

The New Zealand Suicide Prevention Strategy

Looking back to move forward

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New Zealand
Suicide Prevention
Strategy
2006-2016



Suicide Facts

- 2004 - 486 people died by suicide compared to 517 in 2003
- Males have higher rate of death by suicide than females - 3.1:1 in 2002-2004, unchanged from 2001-2003
- 2005 - 4,433 hospitalisations for intentional self-harm, virtually same as 2004
- Women have higher rate than men, 2:1
- Maori hospitalisation rate is almost 1.5 x non-Maori rates

Te Rau Hinengaro - The NZ Mental Health Survey

- About 1 in 5 experienced a mental disorder in last 12 months
- About half of population will meet criteria for a mental disorder by age 75 years
- 15.7% reported having thought seriously about suicide at some time
- 4.5% report having made a suicide attempt
- Suicide Trends reports trends / patterns in suicidal morbidity and mortality from 1921 to 2003 but does not provide explanations for these behaviours

New Zealand Suicide Trends

- Mortality 1921-2003
- Hospitalisations for Intentional Self-Harm 1978-2004
- Data broken down into specific population groups, i.e. age, ethnicity, sex
- To inform prevention efforts and to show whether progress is being made in reducing suicidal behaviour

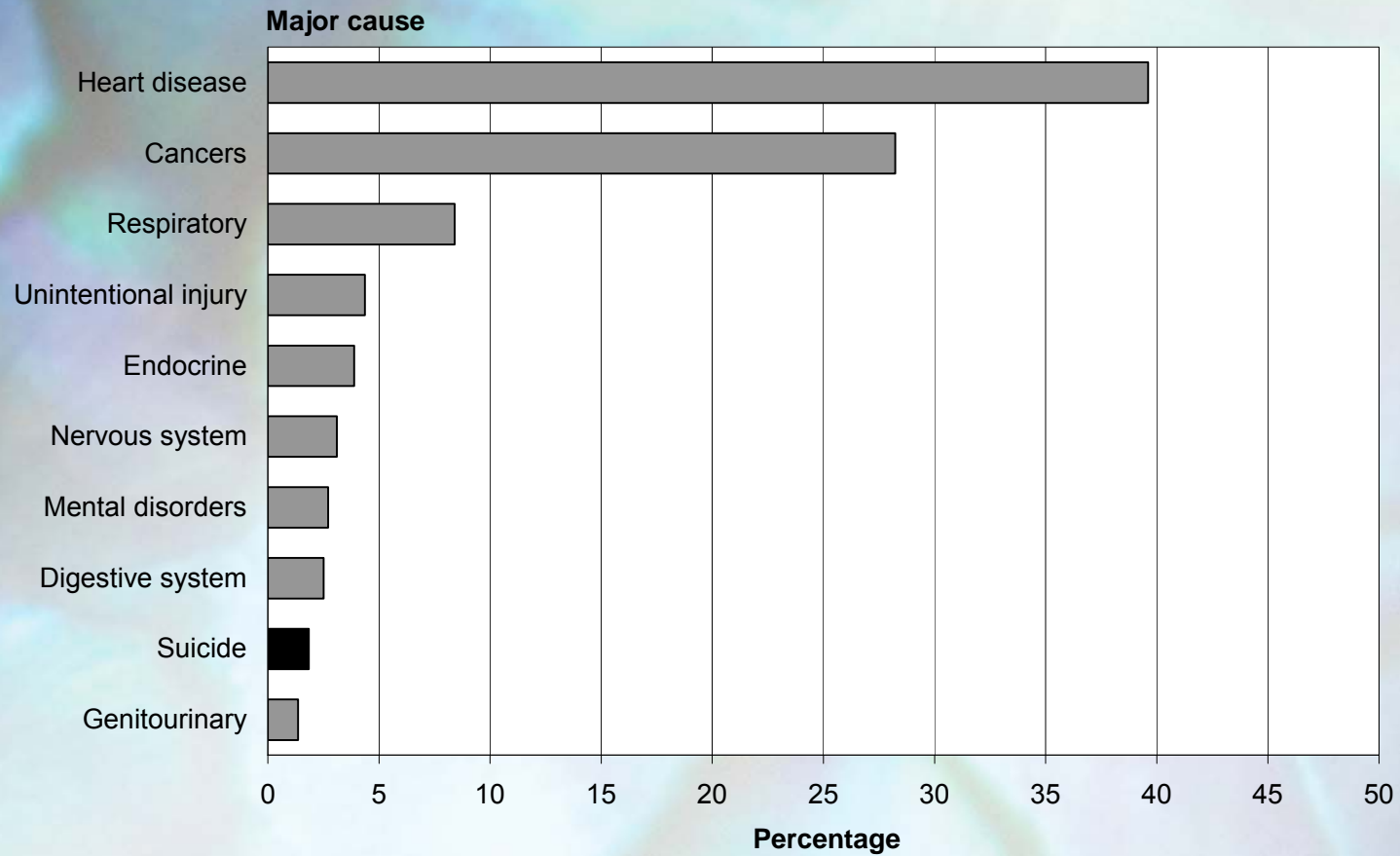
Three-year moving averages

- These are the average age-standardised rates for three year periods
- i.e. 1983-1985, 1984-1986 1985-1987 and so on...
- These allow for underlying trends over time to be more clearly illustrated
- They also provide for a more reasonable level of certainty as to the level of change than would a rate for only one year

