

Newsletter

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The chief coroner and suicide reporting

Sifting through the evidence: improving suicide reporting

An interview with Chief Coroner Judge Neil MacLean

By Chris Banks

CHIEF CORONER'S VIDEO INTERVIEW

"What coroners deal with is the truth, telling it like it is," Judge MacLean says. "Forget about the mystery, forget about the rumours and speculation, here are the facts. Now, make of it what you will."

"Almost everybody has a personal story to tell about a friend or a relative or someone they know who committed suicide. It's one of the taboo topics that we're never very specific about. It was sort of something to be embarrassed and ashamed about."

"I think, unpalatable though it is, more discussion, more accurate information, can only be for the better."

"The Coroners Act 2006 has very clear stipulations about the reporting of suicide: a death cannot be reported publicly as a suicide unless it has been ruled as such by a coroner. If a death



Judge Neil MacLean

The chief coroner and suicide reporting

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is ruled to be a suicide after an inquest, the level of detail released publicly is at the coroner's discretion."

It is about this particular area – post-inquest – that Judge MacLean's references to "more accurate information" are being made. But how much information should be released, and in what context?

Coroners are appointed judicial officers who investigate and identify the causes and circumstances following certain types of deaths, particularly those that are sudden and/or unexplained. Part of their investigation involves making recommendations to the public on how the chances of similar deaths recurring in the future may be prevented.

In addition to the chief coroner, there are 14 coroners based in nine locations throughout New Zealand. Each works within a specific geographic region.

The chief coroner works with coroners and their support staff to promote consistency of practice throughout the country, and raise professionalism. The integrity and effectiveness of the services coroners provide reside with this role.

Neil MacLean is a district court judge. He was a partner in three Christchurch law practices between 1972 and 1993. Before his appointment to the District Court Bench, Judge MacLean served as the Christchurch Coroner from 1978 to 1993.

He has continued to carry out inquests since his judicial appointment, usually for complex matters or where a second inquest has been directed, or where another coroner has a conflict of interest. He also assisted in the preparation of the *Coroner's Manual 1988* and provided consultative information to the chief judge regarding the *Coroners Act 2006*.

In 2006, the coronial system in New Zealand underwent a major overhaul. The Law Commission in 2000 identified a number of issues with the existing system, which were seen to be undermining public confidence in the integrity of the system.

The new act:

- Created the position of chief coroner, of which Judge MacLean was the first.
- Replaced 55 mostly part-time coroners with up to 20 legally qualified full-time coroners.
- Established the Coronial Services Unit, which deals

directly with families and provides a dedicated support service of case management, court taking, typing of findings and recommendations, and transcription of evidence.

The suicide reporting debate

"There is a wide range of views. On the one hand there is still a group which says you shouldn't actually allow anything at all, you shouldn't even talk about it.

"There's another side, which I think could be said is basically the mainstream media view in New Zealand and in Australia, that [says] – look, you can trust us. We are human beings ourselves. We don't want to find out that someone committed suicide because of the crass way we wrote up a story. But for heaven's sake let us publish it.

"I speak to various organisations all round the country and the feedback I get is, 'thank goodness someone's saying what you're saying.' We welcome this being discussed."

"And then of course comes the often quite difficult area where people will get up, and often – I suspect for the first time in their life, in front of a hundred other people – start to tell the story about their son, their daughter, their father."

Bad reporting

"Whatever restrictions there may be, what we don't want is inquest by media. The thing being played out before it's even come before a coroner.

"And, as I've seen on some programmes, going to the park where the person, say, hanged themselves, having an in-depth interview with the grieving mother who's still struggling with the reality of it, and in a very vulnerable state herself. That's not responsible reporting in my view.

"You can't start talking about something as a suicide before it's got to the coroner, in fact you can't really say anything about it before it goes to the coroner. Media should not be speculating about guilt or innocence, cause and effect, that sort of thing – because we have institutions, i.e., the courts, that actually will decide that in a calm, dispassionate and objective way – on evidence.

"Constantly media are pushing the boundaries in this area. We remonstrate with them, and I've spoken with the Freedom In Media group, [saying] make sure your sub editors and your journalists do understand what the law is, and that they can't just start talking about a suicide or a presumed suicide without the permission of the coroner."

The chief coroner and suicide reporting

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After an inquest – more open discussion

“After there’s been the inquest, you can basically only publish what the coroner authorises to be published.

“I’m [now] suggesting to coroners as they grapple with the higher threshold in the 2006 [Coroners] Act that [says] they must be satisfied that it will not cause harm to the public; to turn around and say – would it be beneficial for there to be publication of this amount, or all of, what I’ve just said and heard in court?”

“What I’m picking up increasingly now is, families are asking for that. In the past they’ve been saying – please, this is a personal private tragedy, please don’t publish anything, could you even restrict publication of the name. That’s starting to change.

