spinz SUICIDE PREVENTION INFORMATION NEW ZEALAND

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If recovery is possible, then suicide is preventable

It was a stint in the United States Army that awakened young Paul Quinnett's thirst for learning and desire to understand human behaviour. He began a degree, doing a dual major in writing and psychology. Although originally keen to become a writer, he chose psychology simply because the psychology internships paid better.

"I was starting a family and decided writing could wait," he chuckled.

This pragmatic decision has probably saved thousands of people's lives. As a clinical psychologist, Paul went on to become a persuasive advocate of suicide prevention and the creator of the globally acknowledged suicide prevention method QPR.

Over 90 percent of people who die of suicide in the United States have had a mental illness, yet 80 percent of them will not have seen a mental health professional, had counselling or a course of antidepressants, says Paul.

"They didn't have a chance. Mental health has always been the step-child of health care, and yet suicide is a leading cause of death worldwide, primarily due to untreated mental illness. If recovery is possible, then suicide is preventable."

Suicide prevention became a focus for Paul in the 1980s when he started thinking about patients who had taken their own lives in the community mental health service of which he was director.

Paul Quinnett

Editorial

Kia ora koutou and welcome to the first edition of our newsletter for 2010.

In March, SPINZ, Clinical Advisory Services Aotearoa (CASA) and The University of Auckland hosted Dr Paul Quinnett and Dr Sarah Fortune in A Forum on Suicide Prevention. The forum focussed on challenges and opportunities in suicide prevention, suicidal behaviours and mental health findings from the Youth2000 national health surveys conducted in 2001 and 2007.

It was inspiring and heartening to see so many people from across the suicide prevention sector represented, and to hear Dr Quinnett reaffirm that suicide prevention traverses a broad continuum, from health practitioners and community organisations through to family and friends. In this edition, we interview Dr Quinnett about the suicide prevention method Question Persuade Refer, writing, psychology and fishing.

Also in this edition, we look at how schools can support students after a suicide; from working within postvention guidelines and utilising traumatic incident coordinators, to the importance of developing traumatic incident plans. We also discuss the ways in which parents can support their children through grief, and what is being done to prevent suicide in young people.

Finally, we have our regular suicide prevention sector update, covering suicide prevention content from the 2010 International Gambling Conference, the planned SPINZ World Suicide Prevention Day event coming up in September and SPINZ social media focus, as well as newly published suicide prevention research.

To receive the *SPINZ Newsletter* in your inbox automatically, sign up to the newsletter through our website. You can also sign up for alerts, via RSS feeds, to keep you up-to-date between newsletters on the latest news, research and resources in suicide prevention, both locally and internationally.

Merryn Statham
Director SPINZ

feature

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"At this time suicide prevention was largely an academic subspecialty. Graduate schools weren't preparing clinicians to work with suicidal people; something still true today."

He began to treat suicidal people in his public and private practice. In 1987 he combined his writing and psychological talents to publish his first book Suicide, the Forever Decision. The book, which became a big seller, was based on two suicidal patients, in particular Mary who had made two attempts at her life.

"She is still alive and a grandmother which is good news," he smiles.

Paul had also been involved in helping set up Gatekeepers, a community mental health concept for the elderly designed to locate, identify and refer elderly people who were at home and at risk. People such as postal workers, meter readers and pharmacists were trained to pick up warning signs and refer people who weren't coping physically and mentally. An unexpected benefit was that suicide statistics for elderly people in the state lowered considerably.

"I got thinking this would work for young suicidal people and others as well," says Paul.

On further reflection he came up with the idea of creating a CPR for mental health; QPR - Question, Persuade and Refer. This trained people – lay and professional – to recognise warning signs of suicide and learn how to question and persuade the person to be referred for further help.

In 1999 Paul was offered the opportunity to set QPR up as an independent entity and the QPR Institute was born. He estimates about 10,000 people per month now train in QPR with Clinical Advisory Services Aotearoa (CASA) providing the training in New Zealand.

"Research has shown it to be safe and effective. Like CPR it intervenes before people get into too much trouble," explains Paul.