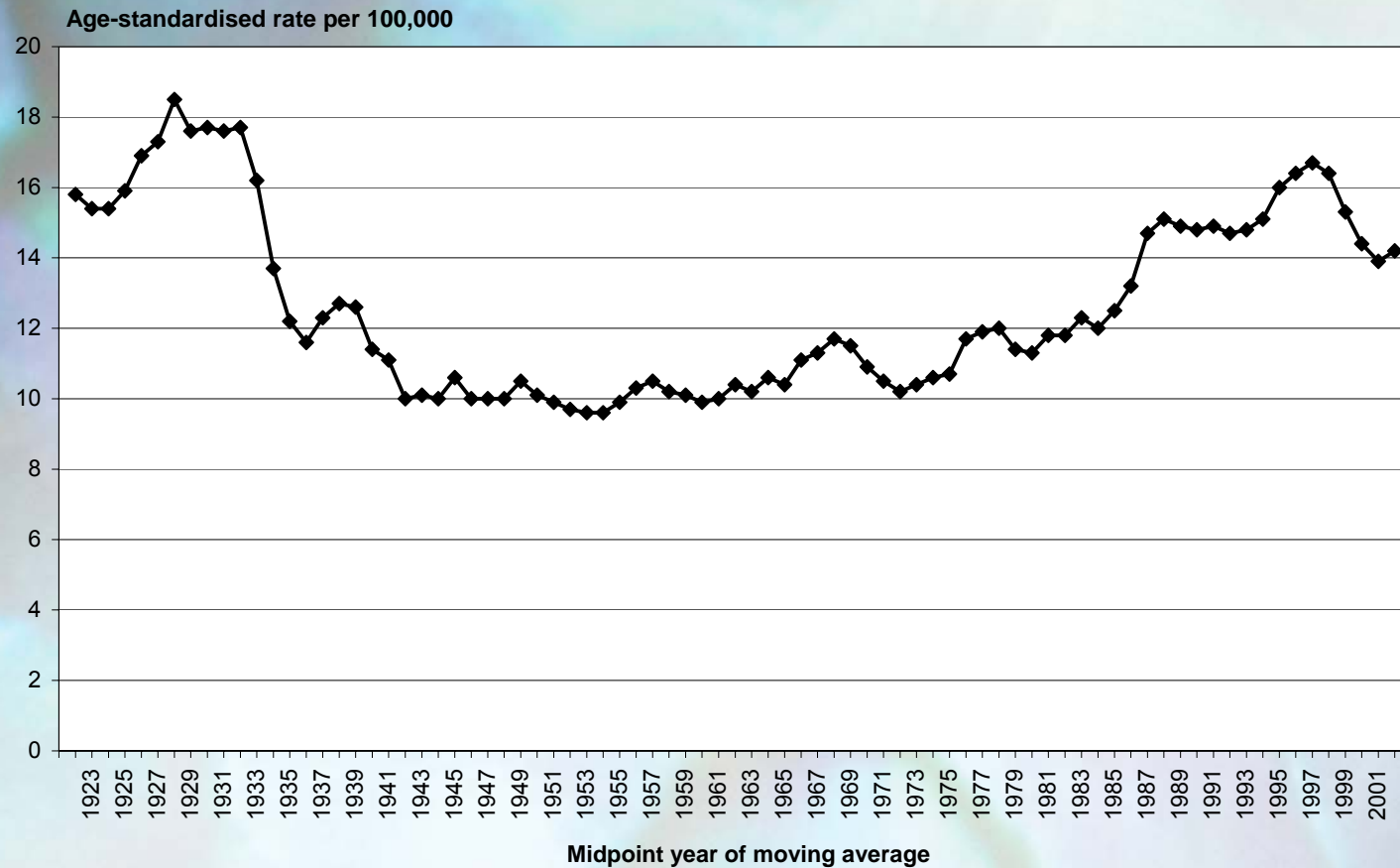
Summary

- Overall pattern
- Then, suicide and hospitalisation trends by:
 - Sex
 - Ethnic Group
 - Age
 - Socioeconomic Status
 - Method
 - DHB area

Leading causes of death for the total population, 2003



Age-standardised suicide rates, 3-year moving averages, 1921-2003



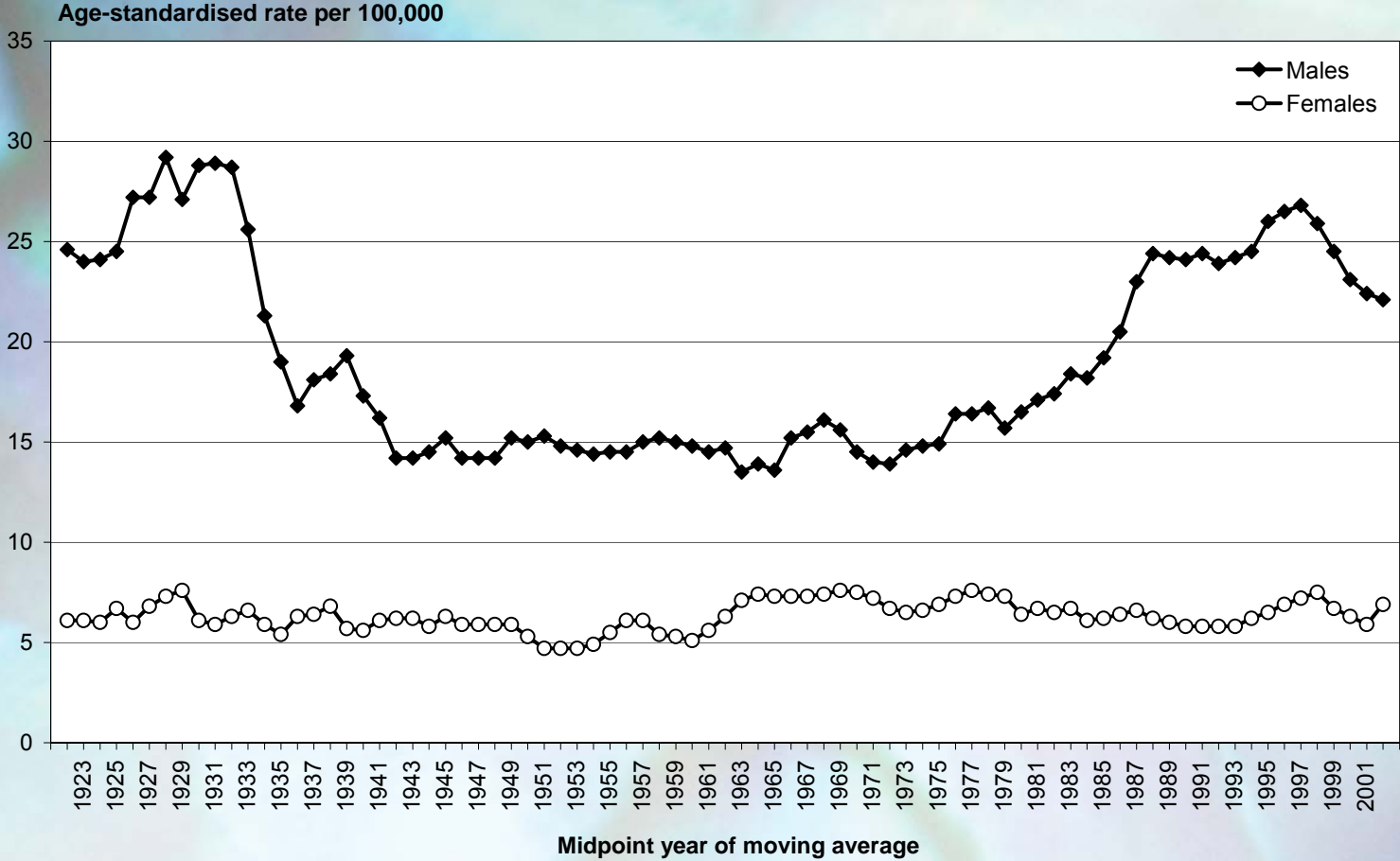
Overall trends

- From 1921 – 2003, two peaks in overall suicide rate
- 1927-1929 – 18.5/100,000
- Steep period of decline to 1942
- Relatively stable to mid-1980s
- 1996-1998 second peak at 16.7/100,000
- Rate declined to 14.2/100,000 in 2001-2003
- Hospitalisation for intentional self-harm, similar trend to increases in suicide rate since the mid 1970s.
- 1978-1980 period – 76.6/100,000
- 1994-1996 – increased to 104/100,000
- Change of data coding in 1999 & 2000 – further increases
- 2002-2004 – 150.5/100,000