“They will often say we don’t want this to ever happen to other parents in a comparable situation.”

How to prevent suicide – more information

“Parents need to know – what are the warning signs? Of course the problem is, what is normal behaviour in an adolescent young man? Parents need to get some help in knowing what’s ok, but what is ringing warning bells.

“To an adult, the apparent catalyst appears quite trivial, and you look at it and say, why on earth would that drive that person to take that final

ultimate step? Because the reality is, you have to go back down the journey, the life journey, [because] it’s been building up to something that’s been going on.

“[People are saying] we’d like someone to tell us what we can do, we’d love to help, but we don’t know how to help.

“As a chief coroner, or a coroner, we’re not the experts in suicide prevention. Our job is [to say] this is what’s going on. We are no better qualified than anybody to say what the right answer is.

“What we can say is, these factors have emerged in this particular case. We can begin to identify, where did it go wrong? Where did this person start to descend or spiral down to the stage where they took their own life?”



Earthquake relief and wellbeing in Christchurch

When the shaking stops - safeguarding a community's wellbeing after a disaster

By Susie Hill

Suicide prevention is often seen as the 'ambulance at the bottom of the cliff', when in fact promoting mental health and wellbeing and preventing mental health problems is goal number one in the [Ministry of Health's Suicide Prevention Strategy and Action Plan](#).

Exposure to trauma, stressful or negative life events and social factors such as isolation, lack of support are all risk factors for suicide.

Vulnerability is a defining word that comes to mind when thinking of the devastating series of earthquakes that have hit Christchurch, but agencies, communities and everyday folk on the ground are doing their bit to promote mental health and wellbeing in their communities and help people through tough times.

We speak to Freedom Preston-Clark from the Mental Health Foundation's southern regional office, and Carol Hippolite from Nelson's Whakatu Marae about their roles at this time of crisis for the people of Christchurch.

Christchurch staff had to flee

Christchurch-based Mental Health Foundation staff had to flee their inner city office and run out into the chaos of Latimer Square on the day of the second major earthquake on 22 February 2011.

Their manager Freedom Preston-Clark was home at the time, returning there after a period of leave. She is incredibly grateful that no one was hurt – their office building and all others around it are now signalled for demolition; their homes and neighbourhoods in disarray. So it is no small feat that the entire team is now meeting once a week to get on with 'business as usual'.

Mental health promoters get involved

Suicide prevention requires a collaborative approach across multiple sectors, and Freedom says her team has

never been more practically involved with organisations than they are right now. Staff are working with the New Brighton Project, Project Lyttleton, Volcano Radio and Women's Refuge.

Such things are now the norm: "These things are not extraordinary, they have become ordinary. Our administrator was feeling lost so, off her own bat, she went to the Red Cross and did data registering."

She says there are no barriers to assisting others and people aren't scared to ask for or offer help. One of her ways of contributing to the local community is meeting her team at places like The Loons – a bar that's just reopened, as a cafe during the day and a bar at night.

Slicing through usual barriers

For those people who need help with their mental health, there are options open to them. Freedom says the usual red tape has been cut through like never before. The Ministry of Youth Development has provided money. Mental health organisations have been working together, such as the Bipolar Trust, Anxiety Support and the Psychiatric Consumers Trust, which was given a green sticker so it could be used as a drop-in centre.

A regular earthquake email from Canterbury DHB keeps Freedom's team up to date with meetings, services and support groups that are still open, have closed or moved.

Healing and wellbeing post earthquake: marae style

One marae in Nelson didn't wait to work out exactly how to help the people of Christchurch following the devastating quake - it just swung into action and put out a message that it was open to earthquake evacuees.

"When we got the news, we went through the marae committee and others, like Te Puni Kokiri and the Maori Party, to see if we could open up. We were able to have a meeting with different agencies in town and ask if there was any support," says Carol Hippolite, health promoter at Whakatu Marae.

As a result they got help from Work and Income, the IRD, the local PHO and DHB, the Red Cross, and the community at large.



Freedom Preston-Clark



Whakatu Marae

Earthquake relief and wellbeing in Christchurch

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“The first group of families arrived on Friday night and we set them up in the marae with bedding and kai, and we got the budget to shop [for other essentials].

“We asked for any offerings and got blankets, food, cots, prams, clothing, towels, pillows, soap and toiletries... it was fantastic.”

The marae and community’s response showed how effective collaboration in the safeguarding of wellbeing can be. The community really rallied around and everything was provided free.

“Some people dropping off food were counsellors so they stopped to talk to people,” Carol says.

The marae temporarily took in 45 whanau, Maori and non-Maori. People on the marae worked creatively to connect agencies with the evacuees: they allowed support workers to base themselves at the marae, and provided them with food and drinks so everyone could get through.

The marae had its own whanau ora services and had a doctor come in to check people and provide medicines.