Paul says three common, but preventable, medical errors can occur with clinicians dealing with suicidal people. Firstly, clinicians often don't ask the person if they're having thoughts of death or suicide so fail to detect the risk.

"You can't assess risk if you don't know the risk is there," states Paul.

There is a high rate of older people killing themselves the day after they had an appointment with their doctor – and they often do it with the medication that they received from the doctor."

Secondly, many don't assess the risk. "You must, even if the person says they're not at risk. If you don't know how high the risk is you can't deal with it effectively."

The third error is failing to establish a monitored risk management plan.

Paul strongly supports family centric assessment.

"There can be too much reliance on self reporting when a suicidal person may have many reasons to deny their intent. My experience is to listen closely to third party observations. The family often brings someone in because they are really worried about their behaviour. They're in a vantage position and should be acknowledged."

He tells how a woman approached him after his New Plymouth presentation to share her husband's story. The husband lost his job, started drinking heavily and was suicidal. She got him to a health provider who wouldn't let her in the room when he was interviewed, then believed her husband when he said he wasn't at risk. The man was dead the next day.

"Family centric assessment may have made all the difference."

Paul is a busy man. He runs the QPR Institute and travels globally to talk about suicide prevention – and fishing. Yes, fishing! A fishing enthusiast, Paul scheduled three fishing trips around the 18 presentations on suicide prevention he gave in New Zealand.

He combines his three loves; writing, fishing and psychology through magazine articles and books he has authored, including Pavlov's Trout: The Incompleat Psychology of Everyday Fishing, and Darwin's Bass: The Evolutionary Psychology of the Fishing Man. Unsurprisingly, these witty and insightful books are as much about humankind as they are about fishing.

An avid believer in the healing power of nature, Paul has studied Zen and is a keen advocate of the contemplative and meditative states achievable in bush or alongside a stream. Although now 70, he still manages to disappear into the Northern Rockies for a couple of days over summer to have time alone with only his fishing rod and Labrador retriever.

"As long as I can fish, nobody needs to worry about my mental health."

His home provides a sanctuary too, located on an acreage in the woods with a big garden and greenhouse. "I also have a loving family of three children and six grandchildren and my wife travels with me to places that interest her," he says, adding with a smile that she has indeed accompanied him to New Zealand.

He writes each morning, getting up at 5.30am and writing until 7.30am.

"Once a writer; you cannot not write. If I don't write for a couple of days, it sort of gushes out when I do sit down."

Paul agrees it is a full life but efficiently managed. This efficiency was honed during his teenage years when he had a job gathering eggs after school. It was a job he absolutely dreaded but once he realised he would get paid the same, no matter how fast or slow he was, he continually looked for ways to be more efficient.

"I became a master of efficiency over that time and I think that lesson really stuck with me."

By Angela McCarthy

Paul Quinnett

Dr Paul Quinnett is an author, fisherman and clinical psychologist – not necessarily in that order. As QPR Institute chief executive, he recently presented a seminar in New Zealand on the challenges and opportunities in preventing patient suicide. Dr Quinnett founded the QPR Institute in 1999, an educational institution dedicated to preventing suicide. Similar to the brief intervention model of CPR, the QPR Gatekeeper Training for Suicide Prevention programme has been taught to more than one million people worldwide and is available in several languages.

"It is about simply doing what humans should be doing for each other," explains Paul.

Supporting young people in schools after suicide

The impact of a death by suicide is far reaching, particularly when a young person takes their own life. How do schools support their students and staff in the aftermath?

Keeping a school going

When a Year 11 female student from Tawa College, near Wellington, died by suicide a few years ago, principal Murray Lucas witnessed the heartache of her family and friends up close and it's a memory, he says, that stays with him.

But like all principals in this situation, his focus after confirming the news was to make sure her friends and classmates were supported and safe, and to keep the school running as normally as possible for the other students.

The crisis team was convened early and the crisis policy set in motion. The school also contacted the Ministry of Education's Special Education Services to call in an expert in traumatic incidents, who gave the school a checklist to ensure all areas were covered.