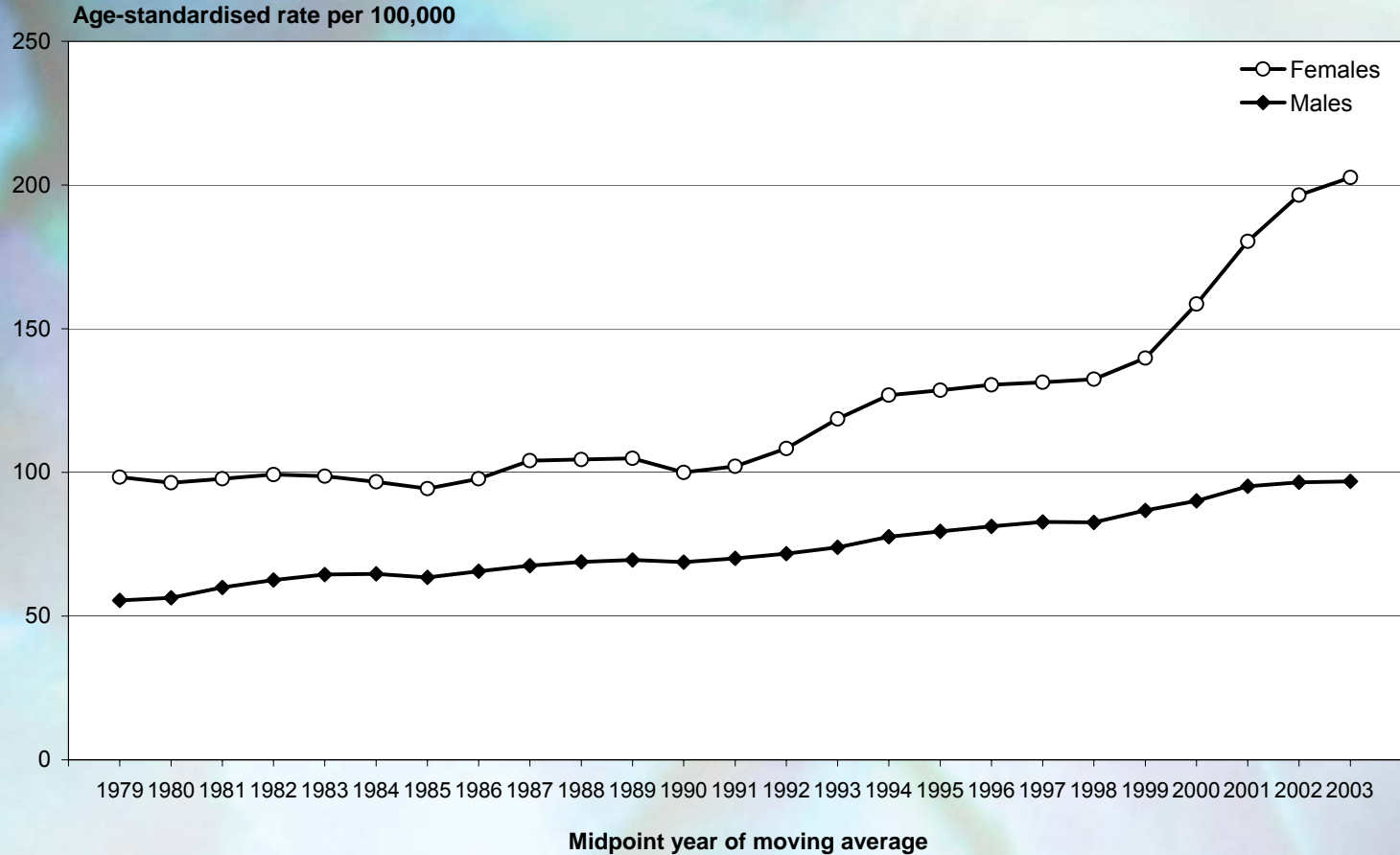
Beneath the overall trends

- Overall trends conceal trends within sex, age and ethnic groups
- Many of the trends in the document are primarily driven by changes of pattern in suicide in younger age groups and by differences between males and females

Suicide rate, by sex, 3-year moving average, 1921-2003



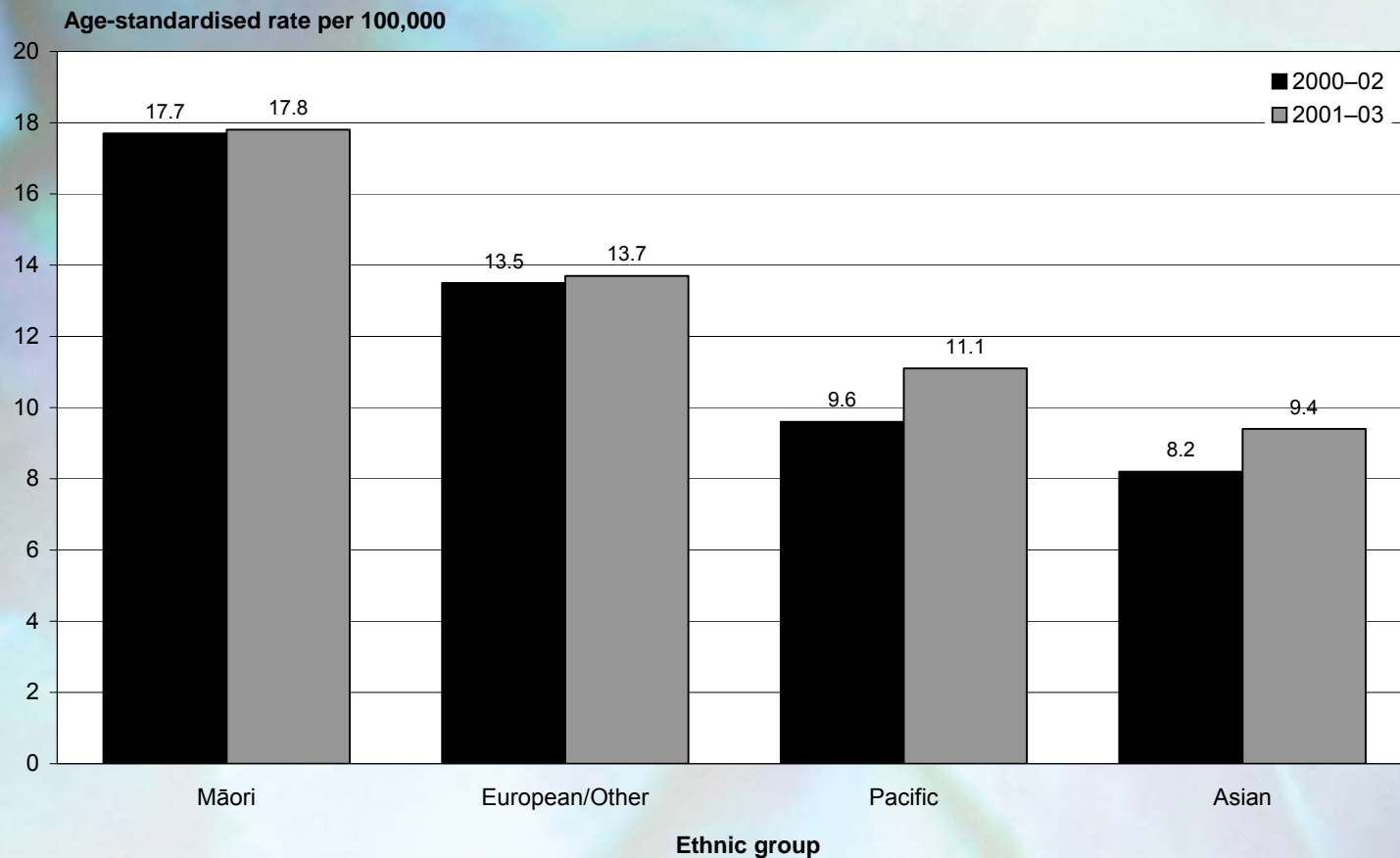
Age-standardised intentional self-harm hospitalisation rates, by sex, 3-year moving averages, 1978-2004



