients at risk of self-harm or suicide) through better communication between emergency department and mental health staff. 3. Progress was being made in meeting the <strong>Discharge Target</strong> (aimed at providing the patient and their family/whanau or significant other, as well as others involved in the person’s care with a written copy of their discharge plan). 4. There was less progress on the <strong>Follow-up Target</strong> (aimed at providing people at risk of self-harm or suicide with a follow-up appointment, and contacting those who do not attend that follow-up appointment) as developing processes for follow-up of non-attendances of services outside DHBs (eg GPs) was not a priority for many DHBs. However communications within DHB services had improved. • Stakeholders were confident that changes would be sustained as they had become part of standard practice for most DHBs. • Satisfaction amongst stakeholders was high, especially regarding the NZGG implementation team’s support, more effective relationships between DHB departments and the flexibility to find local solutions to issues that were encountered.</td>
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Feasibility of evaluating Dialectical Behaviour Therapy for self-harming adolescents

Emily Cooney, Kirsten Davis, Pania Thompson, Julie Wharewarewa-Mika, and Joanna Stewart.
August 2010

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<td>Field trials suggest that dialectical behaviour therapy (DBT) may be effective for reducing self-harm in adolescents; however no randomised controlled trials have been published on the effectiveness of DBT with this population. This small-scale pilot study sought to evaluate the acceptability of DBT treatment and of research participation by New Zealand families with adolescents experiencing self-harm. Early findings from the treatment phase of a planned 18-month study were described. The small randomised controlled trial examined the feasibility of comparing dialectical behaviour therapy (DBT) with treatment as usual (TAU) in two specialty mental health services for youth in the Waitemata region. The study aimed to answer three questions: 1. Is DBT an acceptable treatment for suicidal adolescents, their families and the clinicians providing DBT in NZ child and adolescent mental health services? 2. Is random assignment to one of two treatment conditions acceptable to adolescents, families and the services acting as research sites?</td>
<td>Overall the study findings suggest that DBT was acceptable to the adolescents, families and clinicians involved in the treatment. Findings were as follows: DBT was at least as acceptable to the adolescents, parents, caregivers and clinicians involved in the treatment as standard treatment within services. 93% of young people completed treatment, participants attended 91% of their scheduled individual therapy sessions, and 88% of their group sessions. These rates compared favourably with their counterparts receiving treatment as usual. Consumer-facilitated focus groups indicated that young people and caregivers were satisfied with the programme. Therapists responding to an anonymous survey indicated that while providing treatment within a RCT held significant challenges, on balance they had found it a positive experience. Assessment of therapist burnout, as measured by an adaptation of the Maslach Burnout Inventory, was hampered by missing data and therefore must be interpreted with caution. However, available Maslach Burnout Inventory data indicated that the emotional well-being of DBT therapists was within the normative range for mental health workers. • Families and TAU services accepted randomisation, 70% of the families referred to the study by their clinicians consented to take part. • Adherence checks of DBT sessions, conducted by raters within the treatment developer’s clinic, showed that acceptability was not at the expense of treatment fidelity. • Important lessons were learnt from parents and young people; specifically there was a need for an independent family worker to be built into the programme, to monitor communication between young people to avoid contagion, and to taper treatment endings more gradually. • Owing to high participant co-morbidity, the screens took much longer to administer than had been anticipated. The majority of participants completed the pre-treatment</td>
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3. Are the assessment measures acceptable and feasible?

Twenty-nine adolescents accepted for treatment in two outpatient general mental health clinics, who had a suicide attempt or history of self-injury in the previous 3 months, were randomly assigned to either uncontrolled TAU (n=15) or 6 months of DBT (n=14). DBT consisted of individual therapy, multi-family group skills training, individual parent or caregiver and family sessions as required, and telephone coaching for the adolescent and family. Sessions were coded for adherence to DBT by ‘expert raters’. Suicide attempts, self-injury episodes, suicidal ideation, substance use and ability to regulate emotions were assessed before, during and after treatment by an evaluator who was blind to treatment condition.

screens and assessments without difficulties. However, initial assessments were long and required substantial time and effort from participants and assessors. Researchers believed that the burden on participants was unacceptably high and not justified by the research value of the information gathered.