"The immediate plan identifies the other students who are at risk, it includes considering friends' past history and looking for signs of depression," Lucas says. "The families of close friends were phoned and some students went home, but we certainly didn't let them unless a parent picked them up."

In the school itself a room was opened up for anyone that needed some time out and Lucas says the college appreciated the help of a guidance counsellor from a neighbouring school who assisted the college's own counsellor.

Another consideration for the school was how to honour the life of the student without glorifying her death. "We never called it suicide, we called it a 'sudden death' and the advice we were given from the Ministry's expert was not to have a big service at school. Instead we had form assemblies with a minute's silence and for a few days the flag was at half mast."

Some staff and students attended the girl's funeral; students who wanted to attend had to produce a letter from their parents to say that they could go.

Lucas says that his school was more fortunate than many, in that the suicide didn't receive much media coverage and the girl's family was very supportive of the school.

As well as supporting the students through the difficult time, Lucas had to ensure his staff were also cared for. "Like any staff of 100 people you have 100 different histories, some had experienced suicide in their family and this brings it back," he says. "We were very grateful for the relief teachers who came in so our staff could have time out to reflect."

Lucas adds that families and whānau of all students can be assured that each school has access to Ministry of Education support; and guidelines to refer to in such times. Each school should also have its own crisis team and procedures, which are reviewed by the Education Review Office every few years.

New Zealand schools have access to many services to support students and staff after a suicide.

Keeping guidelines relevant

Work around preventing suicide in young people has proven successful. Ministry of Health figures show a 46.6 percent drop in youth suicide since the peak in 1995, relating to deaths in 2007, the most recent year for which data is available. However people in the field say it is no time for complacency, as New Zealand youth suicide rates are still high internationally. The suicide prevention guidelines for schools are currently being updated, a process that is informed by stakeholder consultation and literature review. This is to incorporate new evidence and services that have emerged since the guidelines were developed 10 years ago.

Suicide prevention expert Barry Taylor is one of the researchers working on the guidelines. "In the postvention guidelines, issues that will be identified are around new technology. The critical thing is how information is available very quickly now so schools really have to be on top of it and responsive. If a suicide happens on a weekend, they have to react immediately, rather than wait until Monday," Taylor explains.

Barry Taylor
Suicide Prevention Researcher

"Another issue is around how you respond to the grief in more culturally diverse school populations and a further consideration is around having the tangi or a ceremony at school; there is still no real evidence one way or another on the advisedness of that."

Schools have the right to choose who they will call for support, Taylor explains, so it is important to ensure the guidelines provide schools with the best information so they can make an informed choice about who should be there.

"There is also some cross referencing to media guidelines and that is usually based around how to respond, things you can and can't say." The guidelines, produced by the Ministry of Health, provide suggestions about how media should report on suicide. Suggestions include presenting suicide as a poor choice, encouraging help-seeking, not using photographs of the person or where they died, and avoiding publishing details about how the person died.

Traumatic Incident Service

In addition to the guidelines, all schools can call the Ministry of Education's Special Education Traumatic Incident Service (TI team) on 0800 84 8326 for support during a crisis. Special education teams that respond to these crises mainly come from an educational psychology background and their aim is to prevent further suicide by assisting the school to restore the learning environment, communicate accurately and appropriately about the event and to support the school in identifying and providing support to any students who may be at risk.

Shelley Dean is the practice advisor in the Professional Practice Advice Unit for Traumatic Incidents at the Ministry of Education. She says the type of support they provide depends on the circumstances at the school and they work with the school management to see what is needed. If possible the team responding – it is usually a two-person team – aims to arrive at the school before school has actually started for the day, and they establish what is known around the event.

"There's often a lot of rumours in the student population," Dean explains. "We can work with both the coroner and the police, and if we think we need to release information we would contact them to seek their guidance. We work to provide prompt and accurate information out to the community as well as providing support through school management."

Dean says that most secondary schools have a crisis team with people taking on different roles, such as security or liaising with whānau, family or media, and TI teams provide problem solving support to this crisis team. Special Education staff work with the school to help teachers and the community to support all students; this takes the onus off just the school guidance counsellor providing this support for the whole school. "We might talk with the parents about ways they could talk with young people about the situation and do the same with teachers. We also let people know about websites and other places they can get information," she says. "It's about psychological first aid: establishing physical and emotional safety. So we support students' understanding about the crises and connect people in the community."