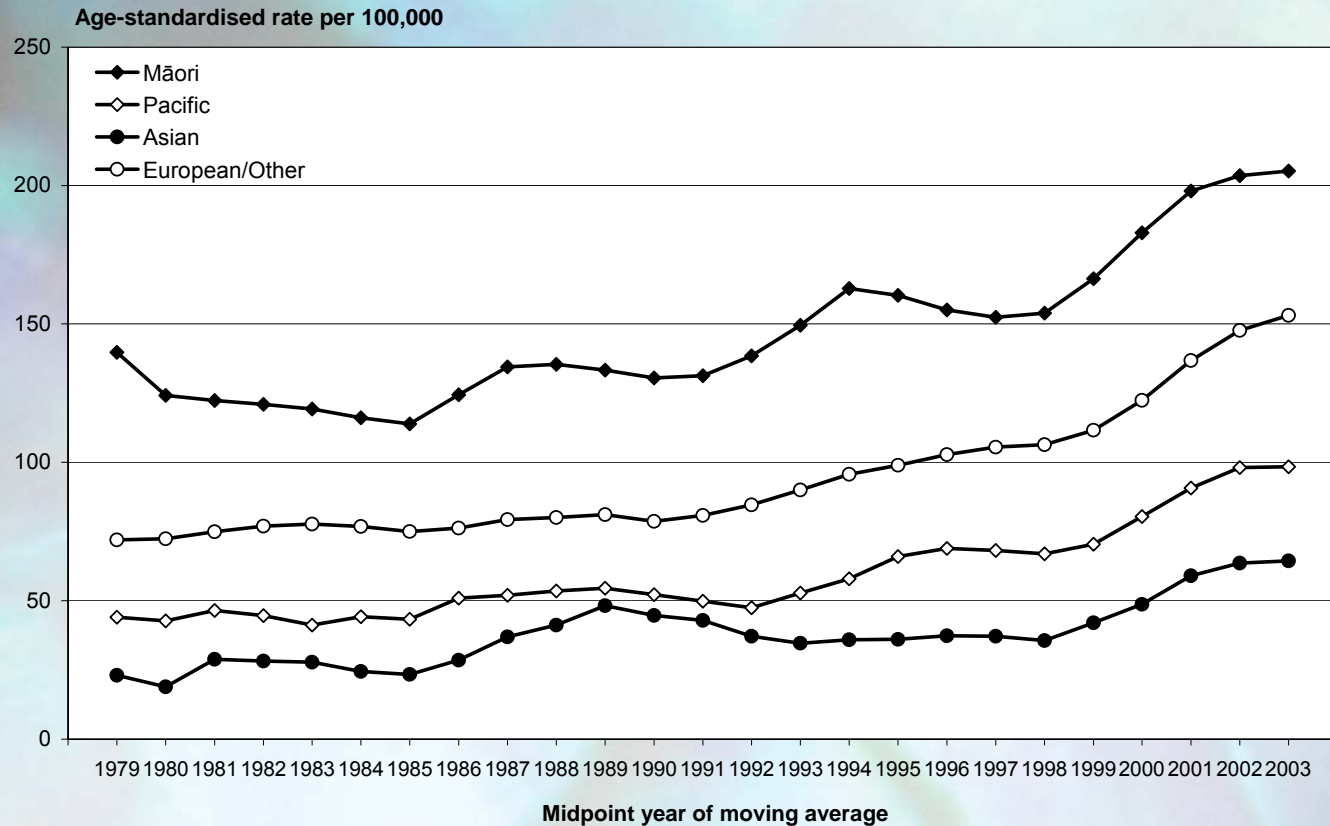
Trends by Sex

- Overall trends in suicide mortality driven by male rates of suicide
- Trends in hospitalisation are driven by female rates

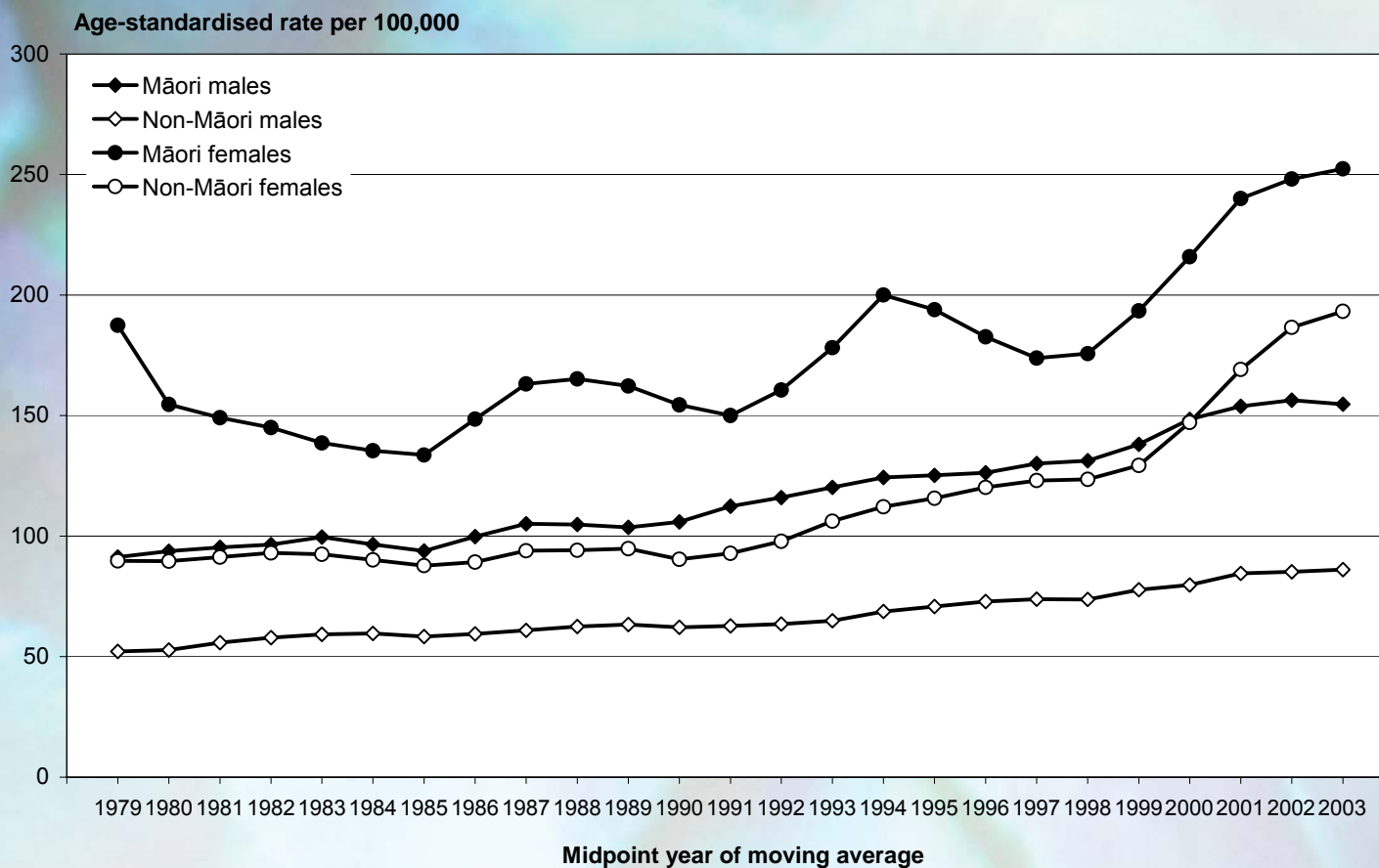
Age-standardised suicide rates, by ethnicity, 3-year moving averages 2000-2003



Age-standardised intentional self-harm hospitalisation rates, by ethnicity, 3-year moving averages, 1978-2004



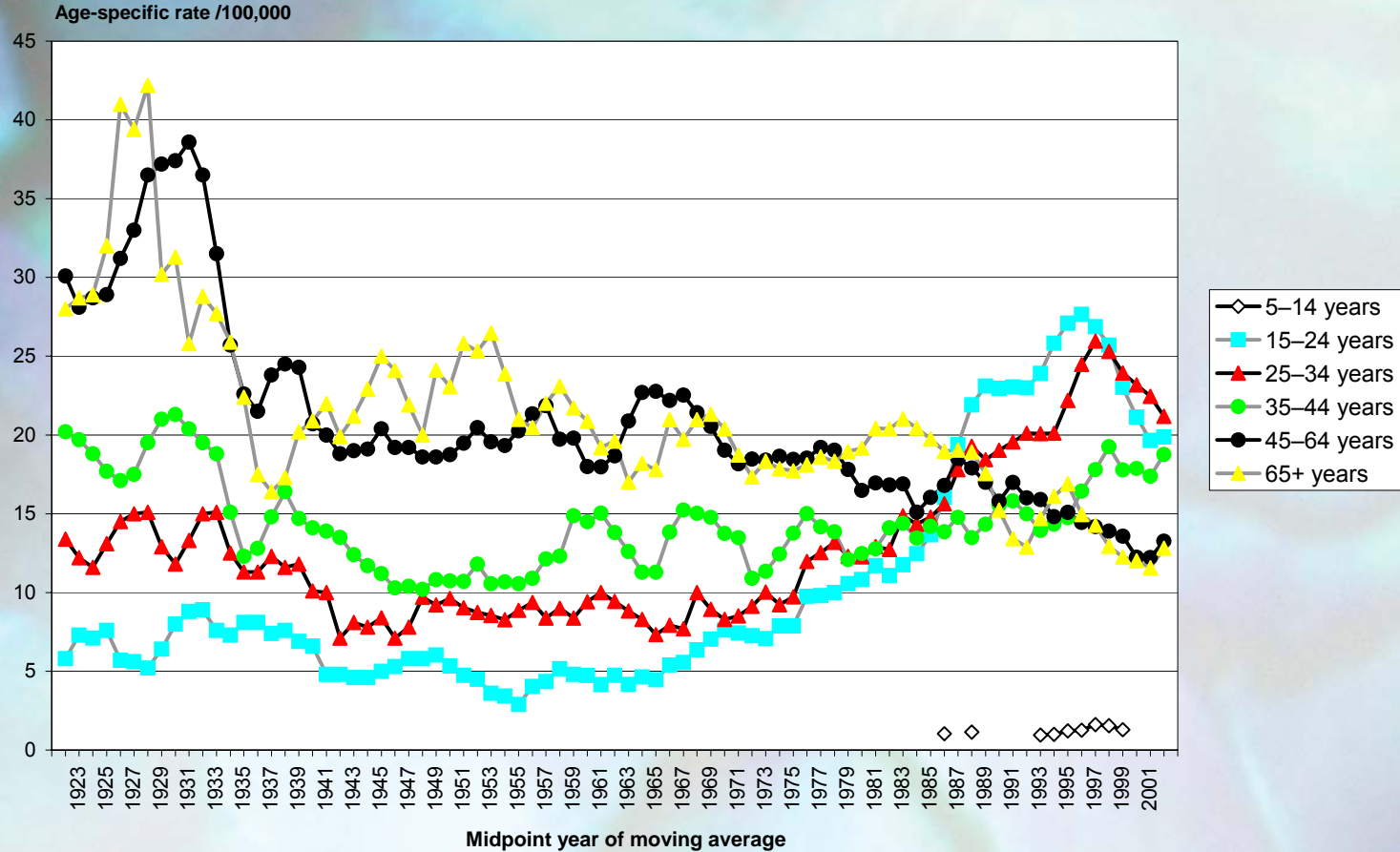
Age-standardised intentional self-harm hospitalisation rates, by ethnicity and sex, 3-year moving averages, 1978-2004