- Six recommendations were made for a full-scale study, as follows: (1) Recruitment of Māori and Pacific youth (2) Stratified randomisation (3) Sufficient resources to fund the involvement of a clinical trials unit (4) Alternative screens and assessment protocols (5) Incorporate the recommendations of families taking part in DBT (6) Evaluating the cost-effectiveness of DBT.
The role of dynamic family factors in the development and management of suicidal risk in young people

John Fitzgerald, Karma Gayler, Phillipa Thomas and Gavin Whiu. July 2010

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| The overall goal of the research was to develop a better understanding of the dynamic and proximal family factors that become relevant when a young family member is at risk of suicide. Of particular interest were the experiences of families who have faced this challenge. From their perspective, the researchers were interested in what family dynamics have the potential to mitigate suicide risk for a young person and to facilitate family resilience. Using a mixed-methodology design, data was collected from family/whānau of young people who had attempted or completed suicide. Families who had no such experiences were also included as a comparison. These groups provided the core research data through semi-structured interviews that explored family history and relationships, strengths, and coping in everyday life and within the context of suicidal risk and behaviour. Psychometric data was collected using a generic measure of psychological distress and a measure of family functioning. A second wave of data collection was undertaken. | Family strengths

Participants expressed an ideal where family members shared a special bond that enabled them to provide care and support for each other. It was not suggested that, on its own, having a strong family bond mitigates suicide risk. Instead the family bond, and the responsibility to care for family members that stems from it, were seen to be guiding principles that ground the operation of family dynamics. Two clear aspects to family strength were identified by families: contributions made by individuals within the family, and strengths that came from the patterns of interaction between family members. Strengths were often person- and context-specific, dynamic in nature, and included elements such as communication, caring, and an attitude of acceptance or forgiveness.

Family dynamics at times of crisis

Families were asked to comment on how their strengths were or were not relevant at the time that their young person was at risk of suicide. Not all family strengths that were evident prior to the young person being at risk, had a protective role in the period leading up to the suicide attempt or completion. Some of the strengths had been developed during the time of crisis.

Within the family group, there were individual differences in reactions to adversity. Some family members tended to withdraw, some initiated discussion about the problem at hand, while others tended to offer emotional or practical support. Individual differences were acknowledged by families, and often accepted as characteristic of the person concerned when the family wanted to engage in a joint coping process.

Facing a challenge together required communication between family members, which often proved to be very difficult at a time of crisis. Some families cited lack of communication as being problematic in the time leading up to a suicide attempt or a completed suicide. Families were often shocked by the event, and
could not immediately identify what could have led to such an extreme action. Some families had been in close contact, but had not talked about problems with their young person. Continuing to talk to each other, despite conflict, was part of being successful when the family was facing a challenge.

Participants whose family member had completed suicide emphasised the ongoing value of being able to talk openly about their loved one.

**General conclusions**

Family relationships were defined in terms of how people felt about each other, and the responsibilities they had to each other, rather than biological or legal ties.

Families need support in developing and maintaining effective communication skills. Young people may also benefit from special attention in this domain, as the most potent influence on developing communication skills can be peers rather than family or parents. Effective communication is a critical component of effective coping, particularly in supporting conflict resolution and joint problem-solving. Problem-solving resources and courses may assist families make the minor adjustments that are often required.

Families at risk, or those that are in a chronic state of challenge and stress, may require more extensive family support. This may include support to identify and use their strengths in a flexible way, explore barriers to compromise, accept diversity or change, and avoid common (and less common) problem-solving dead ends.

Families wanted more information about depression, suicide and trauma. They believed they would have been able to mitigate risk more effectively if they had known what to look out for, including the signs and symptoms of depression, the most common warning signs of suicidal thought and behaviour, and how to recognise a trauma response.
Geospatial mapping of suicide and suicide attempt clusters in New Zealand

Annette Beaudrais, Gregory Larkin. January 2012

Suicides that occur close together in time or space, beyond the rate that would normally be expected in a community, are often described as a 'suicide cluster'. The mechanisms that create, maintain and interrupt clusters, the characteristics of individuals who die as members of a cluster, and the identification of those most vulnerable to cluster suicide have rarely been studied using robust scientific approaches. While spatial analytic methods have been widely used in epidemiological and public health research, there are few examples of their application to the study of suicide.

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<td>Four studies were conducted to explore the phenomenon of suicide clusters. Goals were to apply geospatial mapping techniques to estimate the extent of clustering of suicides, describe the characteristics of decedents(^3) in clusters using existing data, explore time trends in suicide clusters, and identify at-risk sites and populations, which might justify specialised prevention efforts. A preliminary study of the unverified phenomenon of echo suicide clusters was included.</td>
<td>Findings are summarised for each study below.</td>
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**SUICIDE CLUSTERS REVIEW AND DEFINITION**

All studies of suicide clusters published between 1977 and 2009 in the scientific literature were systematically reviewed, to examine and clarify the definitions of a suicide cluster offered across the spectrum, from case reports to more statistically sound analyses of suicide clusters. There were 32 published studies of suicide clusters in the English language literature, an average of one per year. Of these, most were anecdotal reports of a single cluster, unverified by statistical testing and providing an inadequate empiric basis for the development of useful recommendations to address and interrupt suicide clusters. Regardless of the fact that most suicides in the world occur in Asia (Beaudrais 2006) no reports were found in English of suicide clusters occurring in the most populous countries, including China and India. The researchers’ understanding of suicide clusters was informed largely by English-speaking environments and risk factors. The scientific literature on suicide clusters was dominated by