“There are six iwi affiliated to our marae, and we had community support. We forfeited some money ourselves to kick start things, but we did ok in the end.”

Carol says the entire experience was a real eye-opener for the marae and, if such a thing ever happened again, they feel they have learnt enough to be able to set things in place before people arrive.

Connecting with local people

Back in Christchurch, there has been a huge loss in terms of friends and colleagues moving out of the city and, as a result, new connections are being forged.

Freedom’s colleague Ciaran Fox is working with Volcano Radio in Lyttleton - he can’t get through the tunnel easily because the tunnel’s control station has been damaged, so he stays there and responds to his community with the help of the station and business sponsorship.

He is also doing 15 minute presentations through Green Prescription areas, promoting practical and proven ways Cantabrians can support their own wellbeing and the world around them.

Freedom and her team are saturating the city with a series of five posters featuring these messages, based on the [Winning Ways To Wellbeing campaign](#) used for Mental Health Awareness Week in 2009.

The messages are:

- CONNECT – Talk and listen, be there, feel connected

- GIVE – Your time, your words, your presence
- TAKE NOTICE – Remember the simple things that give you joy
- KEEP LEARNING – Embrace new experiences, see opportunities, surprise yourself
- BE ACTIVE – Do what you can, enjoy what you do, move your mood

“These messages are just as important as other public health messages, like boiling your water,” Freedom says. “Mental health needs to be on an equal footing with physical health – that combination is what keeps us all going.”

She says there is a lot being done by other organisations also to increase social cohesion in Christchurch, such as [Gap Filler](#), [Living Streets Aotearoa](#), the [UC Student Volunteer Army](#), and art projects like [A Good Yarn](#).

Some activities wouldn’t necessarily be seen as promotion of mental health and wellbeing, but in fact they contribute to that goal by their very nature.

People with experience of mental illness the real experts

People with experience of mental illness are coping better than others during this time, Freedom believes, because they have learnt how to manage anxiety, know their triggers and realise they don’t have to freak out.

“Some people with experience of mental illness can operate really well under this sort of pressure and it’s fantastic. It’s good for them to see that they can be setting the example – they are the experts on this stuff!”



Mental health in primary care

Working at first base: psychiatrist David Codyre and GP Tane Taylor say primary care is working to improve the nation's mental health

by Susie Hill

"We know that in the month before someone attempts suicide most have visited a GP," says David Codyre. "We know that if people with a mental health problem present anywhere, it is usually in primary care."

Dr Codyre is an Auckland psychiatrist who – unusually – works in primary care. He is Primary Health Organisation ProCare's clinical director of primary mental health, and he says a sharper focus on mental health within primary care is quite capable of reducing suicide rates.

Interestingly, he says, suicide rates have fallen around the country over the past five years, during which time primary care has been better focused on mental health. ProCare has been focusing on mental health care for the last 10 years, he says, ahead of the nation as a whole, which has only been doing so for the past five.

As a result, GPs are getting more proficient in recognising when physical symptoms might indicate emotional problems, and they are being given tools to address this.

Dr Codyre cites three ways in which primary care practice has recently improved mental health care:

- Training and workforce development – where GPs better understand mental health in the context of their everyday work
- Funding for longer consultation times when GPs recognise mental health as an issue
- Upskilling nurses to access self-management tools for patients
- Funding brief access to talking therapies (counselling) where necessary.

"If we do all that better, we will reduce suicide rates," Dr Codyre says.

Talking about suicide

He believes another contributing factor to lowering suicide rates may include a greater national awareness of depression, largely due to the successful [national depression initiative TV and web campaign](#), fronted by former All Black John Kirwan.

Anecdotal evidence from GPs suggest that more people, particularly men, are coming to primary care with depression since the campaign. The flipside of that is that primary care needs a wider range of services to address the upsurge.

The medical profession and others should be able to talk about suicide safely in public, Dr Codyre says.

He cites initiatives like [The Nutters Club](#), a radio and TV show supported by the Mental Health Foundation that he co-hosts with comedian Mike King. The show encourages open discussion about mental health and addiction issues, led by guests and callers who have had personal experience.

Secondary and primary sectors should collaborate

People deemed to have more serious mental illness are elevated to a secondary level of mental health care, but Dr Codyre believes collaboration between frontline services and secondary mental health care could reduce the number of people needing such services.

Secondary mental health care is part of what Dr Codyre calls New Zealand's "institutionalized mentality"; where more money goes to fewer people and there is a mutual lack of trust between sectors. He says it is important



Comedian & Nutters Club host Mike King with Dr David Codyre

Mental health in primary care

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for specialists and primary care to find ways to work together.

“DHBs have to work with PHOs, for example, to get more collaboration and to shift people’s habits of thinking. There is good research to inform this and show that when specialists work with primary care fewer people need to get into specialist services.”

This, he says, is all underpinned by the fact that with better access to mental health care and better standards of care, we will further reduce the suicide rate.