The culture of the school and community is also considered when forming the school crisis team. "Cultural support and activities are important for young people and also provide strong support and understanding about the crises," Dean says. It is also important to respond in a culturally-appropriate way, taking care not to disrupt existing cultural, spiritual or religious practises and beliefs around death. Special Education staff can also help link schools to Māori and other culturally-appropriate networks.

Further support

Pre-emptive support is also available to schools, although Ginny Wilkinson, an independent counsellor who provides counselling, supervision and training to school staff, says it could be taken up more effectively. "In the early 2000s all schools were mandated to participate in workshops on managing crises as part of the New Zealand Youth Suicide Prevention Strategy, and it did gather up a tremendous number of schools, I would think 80 to 90 percent. The hope was that the head of counselling and the deputy principal in charge of student support would attend," Wilkinson explains. "In reality very few deputy principals did attend. This made it difficult for some counsellors to go back and implement all the policy preparation and training that would make the school an effective responder to suicide. It's very complex and it does involve this conversation within the school around how to respond to a suicide death as opposed to a natural death."

Wilkinson advocates principals and counsellors in all schools are clear about their traumatic incident policy, including discussing whether or not there will be a full ceremony at school following a suicide. This helps avoid difficulties within the school hierarchy, and ensures the school can move forward quickly and confidently following a suicide. "Most good crisis policies say be proactive, respond quickly, strongly, confidently, share all information that you've got and tell the truth, although that issue with suicide can be very complex because sometimes families are not able to trace what happened," she says. "With modern technology and Bebo and all that sort of thing the idea that anyone can keep these things a secret is short-sighted. People end up feeling very let down if people in authority have told them one thing and it turns out it wasn't true."

Wilkinson adds that it is important for the principal and counsellor to visit the home of the student as soon as they hear the news. Even if the family or whānau had come to the school to tell them, she advises going to visit with some flowers to talk over the next few steps. "In this way the school then became conduits of the facts and they would then be able to go to the students and invite [any who have taken time off school] to come back and take part in the process and the rituals that schools are able to provide."

The role of whānau and family

Outside of the school environment, parents, whānau and families should also consider the best way to support their young people affected by the death. "I would advise parents not to lose touch with their child. Teenagers want to be together and they will mass, whereas children will want to be with their parents. Between 11 and 13 there's a real shift there," she says, adding that teenagers often go together to the place where their friend has died, which can lead to risky situations, especially as it is common for them to drink alcohol while there.

Wilkinson adds that it is often a young person's first experience of someone they are close to dying, certainly someone their age, and recommends that parents keep that in mind and go to the funeral or tangi with their child: "It's about talking through the protocols of death and bereavement and keeping the dialogue going."

More information for families

By Carrie Briffett

After a suicide, teenagers will want to be together.

Activities in youth suicide prevention

While NZ rates of youth suicide (15-24) remain high in comparison to many OECD countries, there has been a 46.6 percent decline in this age group since the peak in 1995. Although the reasons for this decrease cannot be explained with absolutely certainty, it is thought that evidence based-approaches including giving young people skills to support their emotional development, encouraging help-seeking, treating depression and providing support after a suicide have played an important part.

Evidence-based approaches

The Ministry of Health, along with the Ministries of Youth Affairs and Education produced a Practical Guide in 2003, outlining suicide prevention approaches to be taken in schools. There is also an accompanying research report that underpins this guide. To date, there has not been any significant new evidence that recommends a different approach.

Fostering skills

The evidence available still points to the importance of mental health promotion, i.e., teaching young people skills to support their emotional development, and having systems in place for identifying and appropriately referring individual students at risk. Some suicides will probably still occur despite the most robust systems, excellent curriculum teaching and skilled practitioners. Teaching students problem solving, goal setting, and relaxation are important protective factors against suicide, although they are not 'packaged' as such when taught. They contribute to a range of knowledge and skills that improve a young person's resilience.