\(^3\) Deceased person.
narrative reports of single noteworthy clusters. These reports typically included limited data, lacked comparative or control data from non-cluster cases, failed to generate operational definitions of suicide clusters and, in short, had limited generalisability. An operational definition of a suicide cluster was generated as a starting point for future analyses:

A suicide cluster is a series of three or more closely grouped deaths within three months that can be linked by space or social relationships. In the absence of transparent social connectedness, evidence of space and time linkages are required to define a candidate cluster. In the presence of a strong demonstrated social connection, only temporal significance is required. (Larkin, Beutrais, et al, 2011)

SUICIDE CLUSTERS IN CANTERBURY, NEW ZEALAND
A population-based study was conducted to determine the presence of statistically significant geographical clusters. A spatial scan statistic was used to identify purely spatial and space-time clusters of suicide deaths, in a coronial and research database of 918 suicide deaths recorded in the Canterbury region (population approximately 500,000), during the 18-year period from 1991–2008. Nine candidate clusters, involving a total of 43 individuals, were identified by SaTScan 8.0 (http://www.satscan.org).

Cluster deaths accounted for 4.7 per cent of all suicides. All clusters occurred within the greater Christchurch area. For a regional population of approximately 500,000 there was on average one cluster every 2 years. A striking finding was that decedents within individual clusters lived very close to each other. All members within each suicide cluster were located within circles of radii <2.5km, and no two temporally adjacent cases within a cluster had a time interval longer than four months. In two clusters, the three decedents in each cluster lived ≤ 1km from one another and died within about one month. Decedents in suicide clusters were significantly younger than non-cluster (singleton) decedents (p<.001). While index suicides were more likely than other cluster decedents to have experienced financial stresses preceding their deaths, there were no other significant psychosocial, socio-demographic or psychiatric differences between index suicides in a cluster and subsequent decedents in a cluster.

The study was limited to the aetiological factors that had been abstracted from coronial reports, and was thus subject to the limitations of these reports. To provide a resource for further research, it was suggested that routinely collected coronial data be expanded to include detailed information from multiple sources, including coroner’s and medical examiner’s records, law enforcement and medico-legal investigations following the death, autopsy and toxicology reports, death certificates and narrative fatality review team reports.
**SUICIDE CLUSTERS IN NEW ZEALAND**

The application of GIS analysis was extended to estimate the extent to which suicides cluster on a national scale. National official mortality and population data were obtained for the period 1990-2007. The case definition for suicide was decedents whose death certificates were coded X60–X84, Y87.0, Y10–Y34, or U03 of the International Classification of Disease, 10th Revision (ICD10), US version, or Codes E950–959 or E980–E989 of the International Classification of Disease, 9th Revision (ICD9). Residential addresses for suicide decedents were geocoded using Google maps. (Suicide cluster candidates were identified using SaTScan 8.0 (www.satscan.org) and a space-time permutation model.

GIS modelling identified 15 distinct suicide clusters from 1990 to 2007 in New Zealand. The 15 clusters included 122 decedents and accounted for 1.3 per cent of all suicides during the 18-year study period. The median number of decedents in each cluster was eight, and the median age of cluster decedents was 36 years. The mean cluster radius, defined as half the distance between the pair of suicides that were farthest apart within a cluster, was 3km. Suicide rates in suburbs in which the suicide clusters occurred were, on average, 160 times higher than the suicide rate in the surrounding non-cluster area. The median time span of a cluster was 61 days. The median time between adjacent suicides within a cluster ranged from 3 to 31 days.

**Differences between regional and national cluster solutions**

Cluster solutions for the Canterbury and New Zealand data appear inconsistent. Analysis of the Canterbury data identified nine clusters which account for 4.5 per cent of deaths, while analysis of national data identified 15 clusters accounting for 1.3 per cent of suicides, with only four of these clusters coming from Canterbury. These findings show that the solutions provided by GIS modelling methods are dependent on the data context in which these solutions were based: in-depth local data produce somewhat different results from broader national data because of a combination of the use of different sized databases, adjustment for multiple comparisons, and issues of statistical power.

**ECHO SUICIDE CLUSTERS IN NEW ZEALAND**

The NZ national mortality database of suicide deaths for the period 1990-2007, and time and time-space scans, were used to determine if suicide clusters tended to recur in the same location (echo clusters). The sensitivity of the scan was enhanced by analysing NZ national data in subsets of different geographic areas.

Spatial modelling identified nine distinct New Zealand locations in which nine initial and 10 echo suicide clusters occurred. At these sites, echo clusters occurred on average 7.6 years (range 1.2 to 16.9 years, median 4.7 years) after an initial cluster.