Mainstreaming for Maori: building bridges, not islands

For Maori, there are some GPs who believe the best way to improve the care of people experiencing mental health disorders associated with suicide attempts is to go mainstream – a view which some may find controversial.

Dr Tane Taylor is an Auckland GP and chair of Te Akoranga a Maui, the Royal New Zealand College of General Practitioners (RNZCGP) Maori Faculty and acting chair of the RNZCGP’s Auckland Faculty Board.

“I do not subscribe to the notion of ‘by Maori for Maori’, but the best for Maori - whatever is best for Maori, and wherever it comes from. The average is not cutting it, we need the best,” he says.

Dr Taylor believes the RNZCGP’s Cornerstone Practice Accreditation Programme will go a long way to address unmet Maori health needs, including mental health care. And he says using accreditation modules makes it possible to measure outcomes to prove what works and what doesn’t.

“International evidence supports that if we go after small groups it becomes costly and non-effective, but if we screen for all populations we will capture a lot of Maori.”

Dr Taylor says 98% or more of the Kiwi population is seen in mainstream general practice, so it makes sense to require outcomes for every GP through their accreditation quality processes.

“They are required to look after all Maori on their books, as opposed to those ‘in the community at large’; they need to make sure Maori are being served and managed appropriately with clear outcomes [in order to] reduce disparities.”

The Cornerstone Practice Accreditation Programme ensures GPs identify gaps in their practice. Funded by the Government in the first cycle, general practices go through accreditation every three years, and the accreditation tools used by the RNZCGP are continuously modified.

Under this system, every practice now has to have a Maori health plan; their practice has to show they have engaged with local Maori and that they are making a difference.

“They have to show Maori in their practice have at least the same healthcare as non-Maori, for example, are they getting free chronic diabetes care? This is all measurable.”

But there’s currently no module for mental health. Dr Taylor says this is a priority area.

“My understanding is that in the not too distant future specific modules addressing mental health issues will be made available to the sector.”

He says improving all aspects of Maori health should be about building bridges, not creating islands.

“Maori want and must participate in finding solutions [and we should], but this is not a Maori only issue, it is a New Zealand issue; we all need to be involved.

“We are encouraging initiatives based on family, but they need closer evaluation and outcomes that can be generalised, rather than occurring only in pockets.”

He is very happy with the way accreditation is progressing because instead of looking at islands, general practice is looking for bridges – in alignment with the collaborative approach needed for effective suicide prevention work for all populations.



Dr Tane Taylor

The ripples of grief: after a suicide

By Chris Banks

[TRICIA'S VIDEO INTERVIEW](#)

It's been nearly 14 years since Tricia Henry lost her husband to suicide. Her three children were all under 10 at the time, her youngest daughter only two years old.

"I think I understood suicide always as a tragedy, but I'd never had to personally own it, or really look it in the eye. I'd known people who died by suicide, but no-one really close to me.

"I remember when I got my husband's note. I remember it falling out of my hands, like I was in this weird sort of movie. Picking up the note, reading it again, thinking this has happened, this is real. My next thought was - I could tell everyone it was a heart attack. And then I thought - I probably could pull that off."

Like all families and friends of the 500 New Zealanders who die each year by suicide, nothing prepared Tricia for the journey she was about to embark on.

"I knew that I had to call key people, but after calling three or four people, I actually went into this weird kind of emotionless automatic mode where I knew I had to call this person, this person, this person, but after that - I mean, their reactions at the end of the phone were dreadful - but I didn't feel anything. I was in this numb, cotton wool land. But I knew it wouldn't always be like that."

When grief finally came to Tricia, the intensity astonished her.

"For me, I remember lots of shaking, lots of physical shaking for weeks, even months after it had happened. I remember having a bowl of soup in front of me and hardly being able to get the spoon from the soup up to my mouth, that's how drained I was. I have memories of just lying there, aching from head to toe, thinking can grief do this? And yes, it jolly well can.

"But it's not just physical, it's of course your emotional, your mental side, like getting confused, being forgetful, being distracted, thoughts going over and over and over in your mind, and you know when it's been a suicide it's often the, well, what could I have done, and who's to blame, and why has this happened? Not just a thought floating in and out, but repeating inside. And that can go on for a long time."



Tricia Henry

As Tricia worked through her own grief, she also had to help her children make sense of what they were going through.

"Children might ask the most unnerving questions and details that adults feel uncomfortable about telling them, and they do it with seemingly no emotion. One of my children cried a lot for a very long period of time - years - fretting and being incredibly sad, and expressing that. Another child didn't, and said to me, does that mean I love my dad less? And I said no, it just means you're wired differently, and you're grieving differently. We're all hurting, but we just show it in different ways."

In those early days, Tricia learned to reach out for help, and found it in many places - from friends, family, counsellors, and other bereaved people.