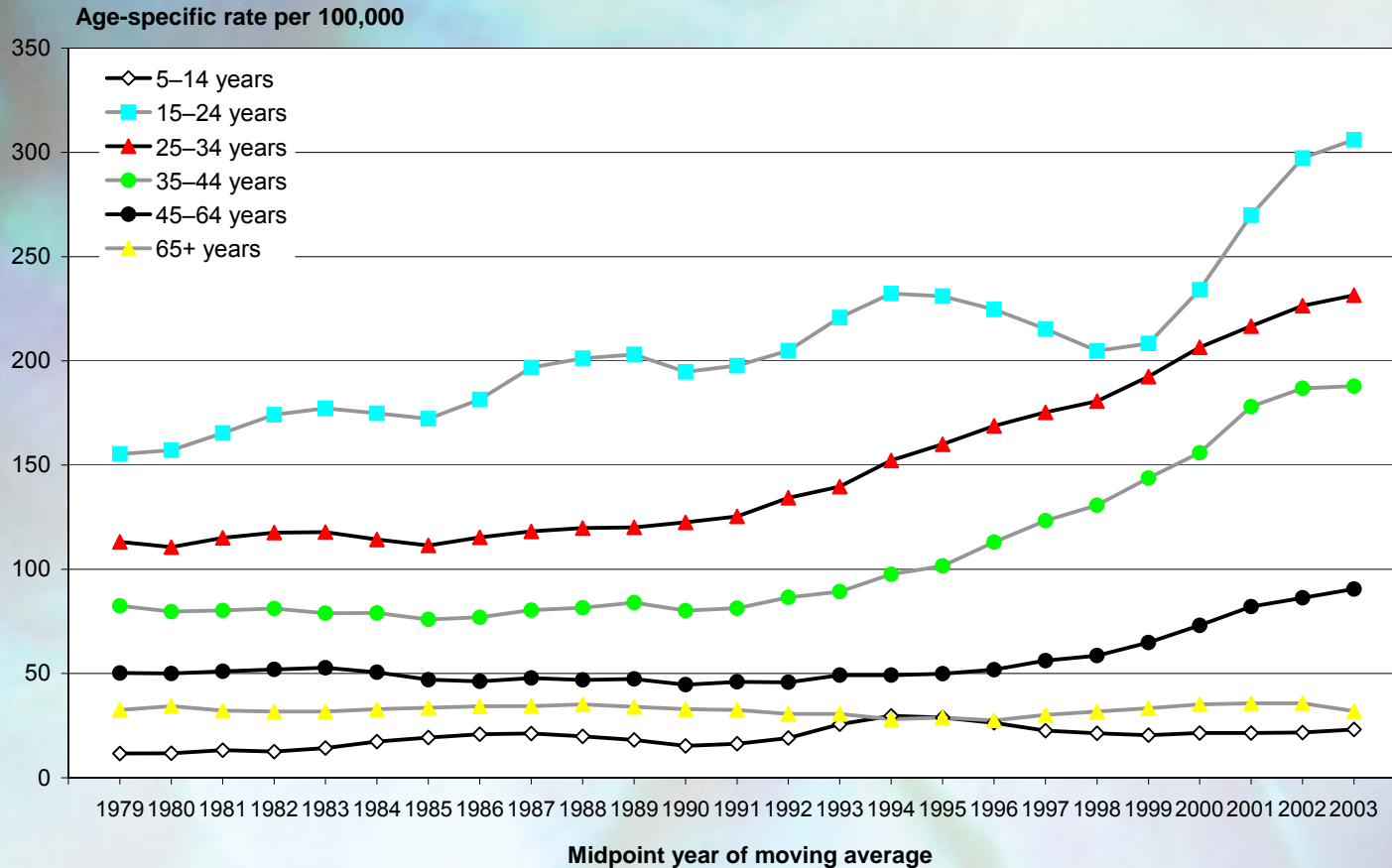
Trends by Ethnic Group

- Highest suicide rate is for Maori, then European / Other, Pacific, then Asian ethnic groups
- Disparity between Maori and all other ethnic groups is particularly high for Maori males < 35years
- Disparity disappears for Maori males > 45
- Maori females had higher rate of hospitalisation than all other combinations of sex & ethnic group
- Maori males had higher rates of hospitalisation than non-Maori males

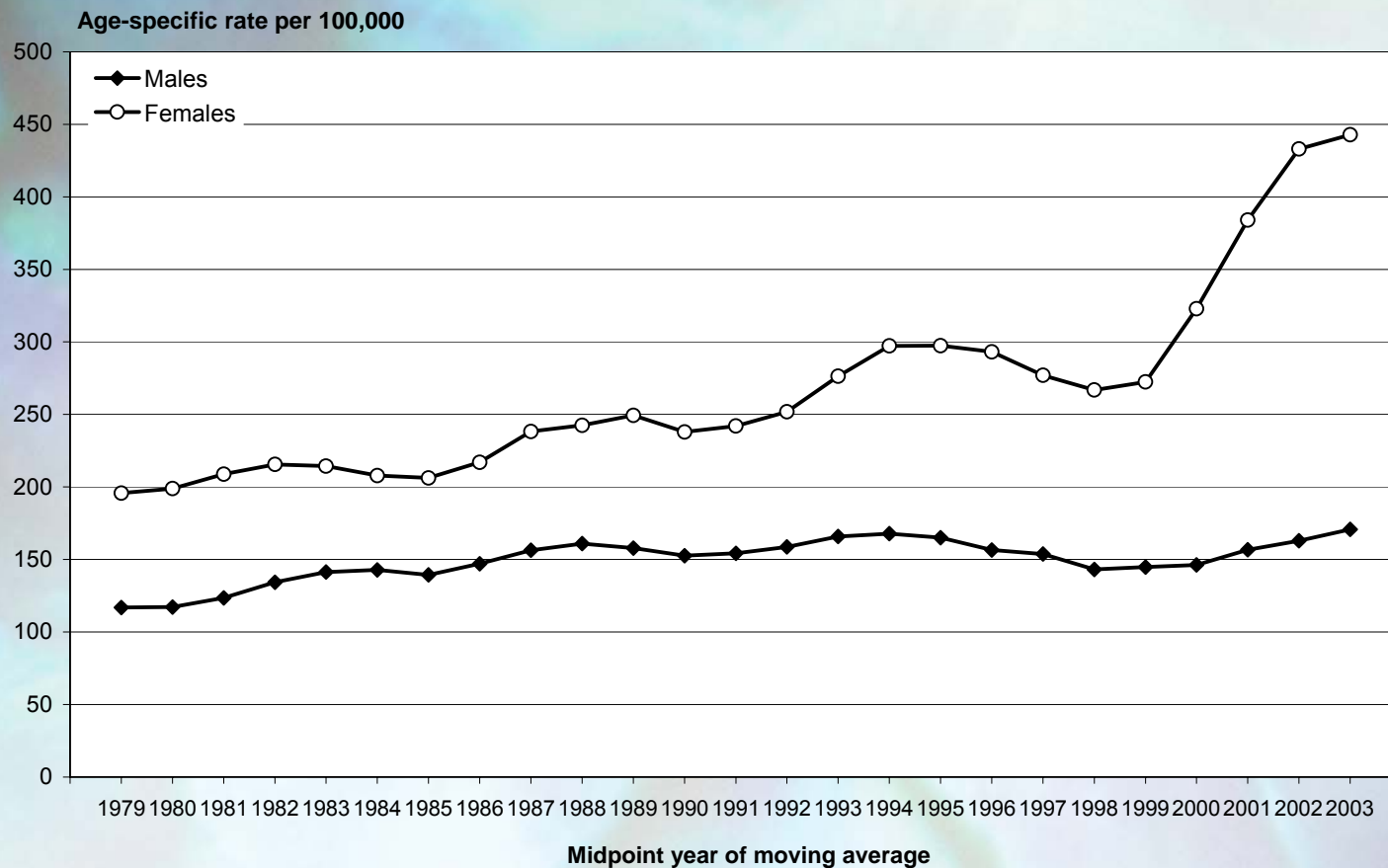
Age-specific suicide rate, by age group, 3-year moving average, 1921-2003