Encouraging help-seeking

Knowing when to ask for help, or identifying when you [the young person] or someone close to you might need help is something many schools actively promote. Well trained and supported staff are critical to these approaches being successful.

Treating depression

Undiagnosed and untreated depression, even in young people, remains the most significant risk factor for suicide. This is referred to in the Practical Guide and is the main reason the Ministry of Health is running the National Depression Initiative, which includes a strong focus on young people, called The Lowdown. The Lowdown is an interactive website for young people, with New Zealand celebrity 'navigators' guiding users through the content. The website provides information on issues such as depression, anxiety, bullying, drugs and alcohol, and suicide, as well as practical suggestions for seeking help and problem solving. It also features stories about depression and help-seeking from New Zealand musicians, celebrities and sportspeople.

The interactive components include a free text message service, operating from noon to midnight, where young

The Lowdown
www.thelowdown.co.nz

people can contact the Lowdown team directly by sending text messages to 5626. Email contact is also available by registering as a member on the website.

The website also has an online message board where young people can post questions or talk about concerns they are having, and receive responses from other users of the website. The Lowdown team do not participate in these conversations, but do moderate the discussions for safety reasons.

Providing support after a suicide

Ensuring that schools can appropriately respond to traumatic incidents such as this means the provision of grief support and counselling, and identifying those that could be at increased risk after such an incident. Traumatic Incident Response teams from Group Special Education are resourced to provide advice and guidance in these cases. In addition Clinical Advisory Services Aotearoa provide a Community Postvention Response Service to advise and guide safe responses where on-going suicide risk is identified. This service is funded by the Ministry of Health.

Young people and grief after a suicide

Suicide leaves behind a network of family, whānau, friends and community to cope with the pain of this type of loss. Young people in particular need ongoing reassurance and support when dealing with grief. At times they may deal with grief slowly or in intermittent bursts, and other times may seek comfort in their regular routines and activities[1].

Some common grief reactions to suicide include[2] :

- *Thinking a lot about how the death occurred*
- *Intense shock and numbness*
- *Conflicting emotions of excessive guilt, sadness, anger, fear, powerlessness, withdrawal, isolation, disbelief, shame, rejection, loneliness and betrayal*
- *Finding it difficult to sleep, nightmares and dreams about the suicide*
- *Loss of security and self-worth*
- *Difficulty concentrating*
- *Not wanting to talk or wanting to talk about it a lot*

Things you can do to support a young person in their bereavement[2]:

- *Spend time and really listen – allow them to talk about what happened*
- *Offer attention, reassurance and support – let them know they are loved, cared for, and safe*
- *Surround them with the support of whānau, family and community*
- *Let them know that what they are experiencing is grief and that this is okay*
- *Indicate that grief takes time*
- *Encourage them to express their feelings in their own way – young people often find music, poetry and writing helpful*
- *Encourage them to return to doing things they enjoy and have a routine or structure to their day*
- *Help them find ways to remember the person who has died and keep a connection with them. Some ideas include making a memory scrapbook, planting a tree, framing a photo or sharing memories and stories about the person.*

When to involve professional help

There is evidence to show that young people bereaved by suicide are at increased risk of suicide themselves. Providing them with safe opportunities to talk about the event and the impact on them can help minimise this risk. If you are concerned the young person you are supporting may be at risk of suicide, it is important to help the person access professional help and support.

Additionally, although grief takes time to work through, if after a few months the young person is still feeling acute grief and finding it very difficult coming to terms with the loss, professional help may be useful in helping them talk about what has happened.

1 Ministry of Youth Development. (2005). After a suicide. Practical information for people bereaved by suicide. [Booklet]. Wellington, New Zealand.

2 Skylight/SPINZ. (2007). After the suicide of someone you know. [Booklet]. Wellington, New Zealand: Irving Hendry, T., Hirsh, L.

Resuming the things they enjoy and having routine and structure to their day will help support young people who are bereaved by suicide.

Suicide prevention and problem gambling

A connection exists between problem gambling and suicide but those in the field say that more research, understanding and awareness is needed around this relationship.