"I think I just intuitively moved toward the people I could be myself most with, who I could trust. And the kids did the same. They used to go to the homes of families where they were just ordinary old kids and they weren't special, they were just who they were before their father died.

"I think I was quite astonished at how much people wanted to help. And people feel so helpless. When you actually give them ways to help, they really go the extra mile for you."

Tricia took solace in music, writing, and taking time out for herself. Eventually, her mind turned to the unanswered questions.

The ripples of grief: after a suicide

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"If something happens, it doesn't matter what it is, the first question tends to be - what happened? So I did whatever I could to understand the nature of suicide, to come to terms with the fact that he had been depressed but we'd called it burnout and being tired, and looking back it's so obvious. I'm stunned that we missed it, but we did."

Like many left behind after a suicide, Tricia started to blame herself.

"But as time went on and you got more perspective, you realise there's no one thing that caused this, this was a mixed bag of life experiences that impacted his life and made him incredibly unwell and distorted his thinking.

"But I don't want to focus on how he died. I've tried to raise the kids and move on based on how he lived, if that makes sense. I know that sounds cheesy, but it's really true for us."

[ELIZA'S VIDEO INTERVIEW](#)

Bringing people together after a suicide, particularly in communities where there have been a series of deaths, requires understanding and respect for the culture of the community where support workers are.

Suicide in a community creates a ripple effect, touching not just the lives of loved ones, but others who may have felt connected to that person.

In Maori communities, Eliza Snelgar, a registered nurse from Clinical Advisory Services Aotearoa (CASA) works with whanau, iwi and hapu to gain trust before work begins.

"With Maori communities there are definite steps that we take around the mihi. Being able to first of all acknowledge the atua. Acknowledge the whare that we're in. Acknowledge the awa, the maunga, the whenua, and allow the grieving and the wairua to take place.

"It's different to a tangi - they're here to get some different results, under a different kaupapa, a different take."

A large and diverse group can be at this initial gathering.

"It's usually a really wide cross-section of the community there, made up of kaumatua, kui, GPs, school principals, teachers... sometimes there will be the whanau pani, or the bereaved family, there, and that brings another

dynamic into the group situation. We need to show particular sensitivity."

Once the discussion has begun, and the taboos are broken down, the results are very positive for whanau and communities affected by a suicide.

"One kaumatua said to me, you know, I walk up the street and I see Aunty so-and-so coming towards me and we can talk now about suicide," Eliza recalls. "They weren't able to do that previously, because of the mamae, the hurt, the grief, and maybe the guilt may still have been there.

"So they get that opportunity to share it rather than carrying it themselves."



Eliza Snelgar

Prison welfare: making it impossible to kill yourself

By Cate Hennessy

“A prison that focuses on needs and strengths would mean we would have a whole new prison system.” – Kim Workman, Director of [Rethinking Crime and Punishment](#).

A major goal in New Zealand’s suicide prevention action plan is reducing access to the means of suicide, particularly in prisons, where hanging is a commonly used method.

But there’s one organisation that believes some prisons are being too myopic in focusing on this goal alone, at the expense of promoting the mental health and wellbeing of prisoners – the ultimate suicide prevention tool.

Rethinking Crime and Punishment is a strategic initiative to increase public debate and discussion about the use of prison and alternative forms of punishment in New Zealand. Its director, Kim Workman, believes New Zealanders need a better understanding of how our criminal justice system works and how well it’s working by promoting transparency and accountability, and encouraging active community involvement and engagement.

Prison population increasing

New Zealand’s current prison population is approximately 9,000 people, and the imprisonment rate has increased by 53% in the last decade. In the western world, New Zealand is second only to the United States in the rate at which it locks people up.

Kim says because numbers have increased so rapidly, basic conditions have decreased.

“This is recognised in the [National Health Committee’s 2010 Health in Justice report](#),” he says. “It paints a pretty miserable picture of health in general, and mental health in particular.”

Some of the issues picked up were prisoners double-bunking, being locked in their cells 20 hours a day and not being allowed to exercise or participate in other activities. Kim believes these infringements of people’s human rights are a mental health issue as well, and tend to aggravate and cause mental health issues, such as depression.

Suicide in prisons

Although even one death is a loss, given the size of the current prison population the rate of suicide among New Zealand prisoners has remained relatively low since it peaked in mid 1980s. The highest in more recent years was in 1994, when there were 10 suicides.

However, according to Kim, the issue is not the number of suicides, it is how self-harm and suicidal behaviour is addressed in prison.

“What is happening is that prisoners are being monitored and medicated, but their issues are not being treated.

“There is a difference between treating a prisoner and ‘managing’ their behaviour. Our research has found that in most prisons self-harm is ‘managed’ by physical isolation, having a cellmate that can ‘sound the alarm’, or by chemical means.