At one site, three distinct clusters occurred within an 8-year period. Further analyses of this data were recommended. The mechanisms of action are likely to include social learning by local exposure to suicide and media transmission of suicide information, coupled with incorporation of a reputation as a suicide site into the identity of the local community. Findings imply the need for careful, informed community postvention policies and management in the aftermath of a suicide, in order to minimise cluster recurrence.
In the balance - Pro-suicide and support material located by New Zealand-based web searches

Sunny Collings, Sarah Fortune and Keith Hawton. September 2010

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<td>This study extends an earlier UK-based study (Biddle, Donovan, Hawton, Kapur &amp; Gunnell, 2008) from a New Zealand perspective. The aims were:</td>
<td>A total of 2160 search results (hits) were evaluated, from 718 distinct sites. Academic and policy hits were the most common, with 21 per cent of hits. News reports on individual suicides, suicide attempts or other articles concerning suicide made up 12.8 per cent of hits. Grouping the three site categories that included pro-suicide or suicide-permissive messages, there were 263 hits, representing 14.8 per cent of all of the relevant or functioning hits. Of the chat rooms, 8.4 per cent featured pro-suicide comments from members, 20.5 per cent were hits on sites that encouraged suicide and 71.1 per cent were hits that provided in-depth information on suicide methods.</td>
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<td>• to describe the presence of suicide method-related content revealed by New Zealand-based searches;</td>
<td>Education sites displaying facts, statistics and definitions of suicide made up 11.3 per cent of hits. References to celebrity suicides, and fictional or other artistic portrayals, made up only 2.5 per cent of all relevant or functioning hits.</td>
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<td>• to describe the balance between pro-suicide and suicide support websites accessed by the searches; and</td>
<td>Chat rooms and online communities constituted 3.8 per cent of all hits, and the majority (91.5 per cent of chat room hits) of these focused on method. The remainder discussed general suicide issues.</td>
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<td>• to characterise the content of suicide-related websites accessible from New Zealand.</td>
<td>Overall, 36.4 per cent of the results were New Zealand-based. Of these 787 New Zealand-based hits, the second most common group was academic and policy at 32.4 per cent. News reports (9.5 per cent) and education sites (7.8 per cent) were the next most significant results. Support sites accounted for 4.8 per cent. Interactive sites represented 21 per cent of the hits. Of these, 29.3 per cent were pro-suicide, with the majority (94) of these pro-suicide hits giving information on method, 22 being chat rooms on methods exhibiting a pro-suicide stance, and 20 being static websites conveying pro-suicide messages. Among the 263 pro-suicide hits in the study, 51.7 per cent were interactive, (compared to only 7 per cent of 201 support hits that were interactive).</td>
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<td>A modified version of the method published by Biddle et al. (2008) was used. The three most popular search engines worldwide (Google, Yahoo, MSN) and three New Zealand engines (AltaVista, GoogleNZ and SearchNZ) were queried. All searches were carried out from New Zealand between November 2008 and January 2009. All were saved and re-run at least once during the 3-month period, for verification of categorisation by the first author (Associate Professor Sunny Collings) and</td>
<td>72 distinct sites appeared as the top result in at least one search.</td>
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checking for stability of site presence. The searches were carried out with all content filters turned off and using Biddle et al.’s search terms throughout.

In order to gain more information about the nature and extent of suicide method-related content, the first 30 results for each search were sampled, i.e. to a depth of the first three pages of search results. Initially the coding frame developed by Biddle et al was used. However, using an iterative process as they had done, it was extended during the early stages of the analysis, so that it represented the variety in the data. Our coding framework had 20 categories, modified and extended from Biddle et al.’s 14. Sites based in New Zealand (as evidenced by their .nz domain name) were searched, and interactive sites (defined as online communities and sites where users can post comments and responses to site-based content).

Of these, the most common were pro-suicide or suicide-permissive sites, at 33.3 per cent. The second most common were support sites at 18.1 per cent. Four pro-suicide sites featured among the 10 most retrieved Google results. None of the top 10 sites from Google were New Zealand-based. Support sites made up 9.3 per cent of all hits, were second most likely to be in the top position of any search, and were the third most likely to display among the top five results of any search.

Overall, the quality of the sponsored support sites appeared poor. They tended to offer non-specific information that was often not evidence-based. Content was frequently associated with commercial advertising. Several of the New Zealand support sites appeared more engaging than those hosted overseas. For example, thelowdown.co.nz, which appeared as a sponsored site in the GoogleNZ search, is a brightly coloured interactive support and information website aimed at people under-25 years of age.

More than one-third of retrieved sites were NZ-based. Of these, only a few were pro-suicide; the vast majority of pro-suicide results were internationally-based. Search engine optimisation may be an effective way to make support sites more accessible to those who search the internet for suicide-related information. Given that the first 10 search results are the most visible, and given that pro-suicide sites occupied most of those spots in our searches, support sites could act to balance the visibility of pro-suicide sites by fighting for higher search engine ranking.