Suicide and gambling connection

"We have a substantial number of clients who have made suicide attempts or have suicide ideation, so [the connection between suicide and gambling] is definitely a concern," Cynthia Orme, the Director of Clinical and Public Health Services for the Problem Gambling Foundation of New Zealand (PGFNZ) says. "It's not only the person who gambles who is affected, it could be a family member or anyone closely connected."

Orme's experiences are echoed by Brent Diak, coordinator of the Oasis Centre for Problem Gambling in Auckland. "So many people present to us having thoughts of suicide and some of them have come to us having been discharged from A&E after attempting suicide," he says.

Figures from the Gambling Helpline New Zealand also show a definite connection between suicide ideation and problem gambling. Dr Maria Bellringer, CEO, says that they always ask first-time callers – who are either problem gamblers or those close to them – about suicide ideation. Of the 1,892 callers in 2009, 7.2 percent said they had thought about suicide; 1.2 percent had planned it; 0.8 percent attempted it within the past 12 months; and 0.5 were seen as currently at risk. "I would say there is a strong link, as we have about 10 percent of people calling for the first time who are contemplating suicide or have thought of suicide," she says. Bellringer adds that those figures have remained constant over the years as it was a similar percentage for both 2008 and 2007.

Dr Maria Bellringer
Gambling Helpline New Zealand

Limitations in understanding

Although the causal relationship between suicidality and gambling is complex, research has identified depression as a common factor between people with suicidal ideation and people with a gambling problem. However, the exact nature of the relationship between suicide and problem gambling remains unclear.

Orme thinks that problem gambling is much easier to hide than problems with alcohol and other drugs and that this makes it harder to fully understand the connection between gambling and suicide. "People around [problem gamblers] might not know about the problem, as there aren't the telltale physical signs of alcohol and drugs," she explains. "Alcohol and drugs are forefront in the public domain and are often considered [following a suicide], but gambling can often be overlooked as a factor," she says.

"To have someone come in with a gambling problem and only a gambling problem is very rare," says Orme. "A huge number of people we see have other sorts of issues, such as depression and anxiety. It's a chicken and egg situation to ask which came first, and the answer seems to depend on which study you read, either way it goes hand-in-hand," she adds.

Recent studies tend to support the explanation that problem gambling and suicide have common risk factors. A Canadian study in 2006 showed that suicide ideation (thoughts of suicide) predated the onset of gambling, rather than following it. It found that those experiencing ideation were more likely to over gamble.

Orme adds that another aspect of the relationship is that problem gambling impacts on someone's whole lifestyle, including affecting an individual's relationships, which can lead on to suicide ideation. "Their partner might question if they are having an affair because they feel something isn't right but don't know what it is," she says. "[Problem gamblers] sometimes cut themselves off and don't connect with others in their lives."

Diak's opinion matches Orme's, he says people often come in following the breakdown of a relationship or fearing that they will lose a relationship. "Sometimes they would rather be out of the picture entirely than face their loved one when they find out [about their gambling problem]."

Some of the people contacting PGF are also having great financial difficulties, including having lost their accommodation or employment, or are afraid of losing them. "Sometimes they have borrowed money that they can't pay back, or they have stolen money. They may have four or five credit cards and they don't see a way out, so see suicide as an option," Orme adds.

Cynthia Orme
Problem Gambling Foundation

Suicide prevention work

PGFNZ held a workshop a couple of years ago for other social service agencies, so they could give them information around what problem gambling looks like, suicide risk and how to make referrals. "This was new information for many and we now do trainings with different organisations to help them understand problem gambling better. We also work with businesses around what signs to look for in employees and how to help that person," Orme explains.

She adds it is also important that anyone closely connected with someone who is, or is suspected of being, a problem gambler, to remember that they can contact PGF too. "It doesn't have to be the person who is gambling who comes in to get help," she says. "They may or may not be ready. Their partner or anyone else connected with them can also come in and get more information about problem gambling. They can find out what they need to do for themselves and how to protect themselves financially too," she adds.

Problem Gambling Helpline's Bellringer says she would like to see further research into the connection between suicide and problem gambling. "We need to try and find out why things are happening, so we can do something about it," she says.