“In the most extreme cases of mental distress, prisoners are moved to special units such as Auckland’s Mason Clinic and the Henry Rongomau Bennett Centre in the Waikato.”

Kim says there is a lot of effort put into physical prevention but not so much effort is put into mental wellbeing – “which is what we would want to see”.

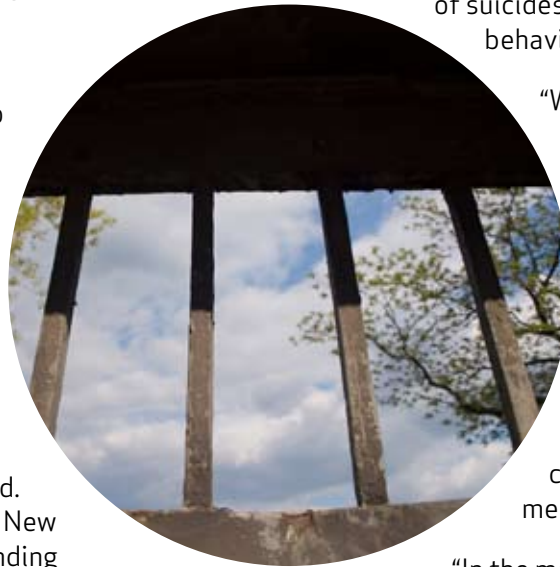
Kim’s colleague, research advisor Catherine McCullough, agrees. She says while custodial prison staff receive some mental health education, the overall approach taken is ‘I am going to make it impossible for you to kill yourself’.

“They will remove the physical dangers, such as shoelaces and belts, but are not able to build up mental wellbeing. This is as far as they are able to go unless we have a massive shift in how we think and manage our prisons.”

Challenges and benefits of promoting wellbeing in a prison

Rethinking Crime and Punishment works within prisons with prisoners to support and educate them about keeping mentally and physically healthy. Kim says what he sees happen sometimes is quite extraordinary.

“One man had a head injury, which made him violent and



Prison welfare

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difficult to manage. He joined the choir in our group and was difficult to begin with. He sang with a tea towel over his head and with his back to the crowd.

“Then he began to relax. After a few months, he decided that he wanted to come off the medication he was on as it was making him very sleepy.”

There were some concerns this would exacerbate his behaviour, but Kim says he was no bother.

“He managed his impulses and two months later he was leading the choir. He went on to lead an exemplary existence within prison and when we checked on him a couple of years later, he was still doing really well.”

Catherine says there are many barriers in place in prison preventing good mental health.

“Access to basic needs such as exercise, sunshine and contact with loved ones is difficult in the custodial prison environment that exists in New Zealand. And if you are in a stressful, degrading and non-therapeutic environment, your mental health deteriorates.”

Kim believes health provision in prisons should occur within a pro-active public health framework, rather than relying on prisoners to report illness, in the expectation that the system will respond. However, that would be reliant on the availability of funding”

He says given the opportunity to address their mental and physical health issues, lots of prisoners are interested in making a permanent change in their lives.

“Seven years ago, when we offered the QUIT programme to prisoners, one third took up the offer. When prisoners are concerned about their health, they will take whatever opportunities are on offer to maintain a healthy lifestyle.”

“Those that come from very poor communities often expect their health to be poor – they don’t know what good health feels like because they’ve never experienced it. Once they start feeling well and realise how good it feels to be healthy it can be a trigger to address other issues.”

The benefits of promoting wellbeing are huge.

“If you can deal with mental health issues in prison then you can reduce incidences of mental distress within prison,” Kim says.

“A prisoner’s mental health is often one of the factors that leads to further

offending. Good mental health also makes for successful reintegration, and can reduce considerably tensions that often exist within the family and whanau, and the wider community.”

What next?

Kim suggests we should be taking our lead on how to improve wellbeing in prisons from existing [international models](#).

“The World Health Organization’s [Health in Prisons](#) or Professor Andrew Coyle’s [A Human Rights Approach to Prison Management](#) developed at the International Centre for Prison Studies could provide a guide.”

“The basic question we need to ask is whether it is necessary to send people to prison? The evidence would suggest that community based treatment is better.”

Catherine adds, “We need to think about who ‘we are angry at and who we are afraid of, for example, sociopaths, psychopaths. Prison is not the place to ‘teach people a lesson’ and even for the people who are the worst of the worst, there are ways of running a prison humanely.”

Did you know that:

- New Zealand prisoners are charged \$1 per minute to make phone calls – a deterrent to keeping in contact with their families.
- New Zealand prisoners tend to lose their rights as citizens - most recently, the right to vote.
- In Scandinavian countries, the focus is on keeping
- In Scandinavian countries, the focus is on keeping people in their communities where possible and to provide treatment for any alcohol and drug or mental health issues instead of sending them to prison. Those who are sent to prison can be sent to either a ‘closed’ or ‘open’ prison. While ‘closed’ prisons are similar to what we have in NZ, open prisons allow people to leave the grounds for work and other appointments (e.g., doctor’s visits) - returning to prison at night.
- There are programmes such as at the Samaritans [Prison Listener’s scheme in the UK](#), which promotes wellbeing by teaching prisoners how to listen to each other.