Support sites should attempt to provide readers with validation, while not promoting suicide as an effective solution to problems. Both short-term problem-solving and long-term support strategies should be offered, through access to support help-lines and links to other well-designed support sites. The use of moderated interactive forums could be explored, as these could allow users to share coping strategies and skills to deal with their emotions. Sites that let young users engage with supportive online communities may be particularly effective, given the well-documented adolescent tendency to seek informal sources of help. Support sites commonly focus on a particular demographic subgroup, commonly age-based. The report suggests that such sites include links to alternatives for those outside the target group.
Media influences on suicidal behaviour - an interview study of young people in New Zealand


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<th>Aims and methods</th>
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<td>This study contributes to the evidence about the relevance of media to the pathway to suicide for young people. It describes the influences of media on suicidal behaviours, from the perspectives of young people who recently intentionally self-harmed and who were engaged with clinical services. The sample consisted of 56 female and 15 male (N=71) young people between 13 and 25 years of age, of whom 60 per cent were European, 15.5 per cent Māori, 7 per cent Pacific and 8.5 per cent other ethnicities. It is known that certain types of media reports and portrayals of suicide and self-harm can increase the risk of suicidal behaviours amongst vulnerable people, especially young people. The proliferation and evolution of newer forms of media content, combined with rapid development of the technologies making access, content sharing and person-to-person communication possible at any time and in any</td>
<td>Significant negative events resulting in some form of loss, stress or isolation occurred around the time the study participants first thought of or began to self-harm. The mean recalled age for first suicidal ideation was 12.5, and the mean reported age at first self-harm behaviour was 13.7 years. For most, the motive for self-harm was to escape their current situation and gain some form of control. Twenty-seven (38 per cent) intended to die as a consequence of this self-harm episode. Choice of method was associated with intent, with 76.9 per cent of those who used high lethality methods intending to die. For 28 (39.4 per cent) the act was planned for less than one hour; for 15 (21.1 per cent) planning was between 1 and 24 hours; while 13 (18.3 per cent) had planned for more than a day, but less than a week; fifteen (21.2 per cent) for more than a week. Spontaneity was weakly associated with gender, with males being more likely to plan for longer periods. Participants were asked to report where they first learnt that people sometimes harm or kill themselves. These sources differed by gender with females citing television news/documentaries, school/teachers and friends while males responded that school/teachers was the most common source. The internet was nominated by only one person. There was no association between age of first learning about suicidal behaviours and type of information source. Television, movies, the internet and songs and music videos were the most common source of any media exposure to portrayals of suicidal behaviours. Forty-five people reported having at some time hearing or seeing someone harming or killing themselves in a fictional portrayal, including movies, shown on television. Over half of these recalled seeing the material on TV2, with a particular episode of Shortland</td>
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4 In this report the term 'suicidal behaviours' includes self-injurious behaviours with and without suicidal intent
Place, means that these methods of communication may have some relevance to suicidal behaviours.

| Street that featured an overdose cited. Forty-three participants reported exposure via non-fictional television portrayal of self-harm and suicide, such as news and documentaries and 46 reported exposure through movies at cinemas and on DVD. Forty-seven participants reported having heard or seen suicide or self-harm-related material on the internet.

Sixty-six participants used one or more social networking sites, and 27 participants had accessed suicide or self-harm-related material from these sources. Thirty-six participants had actively searched for web content about suicidal behaviours. The most common reasons were to find information or get help about problems and to get information about how to harm or kill oneself.

Few participants reported using the internet to meet others who self-harm. Forty-nine participants had been exposed to suicide and self-harm themes via music and music videos. While some felt it had nil or minimal impact, or was a “release” for distressing feelings, a small number recognised some music as “trigger songs”, which led them to self-harm.

Fewer than half of the participants reported exposure to suicide or self-harm-related material on their mobile phone, most commonly text messages from close friends that included requests for help or offers of support.

The findings are consistent with emerging evidence from elsewhere indicating that cutting is not a behaviour confined to young women. Young people who have harmed themselves, and who are accessing mental health services in New Zealand, appear to be well aware of the lethal potential of some methods of self-harm.

The internet and mobile phone were rare first sources of knowledge about suicidal behaviours, and it appears that at least among young people with clinically significant self-harm, emerging media are used for gaining or sharing information, rather than being a specific risk due to introducing self-harm or suicide as a novel idea.