More information on suicide and problem gambling

More information on the risk factors of suicide

By Carrie Briffett

Updates

Plans for SPINZ World Suicide Prevention Day Event

Plans are underway for the SPINZ event marking World Suicide Prevention Day on September 10 this year. The event will focus on profiling current New Zealand suicide prevention research, funded by the Ministry of Health under the Suicide Prevention Research Fund. The fund is managed by Te Pou , who will be working with SPINZ on the event. Nine projects are being run through the fund, and the SPINZ event will profile a number of these.

Mark September 10 in your diaries now and keep an eye on our website for further details about this event.

Social media focus for SPINZ

Are you a supporter of SPINZ online? Along with the official SPINZ website you can now keep up-to-date with SPINZ on Twitter. Here you will get the most up-to-date news, events, research and trends in suicide prevention; and you can also support us by 'retweeting' our information. We have also launched a YouTube channel that will host informative videos from events such as the 2009 SPINZ National Symposium.

Both sites give us, and you, the ability to spread suicide prevention messages to new audiences who often get their information through social media channels.

◀ *SPINZ website*
www.spinz.org.nz

▲ *YouTube channel*
www.youtube.com/SuicidePreventionNZ

▲ *SPINZ on Twitter*
http://twitter.com/suicidenz

Research

This section showcases recent research in the field of suicide prevention. We have chosen these projects as they support the goals of the New Zealand Suicide Prevention Strategy 2006-2016.

Suicide and fatal drug overdose in child sexual abuse victims: a historical cohort study.

This research paper supports Goal 1: Promote mental health and wellbeing, and prevent mental health problems; and Goal 7: Expand the evidence about rates, causes and effective interventions.

Cutajar, M. C., Mullen, P. E., Ogloff, J. R., Thomas, S. D, Wells, D. L., & Spataro, J. (2010).

Medical Journal of Australia, 192(4),184-7.

Abstract

Numerous research studies have linked child sexual abuse to various negative outcomes, including suicide, suicide attempt and other self-destructive behaviour. However, few have used official records and measurements of sexual abuse, or had an adequate sample size and follow-up period to detect the outcome of suicide, which has a low rate in the general population. This study aimed to investigate the rate and risk of suicide and accidental fatal drug overdose in individuals who had been medically ascertained as having experienced sexual abuse in their childhood, over a follow-up period of up to 44 years.

The study examined forensic medical reports from the Victorian Institute of Forensic Medicine of 2759 children who had experienced child sexual abuse. The data from individuals in this group was then linked with data from unnatural deaths recorded in coronial databases. Rates of suicide were then compared with rates from the general population, taken from the Australian Bureau of Statistics.

Twenty one cases of fatal self-harm were reported in the group who had experienced child sexual abuse, eight of which were identified as suicide. Findings indicated that risk of suicide in both males and females who had experienced child sexual abuse was significantly higher than that of both males and females in the general population group. The same finding was observed for the outcome of accidental fatal overdose.

However, the study also found that individuals who died by suicide did so many years after the abuse they experienced, averaging 18 years after the abuse occurred. Therefore, there is hope that considerable opportunity exists to implement interventions after an experience of child sexual abuse to reduce this risk of suicide.

For full-text electronic copies of this research email Russell Tuffery (info@spinz.org.nz) or phone 09 300 7035.

Emergency departments are underutilised sites for suicide prevention.

This research paper supports Goal 2: Improve the care of people who are experiencing mental disorders associated with suicidal behaviours; Goal 3: Improve the care of people who make non-fatal suicide attempts; and Goal 7: Expand the evidence about rates, causes and effective interventions.

Larkin, G. L., Beautrais A. L. (2010). Crisis, 31(1), 1-6.

Free full text

Emergency departments (EDs) are a critical site for implementing interventions and linking to outpatient care for people who have made a suicide attempt. EDs in the United States record 500,000 suicide-related visits every year, and research indicates about a quarter of these people make another attempt, and 5-10 percent eventually die by suicide. Preventing these further suicide attempts and completed suicides requires ensuring people who make a suicide-related visit to the ED are engaged and referred into outpatient care and suicide prevention management.