Age-specific intentional self-harm hospitalisation rates, by age group, 3-year moving averages, 1978-2004



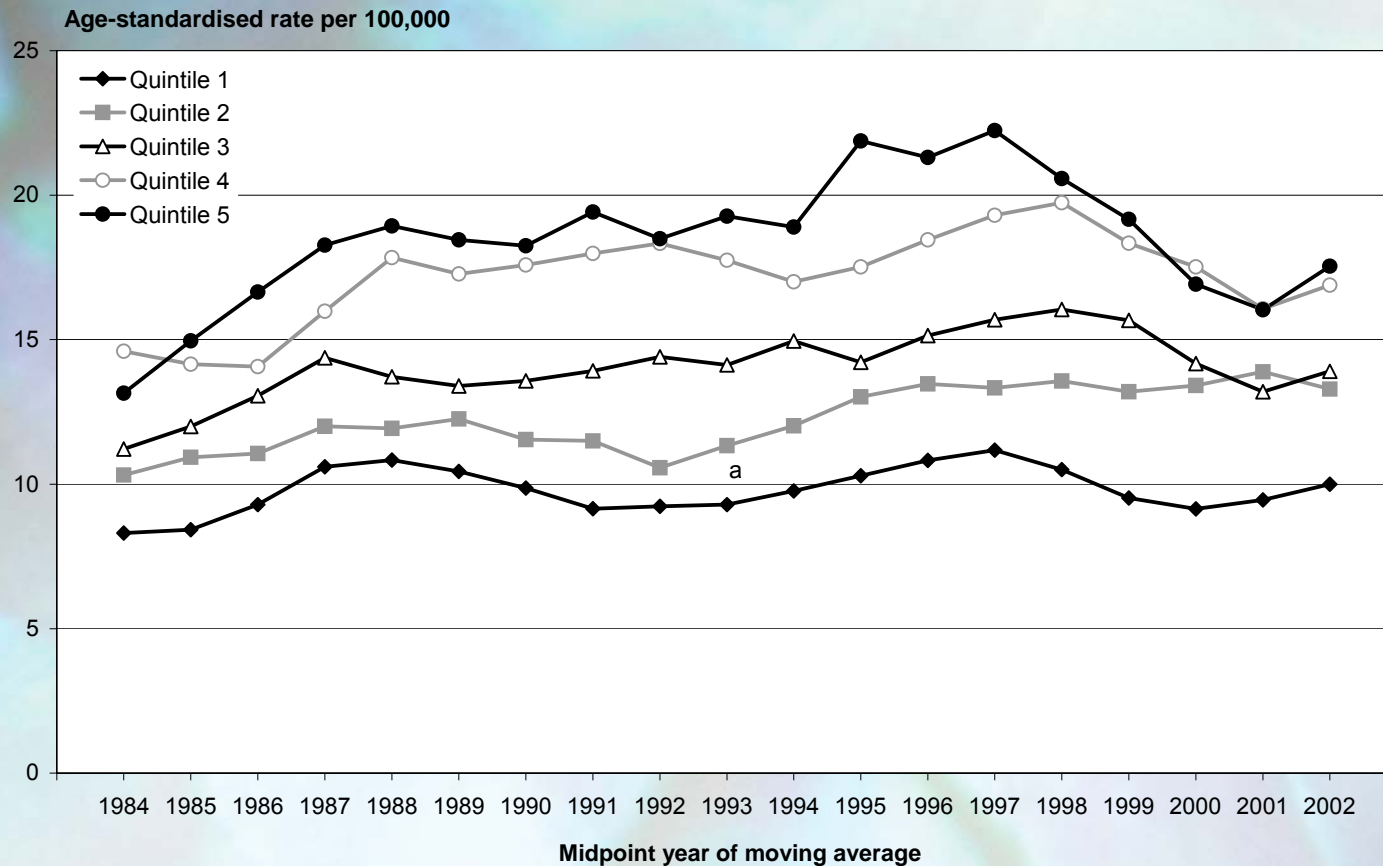
Age-specific intentional self-harm hospitalisation rates by sex, 15-24 years, 3-year moving averages, 1978-2004



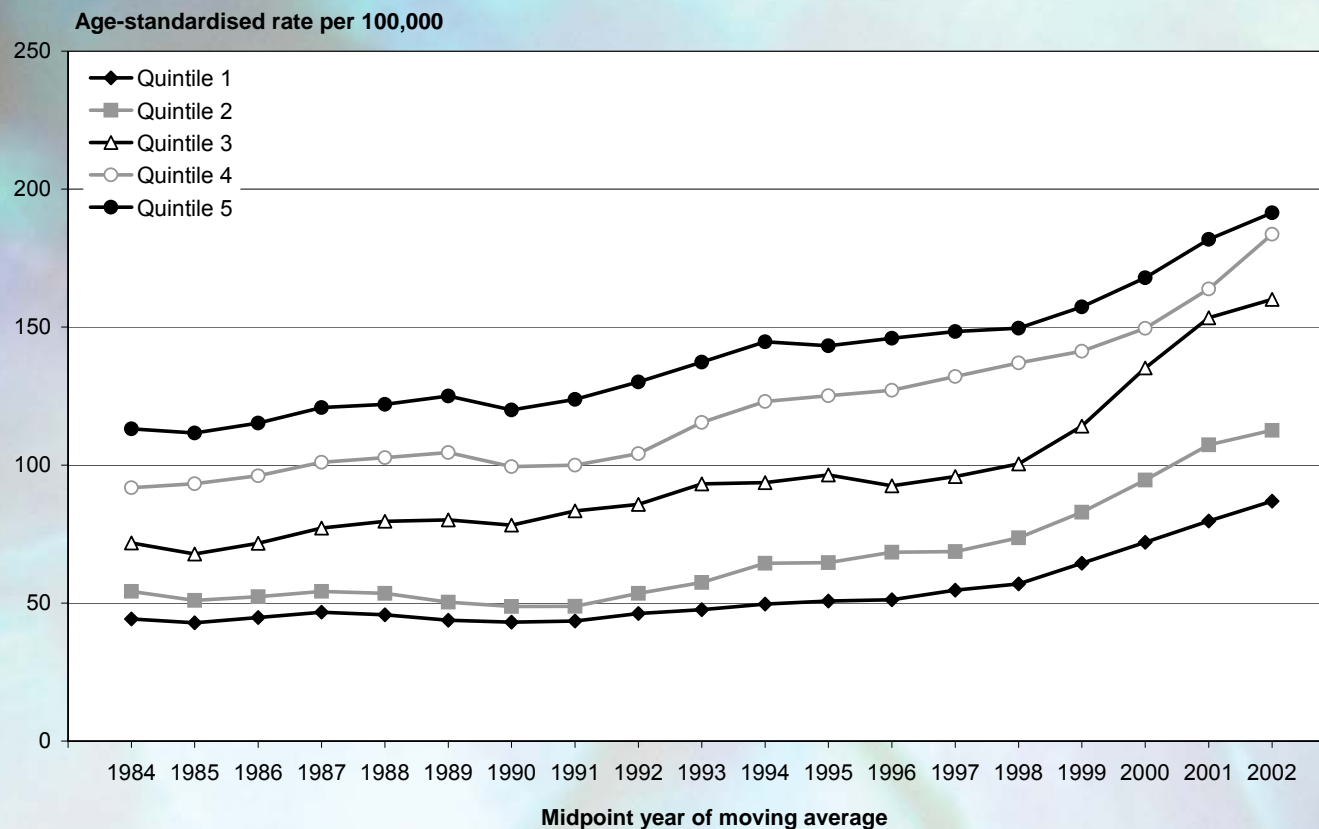
Trends by Age Group

- Major changes in pattern over time
- 1921-1987 suicide deaths most common in those aged > 45 years
- 1987 onwards, suicide deaths more common in those 15-24 years, then 25-34 years
- Changes seem to have begun in the mid-1970s, though disparity between age groups have reduced over time