The content of some of the text messages was disturbing; however, the qualitative data indicated that, a single text cannot be seen in isolation. Furthermore, texting was portrayed as a major vehicle for young people offering support to one another “in the moment”, and was often followed by supportive phone calls. |
## Analysis of suicide methods and locations

*Sunny Collings, Barry Taylor. September 2010*

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<td>Goal 4 of the NZ Suicide Prevention Strategy – <em>Reduce access to the means of suicide</em> – supports the development of policies, strategies and regulations to reduce access to, and the lethality of, the means of suicide. This analysis provides evidence to ensure the activities of this Goal are appropriately targeted.</td>
<td>Most suicides are a private and opportunistic event occurring commonly in the deceased’s home. The four most common methods i.e. hanging, carbon monoxide (CO) poisoning, firearms and overdosing accounted for 88% of all deaths. Public sites accounted for only 22% of the suicides reviewed. There were no strongly emergent specific locations, location types or methods of death arising across the observation periods. There are a small number of ‘iconic’ public sites for suicide in New Zealand but none have newly emerged. For two of these sites it appears that it is the location rather than an associated method that is important in the ‘iconic’ status.</td>
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| The study aims were to: 1) identify changes in patterns of locations using data from 1997-1998 and 2005-2006; 2) report on emerging methods that may have been noted anecdotally but which are not discernible in the current ICD reporting system; 3) contribute to prevention policy and programme development in respect of restriction of access to locations and means. Using simple descriptive methods the researchers applied these aims to two datasets, the Ministry of Health Mortality Data Collection 1997-1998 and 2005-2006, and the Coroner’s Files 2005-2006. The analyses looked for any differences by gender, age and ethnicity. | Men and women across all age groups and ethnicities made similar choices of location, with their own home being the most common. Suicides in institutions were a very small proportion of the locations. For men who die by suicide in institutions this is more likely to be in a prison, whereas for women it was hospitals. Among men dying in prison, Māori and European men were in equal proportion. The proximity of the location to the opportunity to access the method, combined with impulsivity, seem to be the key factors influencing the choice of both the location and method. There were similar patterns in the methods of suicide across gender, age and ethnicity with hanging being the most common method. It is recommended that Coroners’ summary sheets are reviewed and updated and education be undertaken with the Police to ensure full accounts of all salient details are recorded on the Coroner’s summary sheets. Where any death may be due to suicide, it is recommended that full alcohol and drug screening is performed and the results recorded as part of the Coronial verdict. Considerable effort has been made in New Zealand to reduce suicide in institutions, which in these data contributed only 4% of all suicides. It is important that this is supported by regular staff training in suicide prevention, risk assessment, monitoring and management. Where it is not already happening, staff in aged care
facilities should be trained to identify and, where appropriate, manage and monitor depression and suicide risk.

Vehicle exhaust gas is the second most common method of suicide in this analysis, attributed to 18% of deaths in 2005-6. It is recommended that consideration of initiatives to modernise the vehicle fleet such as the installation of safety devices is prioritised. The use of other methods of carbon monoxide poisoning should be closely monitored.

Firearms contributed only 10% of suicide deaths. Where reported, over half the firearms used were not owned by the deceased, and it was common for the deceased to have borrowed the firearm. In several cases, the firearm owner had felt uncomfortable about the request. Future campaigns about firearm safety, and information given out to those gaining a firearms licence could address this.

Self-poisoning was predominantly by prescription or over-the-counter medications, most commonly taken in combinations. Prescribed psychotropic medications were commonly used, with antidepressants in particular having being more commonly prescribed by GPs. How much monitoring GPs were able to provide was not well recorded. This, alongside an increased use of ‘close control’ prescriptions in primary care, may help reduce the number of people dying by overdose of prescription medications.

Only one location was identified as a jump site. Since the time of this study safety measures have reduced the likelihood of deaths occurring at this site. As favoured jump sites might arise at any time, we suggest the development of simple guidance to support agencies such as local authorities to undertake site audits and manage such ‘hot spots’ when they emerge.
**Report to inform the provision of mental health promotion and prevention services to gay, lesbian, bisexual, transgender and intersex populations in New Zealand**

*Adams, Pauline Dickinson, Launuola Asiasiga, Tim McCreanor, Helen Moewaka Barnes.*