New 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](#).

Contact Russell Tuffery (info@spinz.org.nz) if you would like copies of these articles and resources.



[Diagnostic and individual characteristics in a clinical sample, 2011](#)

Fernando K, Carter JD, Frampton CM, Luty SE, McKenzie J, Mulder RT, Joyce PR. *Comprehensive Psychiatry*. 2011 Mar 1. [online, ahead of print]

Onset of depression at an early age (14 to 25 years) is associated with a number of increased risks including greater suicidality. Particular personality characteristics may also be associated with an earlier onset of depression. Also, at puberty the prevalence of depression increases, and sex differences emerge.

The research sample was 372 depressed outpatients from Christchurch (62 childhood-onset participants, 101 teenage-onset and 209 adult-onset) and this study sought to compare the three age groups.

While the researchers found fewer differences between the onset groups than expected, the results suggested childhood and teenage onset had a higher likelihood of comorbid Axis I & II diagnoses (particularly alcohol and substance abuse, OCD, social phobia) and attempted suicide.

Childhood-onset depression is associated with greater comorbidity (when two or more disorders or illnesses occur in the same person).

[Sexual attraction, depression, self-harm, suicidality and help-seeking behaviour in New Zealand secondary school students, 2011](#)

Lucassen MF, Merry SN, Robinson EM, Denny S, Clark T, Ameratunga S, Crengle S, Rossen FV. *Australian and New Zealand Journal of Psychiatry*, Mar 2. [online ahead of print]

Using data collected from *Youth'07* - over 9,000 randomly selected New Zealand secondary school students - the study investigated the associations between sexual attraction and depression, self-harm, suicidality and help-seeking behaviour.

Research has confirmed that gay, lesbian and bisexual young people are at higher risk of depression and suicide, in particular because of negative and unsupportive environments. Few studies have looked at a comparison group with heterosexual young people.

The Youth2000 survey, showed almost a quarter of 'sexual minority' students reported increased depression and suicidality. In this *Youth'07* sample, about a third of gay students had come out (23 of the 73), while less than half of bisexual students had come out (111 of the 270). Most students in the sample were aged 15 years or less.

Students who were attracted to the same or both sexes consistently had higher rates of depression, suicidality and self-harming. They were also more likely to have seen a medical professional for emotional worries and to have had more problems getting this help.

"This is in line with previous research that has shown that although the majority of gay, lesbian and bisexual adolescents will grow up to lead happy, healthy, productive lives, they are at greater risk of self-harm, depression and suicide."

Bisexual students were found to be most vulnerable, likely due to struggling to find an identity and not fitting in well with either heterosexual and gay or lesbian networks.

Do schools influence student risk-taking behaviors and emotional health symptoms? (2011)

Denny SJ, Robinson EM, Utter J, Fleming TM, Grant S, Milfont TL, Crengle S, Ameratunga SN, Clark T.

Journal of Adolescent Health. 2011 Mar;48(3):259-67.

Family, peers, schools and the community are the main influences on a young adult's risk-taking behaviours and emotional wellbeing. School-based interventions can be effective but are often poorly implemented, and effects lower than in trials. A positive school climate is associated with better student and teacher wellbeing. Whole-school health promoting programmes have been shown to be effective.

Over 9,000 New Zealand secondary school students took part in this study, most students were aged between 13 and 17 years old. Also, nearly 3,000 teachers, and 91 school administrators took part.

The most common risk taking was cigarette smoking and risky motor vehicle use, with unsafe sex and attempted suicide the least common. Sense of belonging and a supportive school environment was associated with less risk-taking behaviours for alcohol use, violence and risky motor vehicle behaviours. Teacher wellbeing was found not to be associated with student risk behaviours, but schools with higher average wellbeing of teachers had lower rates of depression among students.

The study concludes that overall school effects were modest, and questions whether health promoting

programmes are achieving the desired benefits. The authors call for more rigorous best practice implementation of programmes.

Twelve month prevalence of and risk factors for suicide attempts in the World Health Organization World Mental Health Surveys, 2010

Borges G, Nock MK, Haro Abad JM, Hwang I, Sampson NA, Alonso J, Andrade LH, Angermeyer MC, Beautrais A, Bromet E, Bruffaerts R, de Girolamo G, Florescu S, Gureje O, Hu C, Karam EG, Kovess-Masfety V, Lee S, Levinson D, Medina-Mora ME, Ormel J, Posada-Villa J, Sagar R, Tomov T, Uda H, Williams DR, Kessler RC. *Journal of Clinical Psychiatry*, 71(12):1617-28.