Age-standardised suicide rates, by quintile of deprivation (NZDep01), 3-year moving averages, 1983-2004



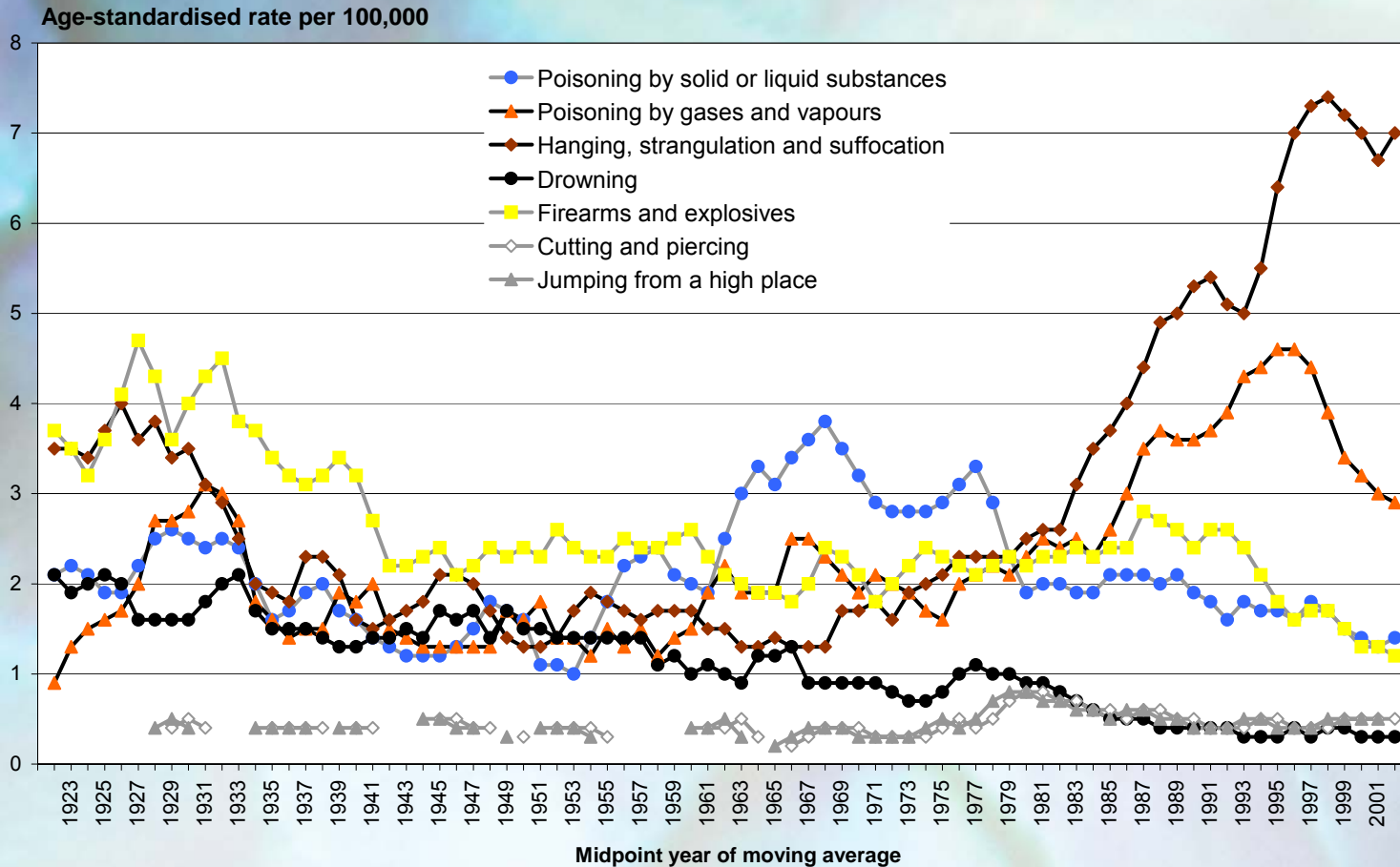
Age-standardised intentional self-harm hospitalisation rate, by quintile of depression, 3-year moving averages, 1983-2003



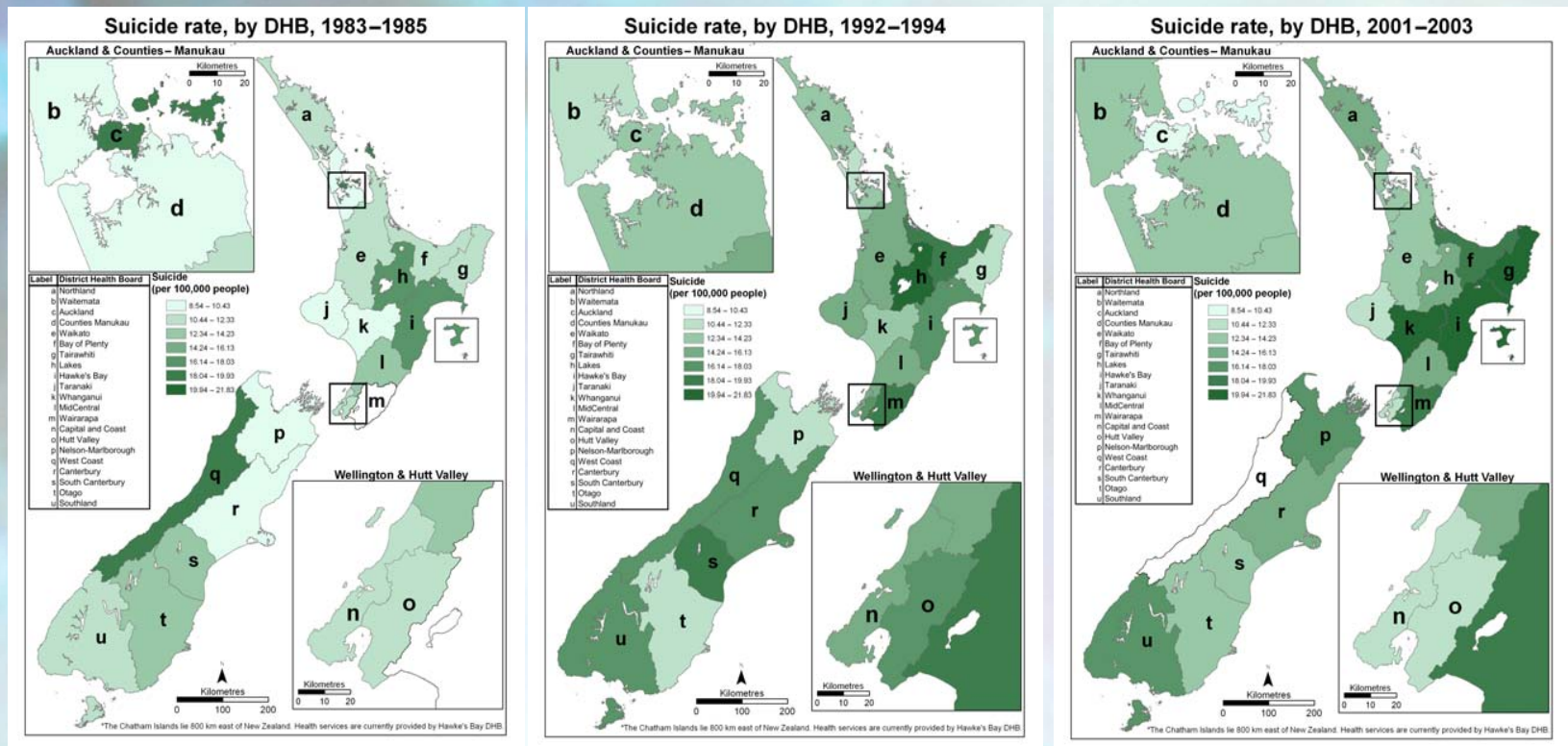
Trends by socioeconomic status

- Over last 20 years, clear, unambiguous trend of higher rates of suicide in more deprived areas of NZ
- Suicide rates in the least deprived areas are higher than any other time in last 20 years
- Rates of hospitalisation have increased since 1983-1985 at all levels of deprivation - least deprived = biggest increases