*January 2012.*

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<td>This needs assessment comprises:</td>
<td>Little was found about the effectiveness of mental health promotion initiatives specifically targeting GLBTI people. However it is recognised that groups of protective and risk factors can be enhanced or reduced by interventions. Specifically, promising mental health promotion activities are those that:</td>
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<td>• a review of the evidence (literature review)</td>
<td>• strengthen individuals’ self-esteem, self-efficacy, life and coping skills, relationships and social connections</td>
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<td>• a description of existing services, including identification of any gaps (service stocktake)</td>
<td>• strengthen organisations, to ensure environments are inclusive, safe, and supportive</td>
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<td>• a description of key issues and gaps (stakeholder consultation: key informants and GLBTI individuals)</td>
<td>• strengthen communities to increase social cohesion, social participation and inclusion</td>
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<td>• recommendations for mental health promotion and service delivery.</td>
<td>• strengthen whole societies through interventions designed to counter stigma and discrimination and reduce inequalities.</td>
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<td>The research used an exploratory qualitative descriptive approach. It consisted of a literature review and stakeholder consultation. The consultation was designed to obtain a description of current mental health promotion and prevention services or programmes for some or all of the GLBTI populations, and to obtain the views of stakeholders on current service delivery and the issues facing the sector.</td>
<td>There is convincing international evidence that GLBT individuals experience higher levels of mental health distress than their heterosexual counterparts. In New Zealand there is robust evidence that non-heterosexual populations are more at risk of suicide and mental health problems than the heterosexual population (Fergusson, Horwood, &amp; Beautrais, 1999; Fergusson, Horwood, Ridder, &amp; Beautrais, 2005). Links between sexual orientation and self-harm, suicide ideation and attempted suicide have also been made (Skegg, Nada-Raja, Dickson, Paul, &amp; Williams, 2003).</td>
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<td>For the stakeholder consultation three means of data collection were undertaken: (1) an email survey of service</td>
<td>The mental health of GLBT people is impacted by repeated exposure to a wide range of psychosocial stressors associated with anti-GLBT attitudes and behaviours, which include stigmatisation, discrimination and violence. Experiencing these stressors is associated with increased mental health distress and suicidality, and is often referred to as ‘minority stress’.</td>
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<td></td>
<td>Addressing the mental health promotion and prevention needs of</td>
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*With regard to mental health service provision, health*
providers;
(2) interviews with key informants; and
(3) an online submission form completed by GLBTI individuals.

professionals need to be well-trained in relation to GLBTI issues and inequalities, as well as working in a non-judgemental, respectful and sensitive manner.

Very few organisations were identified that provided specific services and programmes to some or all of the GLBTI populations. Such services are currently provided by five organisations: Auckland CADS (Community Alcohol and Drug Services), OUTLine NZ, NZ AIDS Foundation (NZAF), Rainbow Youth, and City Associates. Several mental health promotion resources focused on GLBTI populations were identified. No GLBTI organisations were actively involved in mental health promotion on a national level.

A key issue for informants and respondents was the negative impacts on the mental health of GLBTI people that arose from stigma and homophobia or trans-phobia. Education and general public awareness campaigns were suggested as one way to address these issues and to raise understanding amongst mainstream society of GLBTI issues.

The informants and respondents also reported a need to des-stigmatise mental health issues – both within society as a whole and within the GLBTI community. Awareness campaigns were suggested as an appropriate way to address these issues. Health promotion activities need to recognise the diversity with the GLBTI population.

Access to mental health services and the competency of mental health services were the two overarching issues for informants and respondents. For all respondents who are currently accessing, or would like to access, mental health counselling and other services the most widely reported issue that hindered access to these services was cost. The main competency issue identified was that all services should be provided in a culturally safe and appropriate way. For GLBTI people, culture may relate to issues associated with sexual or gender identity, or body diversity, as well as ethnic identity. Ensuring that mental health staff displayed appropriate attitudes, had the necessary skills and abilities to work with GLBTI people, and did not make assumptions around sexual and gender identity were important.
## Review of evidence and update of suicide prevention guidelines for schools

*Sunny Collings* December 2012

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<td>Existing suicide prevention guidelines for schools were reviewed and updated. New evidence and services had emerged since the original guidelines were developed over 10 years ago. The guidelines update was informed by stakeholder consultation, a literature review, and consultation with teachers on the updated (draft) guidelines. The researchers produced a full guideline, literature review and summary aimed at school stakeholder audiences. These documents include evidence-based recommendations for safe and effective suicide prevention in schools.</td>
<td>This guide is divided into the three areas of <strong>prevention</strong>, <strong>recognition</strong> and supporting the wellbeing of students, and <strong>postvention</strong> or responding after a suicide or an attempt and summarises what is known in each area to be the safest and most effective approaches for schools to take.</td>
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### 1. **Primary Prevention**

The focus of primary prevention activity in a school is to support well-being for all students. This can be achieved through the creation of a safe and supportive developmental environment. Primary prevention addresses the underlying causes of mental health and personal adjustment problems in young people.

Prevention efforts in schools should occur within the context of:

- The Health and Physical Education Curriculum, and
- Policies, practices, and programmes that support positive pro-social behaviour, family engagement, school engagement/connectedness and cultural and civic development
- Policies and practices that address truancy, abuse, bullying and violence
- Skilled staff to address and manage the difficulties faced by young people from adverse childhood backgrounds who have multiple problems of personal adjustment and stress
- Improving teacher recognition and response to mental health problems in young people.

### 2. **Recognition and obtaining support for at-risk students**

School-based suicide prevention programmes have been shown to be effective in recognising and providing assistance for young people who are at risk of suicidal behaviours. Schools should identify those who are at risk and seek appropriate support, care and management for them.

Provision of effective support to students at risk of suicide requires partnerships with family/whanau/caregivers and other professional support agencies. The factors which contribute to a young person
seriously contemplating suicide are mostly located in the young person’s life outside of the school.