Research shows some 9% of people report having serious thoughts of suicide at some stage in their life, and 3% will actually make a suicide attempt. Although most attempts do not result in suicide, this heightens further risk of chronic mental illness and suicide attempts. Trying to predict suicide attempts is of critical importance.

While many risk factors have been identified (demographic, family history, childhood adversities, psychiatric disorders, a history of attempts) applying these useful in a clinical setting has been difficult.

Obstacles include: small sample sizes, risk factors which are long-term, predicting those ideators most at risk of attempts, problems of assessing risk factors in clinical settings, and finding a way of combining risk factors to derive a single measure or level of short-

Continued...



New research

... continued

...Continued

term risk. This study sought to develop such a risk index.

The World Mental Health surveys were carried out in 10 developed countries (including New Zealand) and 11 developing countries between 2001 and 2007. The total sample was over 108,000, and the sample in New Zealand was 12,790. The focus was on suicidal behaviours within the past 12 months (ideation, plans, attempts).

Unplanned attempts were about one third of all attempts and the unplanned rate was higher in developed countries. Five sets of possible predictors of suicide attempts among those with ideation were examined:

- Sociodemographic characteristics (age, gender, education, family income, marital status, employment)
- Parental psychopathology (major depression, panic disorder, anxiety, substance abuse, antisocial personality disorder, past suicidal behaviour)
- Childhood adversities (loss, abuse, violence, economic adversity, chronic physical illness)
- Past suicidal behaviours
- DSM IV mental disorders (anxiety disorders, mood disorders, externalising disorders (eg, ADHD, conduct), substance disorders.

The study had three notable results.

1. Estimated the 12 month prevalence of suicidal behaviours among adults (18 plus) in 21 countries: 14.6 suicide attempts for every one suicide death (ideation 2%, plans 0.6%, attempts 0.3%).
2. Significant risk factors were: being female, younger age, lower education and income, unmarried status, unemployment, parental psychopathology, childhood adversities, mental disorders, and psychiatric comorbidity. Conduct disorder, anxiety and substance use disorders were the most significant predictor of attempts (i.e., disorders characterised by impulse-control and anxiety). Prior attempts are affirmed as significant factors and in particular that unplanned predicted further unplanned attempts (but not planned), and planned attempts likewise. The study reports an “intriguing result” that previous ideation can be ‘protective’ for attempts as opposed to those who attempt, who have never ideated before the last 12 months.
3. Risk factor indices were developed, that “might prove useful in predicting suicide attempts in clinical settings” and represents “an important initial step toward bridging the gap between the science and practice of suicide risk assessment.” Suicide prevention programmes that include a focus on screening those for elevated risk of suicide, are among those most likely to reduce the rate of suicide, but such programmes are not used in most clinical settings.

These indices may be most useful in identifying those at high risk for suicide attempt.





Contact us

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Media enquiries

For contact details and resources for journalists, visit our [media centre](#)

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

Suicide Prevention Information New Zealand is part of the Mental Health Foundation of New Zealand

URL references

Video interview with Chief Coroner Judge Neil MacLean

<http://www.spinz.org.nz/page/157-may-2011+improving-suicide-reporting-the-chief-coroners-view>

Ministry of Health Suicide Prevention Action Plan

<http://www.moh.govt.nz/moh.nsf/indexmh/nz-suicide-prevention-action-plan-2008-2012>

Mental Health Foundation Winning Ways To Wellbeing campaign

<http://www.mentalhealth.org.nz/page/29-welcome>

Gap Filler

<http://www.gapfiller.org.nz>

Living Streets Aotearoa

<http://www.livingstreets.org.nz>

UC Student Volunteer Army

<http://www.facebook.com/StudentVolunteerArmy>

A Good Yarn

<http://www.agoodyarn.org.nz>

National Depression Initiative with John Kirwan

<http://www.depression.org.nz>

The Nutters Club Radio Show

<http://www.radiolive.co.nz/WeekendHosts/MikeKing.aspx>

Video interview with Tricia Hendry about suicide bereavement

<http://www.spinz.org.nz/page/151-suicide-bereavement>

Video interview with Eliza Snelgar from CASA about suicide in communities

<http://www.spinz.org.nz/page/153-suicide-in-communities>

Rethinking Crime and Punishment

<http://www.rethinking.org.nz/>

National Health Committee's 2010 Health In Justice Report

<http://www.nhc.health.govt.nz/moh.nsf/indexcm/nhc-health-in-justice>

International models of prison wellbeing

http://www.who.int/mental_health/prevention/suicide/resource_jails_prisons.pdf

World Health Organization's Health In Prisons

http://www.euro.who.int/_data/assets/pdf_file/0009/99018/E90174.pdf

A Human Rights Approach To Prison Management

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<http://www.samaritans.org/derby/prisons.html>

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<http://www.ncbi.nlm.nih.gov/pubmed/21338897>

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