The authors identify three distinct groups of people visiting EDs at significant risk of suicidal ideation and behaviour where the potential exists for further screening and intervention. These include people coming into the ED thinking about suicide or who have made a suicide attempt, people who attend with a mental health disorder, and people who present with physical problems but who may have hidden suicide risk. Within these groups of people, numerous suicide-related factors are present, including being male, youth, an older adult, owning a gun, and having depression or a substance abuse problem, among others.

Research indicates that ED-based brief interventions and facilitated referrals to longer-term treatment have been effectual and cost-effective for patients with substance abuse problems. The authors argue that suicidal patients have a similar level of complexity in their psychosocial needs, and so screening and intervention for these patients in the ED is an important area to explore.

Potential interventions include teaching brief problem-solving, coping and self-soothing skills; informal help with psychological and social needs; creating safety plans; and follow-up letters or phone calls to the patient after discharge. Underpinning these interventions with staff education about suicidal behaviours and suicide prevention is also crucial.

For full-text electronic copies of this research email Russell Tuffery (info@spinz.org.nz) or phone 09 300 7035.

Contact us

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For contact details and resources for journalists, click here.

NB: The Mental Health Foundation library, which houses the SPINZ collection, is located at our Auckland office. You can contact a librarian by email: resource@mentalhealth.org.nz

spinz SUICIDE PREVENTION INFORMATION NEW ZEALAND

URL references

If you are viewing this newsletter in hard copy, please find a list of relevant URLs below:

Clinical Advisory Services Aotearoa (CASA)
http://www.casa.org.nz

Community Postvention Response Service
http://www.casa.org.nz/current-programmes/community-postvention-response

Emergency departments are underutilised sites for suicide prevention
http://psycontent.metapress.com/content/q3874gm09801q58p/fulltext.pdf

Evidence-based approaches – Practical Guide
http://www.moh.govt.nz/moh.nsf/0/567A24EE4A6EB85ACC2570A7000C1C45/$File/youthsuicidepreventioninschools.pdf

Evidence-based approaches – Research Report
http://www.fmhs.auckland.ac.nz/soph/centres/ipic/_docs/cr72.pdf

Gambling Helpline New Zealand
http://www.gamblingproblem.co.nz

Media guidelines
http://www.spinz.org.nz/file/downloads/pdf/file_50.pdf

Ministry of Education's Special Education Services
http://www.minedu.govt.nz/NZEducation/EducationPolicies/SpecialEducation.aspx

More information for families
http://www.spinz.org.nz/page/30-Family-Friends

More information on suicide and problem gambling
http://www.pgfnz.org.nz/Uploads/PDFDocs/Suicide_and_gambling_fact_sheet_2008.pdf

More information on the risk factors of suicide
http://www.spinz.org.nz/file/downloads/pdf/file_144.pdf

New Zealand Suicide Prevention Strategy 2006-2016
http://moh.govt.nz/moh.nsf/indexmh/suicideprevention-strategyandplan

Oasis Centre for Problem Gambling
http://www.oasiscentre.org.nz/home.php

Problem Gambling Foundation of New Zealand (PGFNZ)
http://www.pgfnz.org.nz/Home/0,271,1132,00.html

SPINZ on Twitter
http://twitter.com/suicidenz

SPINZ website
http://www.spinz.org.nz

Suicide and fatal drug overdose in child sexual abuse victims: a historical cohort study
http://www.ncbi.nlm.nih.gov/pubmed/20170453

Suicide prevention and problem gambling – Canadian study 2006
http://www.informaworld.com/smpp/6561329-46267668/content-db=all-content=a756622479

Suicide Prevention Research Fund
http://www.tepou.co.nz/page/419-suicide-prevention-research-fund

Te Pou
http://www.tepou.co.nz

The Lowdown
http://www.thelowdown.co.nz

Treating Depression – Practical Guide
http://www.moh.govt.nz/moh.nsf/0/567A24EE4A6EB85ACC2570A7000C1C45/$File/youthsuicidepreventioninschools.pdf

YouTube channel
http://www.youtube.com/SuicidePreventionNZ