3. **After a serious attempt or death by suicide - postvention**

The impact of a serious attempt or death by suicide or other crises or emergency situation in schools such as the sudden death or injury of a student or teacher can have an effect on the whole school community. Added to the emotional distress of the death itself is the potential for suicide contagion. The way a school responds, communicates with and supports students affected about the sudden death or injury is important in decreasing further suicidal behaviour. This response must include procedures to recognise those who may be potentially at risk of suicide.

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<td>School-based programmes are now accepted as an effective way to recognise and support youth at risk of suicide, although the focus and balance of programmes has shifted as new evidence about benefits and harms has become known. For example, recent evidence suggests that some school-based programmes may be strengthened by including attention to the young person’s relationships with parents and family. Schools need to be supported in this by the availability of accessible and appropriate materials so they can make pragmatic and evidence-led decisions.</td>
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This evidence review suggests there are a number of key aspects to successful suicide prevention, recognition and management of risk, and postvention in schools:

- The emerging model of suicide prevention in schools is known as the ‘whole school’ model. This model recognizes that suicide prevention needs to be a part of comprehensive health education activities such as those provided for in the New Zealand Health and Physical Education Curriculum.
- Schools should ensure that any programme delivered by an external provider uses trained professionals - people without specialist expertise should not deliver school-based suicide prevention programmes with young people.
- Suicide prevention programmes must firstly, have a robust theoretical model underpinning their content, design and delivery; secondly, be informed by an expert understanding of the contributing roles of various risk and protective factors for suicidal behaviours among young people; thirdly, have established robust links with mental health and social services agencies outside the
school; and fourthly, have been subject to rigorous publicly available evaluation.

- New Zealand schools are expected to provide a safe physical and emotional environment in classrooms and the wider school. Programme planners and implementers must be aware that, like most health interventions, suicide prevention efforts may have unforeseen negative consequences.

- For schools to contribute safely to suicide prevention, it is essential that referral pathways are effective. The development and enhancement of whole school approaches should include careful attention to the development and maintenance of strong relationships with named staff in local services outside the school.

- Evaluation provides an important safety framework for schools and potential participants. Any new programme must have been comprehensively evaluated, and evaluation findings must be available for consideration by schools. The programme must also be accompanied by a clear and logical ongoing evaluation framework.

- It is recommended that schools develop, adopt and regularly review a clear and documented process to detect young people who are emotionally distressed and consequently may be at risk of suicidal behaviour.

- The evidence suggests that all teachers, and to a lesser extent other school staff, should receive initial training and then ongoing awareness training of common signs which might give rise to concern about a young person and consideration of a referral to a counsellor.

- Regular staff training should include information on the symptoms of psychosocial distress, depression and risk of suicide, so staff can develop the confidence and competence to refer and support distressed young people.

- Such training should be linked to the regular review and update of policy and processes relating to the school’s approach to suicide prevention. The utility of any guideline or policy is entirely dependent on staff being familiar with it and competent and confident in their roles.

Certain interventions are not recommended. These include:

- the use of screening instruments for the identification of young people at risk of suicide except as part of comprehensive whole-school approaches which are being subjected to external evaluation. However, educators and other school staff can play an important role in recognising the warning signs of suicidal behaviour.
the use of peer support programmes as part of the whole-school approach to suicide prevention. To date there is an insufficient body of evidence supporting the efficacy or safety of peer support programmes in suicide prevention.

**Suicide postvention**

Any school may have a student who seriously attempts or completes suicide. When this happens, there may be consequences for other students. Some level of traumatic incident response, based on sound and safe suicide postvention principles, needs to occur in the schools since “doing nothing” is considered to be potentially harmful.

The aim of the postvention response is to assist the school community to return to a normal routine as soon as possible. The evidence suggests:

- It is recommended that a specific section on suicide is included in the school’s Traumatic Incident Response Policy (TIRP) as opposed to developing a stand-alone suicide postvention plan.
- The management of traumatic incidents requires high levels of teamwork. Traumatic incident response plans provide the basis for teamwork following a suicide or attempted suicide.
- Students who are vulnerable should be identified. All staff should be reminded about the referral procedures for at-risk students.
- Those students who had been identified as at-risk should be regularly monitored over the next 6 – 8 weeks and then their risk status reviewed. Monitoring of at-risk students may need to be ongoing.
- New Zealand schools need to be cognisant of the legal stipulations of the Coroners Act 2006 which states that a death can only be legally classified as suicide by a coroner’s finding.
- It is important that staff are supported not only to undertake the support role to students but to address their own response to the death.

Finally, because suicide in any single school is likely to be a rare event, it is critical that the introduction of a new policy or guideline is not seen as a one-off event but as the establishment of an ongoing process of working towards suicide prevention in schools.
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