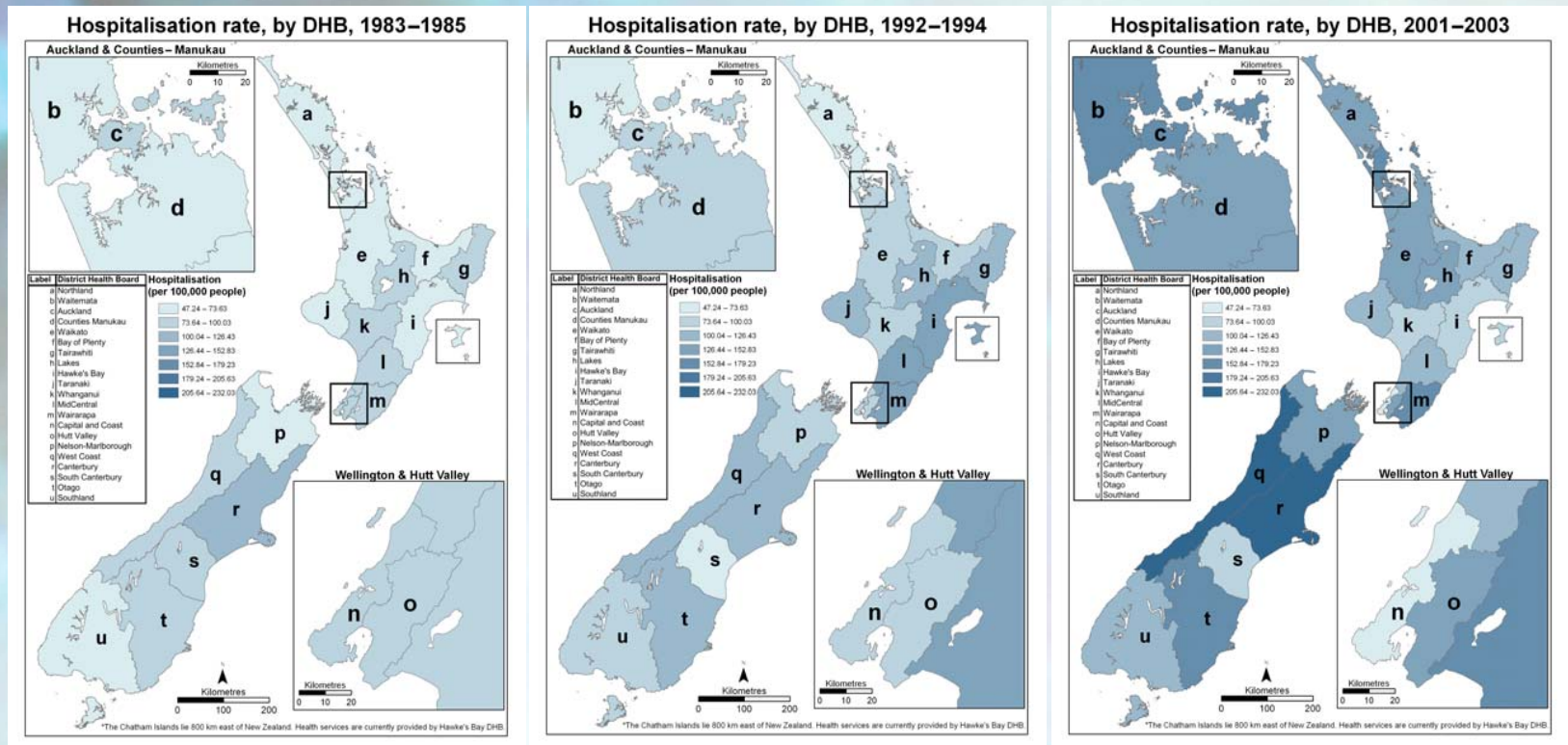
Suicide rate, by method, 3-year moving average, 1921-2003



Maps of age-standardised suicide rates, by District Health Board (DHB), three-year moving averages, 1983–1985, 1992–1994 and 2001–2003



Maps of age-standardised intentional self-harm hospitalisation rates, by District Health Board (DHB), three-year moving averages, 1983–1985, 1992–1994, 2001–2003



Trends by DHBs

- No consistent trends in suicide and intentional self-harm hospitalisation rates across DHBs
- However, some indication that DHBs with high suicide rates have low rates of hospitalisation
- Those with low rates of suicide have high rates of hospitalisation
- HOWEVER, low numbers of suicide at DHB level of analysis so comparisons need to be interpreted cautiously

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Why do we need a Strategy?

- Suicide is complex
- Contributing factors are many and varied
- Requires a multi-sectoral approach
- Linking of individual and population approaches
- Need for a mechanism to organise and mobilise these efforts nationally, to address gaps and monitor progress.

Purpose

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

Principles

- **Be evidence based**
- **Be safe and effective**
- **Be responsive to Maori**
- **Recognise and respect diversity**
- **Reflect a coordinated multisectoral approach**
- **Demonstrate sustainability and long term commitment**
- **Acknowledge that everyone has a role in suicide prevention**
- **Have a commitment to reduce inequalities**

Pathways to suicidal behaviour

- Wide range of factors – individual to macro-social
- These can contribute directly, but also indirectly by influencing susceptibility to mental health problems

Pathways to suicidal behaviour (ctd)

- **Contextual factors also influence the extent to how these factors contribute to suicidal behaviours, eg:**
 - Cultural factors may modify risk and protective factors
 - Institutional settings (school, workplaces, hospitals and prisons) may influence risk
 - Media climates may influence extent and expression of suicidal tendencies
 - Physical environments may influence availability of methods

Risk factors

- A mix of conditions that contribute to the end point of suicide:
 - Mental disorders, including depression, bipolar disorders, schizophrenia, anxiety disorders, substance use disorders, antisocial and offending behaviours
 - Exposure to recent stress or life difficulty
 - Exposure to childhood adversity and trauma
 - Tendencies to react impulsively or aggressively under stress
 - Socioeconomic and educational disadvantages

Protective factors

- Good coping and problem solving skills
- Positive beliefs and values
- Feelings of self-esteem and belonging
- Social connections
- Secure cultural identity
- Supportive and nurturing family
- Responsibility for children
- Social support and access to services
- Holding attitudes against suicide

Goal 1.

- **Promote mental health and wellbeing, and prevent mental health problems.**

Goal 2.

- **Improve the care of people who are experiencing mental disorders associated with suicidal behaviour.**

Goal 3.

- **Improve the care of people who make non-fatal suicide attempts.**

Goal 4.

- **Reduce access to the means of suicide.**

Goal 5.

- **Promote the safe reporting and portrayal of suicidal behaviour by the media.**

Goal 6.

- **Support families/whanau, friends and others affected by a suicide or suicide attempt .**

Goal 7.

- **Expand the evidence about the rates, causes and effective interventions .**

Next steps

- **Identify what works**
- **Take stock of what we have, what we don't have, and what we need more of**
- **Agree to a plan of action for the next 5 years**
- **Establish a system to monitor our efforts nationally**

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