Suicide and the media

The reporting and portrayal
of suicide in the media

A resource

The New Zealand Youth Suicide Prevention Strategy

1999

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Foreword

Suicide rates for those aged 15 to 24 have doubled since 1985. In 1995, New Zealand had the highest death rate in this age group in selected OECD countries.[1]

While the causes of suicide are complex, there is scientific evidence to show media reports of suicide may increase the risk of further suicides for a period of time after that media publicity. The risk of 'copycat' suicide poses a dilemma for journalists trying to report suicide stories that are in the public interest.

There is ongoing discourse between the media and researchers about the extent of the links between reporting of suicide and suicidal behaviour. However, the weight of evidence tends to suggest the links are significant.

This resource aims to provide the media with information about suicide and to educate the media about the effect articles and reports may have on vulnerable people. We hope this handbook will be used as an information resource by your media organisation.

Media organisations that may find this resource useful include television (dramas, documentaries, news), film, radio, newspapers (news stories and feature articles), magazines, the Internet, and organisations hosting billboards.

People who comment in the media may also find this information valuable. Police, coroners, mayors, school principals, researchers, and mental health professionals are asked to comment on youth suicide, and we hope this document will give useful background material.

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[1] OECD countries compared were New Zealand, Finland, Australia, Canada, USA, Norway, France, Denmark, Sweden, Germany, Japan, UK and the Netherlands. For information on youth suicide in New Zealand see *Part 2: Facts about Suicide.* More information is also available through our Web site www.moh.govt.nz/youthsuicide.html.

Contents

PART 1: Reporting and Portrayal of Suicide

Evidence about 'suicide contagion' or 'copycat' suicide

The Ministry of Health has analysed the published studies and concluded that a large body of research does show a link between media coverage of suicide and a subsequent increase in suicides and suicide attempts. Evidence suggests if suicide is communicated publicly then some vulnerable individuals may consider it as an option. This increased risk of suicide has been shown across all age groups, but young people who are struggling with apparently insurmountable personal, interpersonal, or family problems may be the most vulnerable.

In most cases it appears the person may have been influenced by either the suicide of someone else or the depiction of suicide, factual or fictional. This is referred to as copycat suicide or suicide contagion and has been linked to books, movies, television dramas, documentaries, magazines, and news coverage of suicide. This phenomenon is usually due to the power of suggestion and normalisation presented in these media representations.

The Ministry of Health acknowledges that there is ongoing debate between media commentators and researchers around the significance of the link between media reports and subsequent increases in suicide rates. Although some research is inconclusive about the linkages between media reporting of suicide (stating only that the reporting of suicide *may* have a link), on balance, the majority of scientific research demonstrates a link. There are a number of difficulties in demonstrating clear and direct linkages between

publicity and subsequent suicidal behaviour. These difficulties arise because suicide is a rare event and therefore, much of the work must, of necessity, rely on aggregate data and there may be 'sleeper' (delayed) effects. Despite these difficulties, the weight of evidence suggests that these research findings need to be taken into account by the media. A number of researchers state that adverse publicity about suicide can be minimised if media handle information appropriately.

Non-fictional reporting of suicide in print media

There is a large amount of research which has examined whether or not media publicity about suicide is associated with subsequent suicide. Here is a brief summary of some of the most significant research.

- The World Health Organization (WHO) has recommended that toning down reports in the media is one of the six basic steps for the prevention of suicide (Bertolote 1993).
- Phillips and Carstensen's major study in 1986 examined monthly US suicide data from 1948 to 1968 and revealed that suicides increased significantly after the latest suicide stories.
- A further report by Barraclough et al in 1977 showed a significant rise in male suicide in Portsmouth after newspaper reports of suicide.
- A number of researchers have demonstrated that there is an increased risk for suicide from placement of stories on the front page of newspapers (Phillips 1982; Ganzeboom and de Haan 1982; Kopping et al 1989; Ishii 1991; Yoshida et al 1991).

- Headlines containing the word 'suicide' also have an impact. Imitation is also more likely when the report features pictures and uses large headlines containing the word 'suicide' (Phillips et al 1992).
- Some research has shown that suicides are more likely to increase after celebrity suicide (Wasserman 1984), although this was later refuted by Stack (1987 and 1990). However, further work by Stack concluded that celebrity suicides may influence suicide rates in some situations where certain cultural contexts can make an individual more likely to respond to suicide messages in the media (Stack 1992).
- In Vienna in 1987, subway suicides were reduced when two of the largest circulation newspapers were persuaded to curtail their reporting of subway suicide (Sonneck et al 1994).
- A number of researchers have also noted that appropriate reporting of suicide can minimise adverse effects if reports include explanations of how to identify persons at risk of suicide, or present information about risk factors for suicide and positive alternatives to suicidal behaviour (Goldney 1989; Center for Disease Control and Prevention 1994).

Documentaries

Makers of documentaries also need to consider the impact of the reporting and portrayal of suicide. Documentaries are classed as non-fiction and often take a more in-depth look into an issue with the aim of presenting a balanced viewpoint. However, it is important to consider the principles outlined in *Considerations when reporting or portraying suicides* (page 23) to ensure that unintended copycat effects do not result from the production. An important finding of the research into non-fictional portrayal of suicide is that 'neutral reporting' can influence suicidal behaviour among vulnerable people (Goldney 1989).

Real TV

Although Real TV is currently not a well-researched television format, it is a developing area of broadcasting and appears to have a measure of popularity in New Zealand. These shows cover a wide range of topics, and although presented as non-fiction often tend to be presented in a sensationalising way, sometimes with a repetitious style. There are concerns over the potential copycat impact of these types of shows, and they will require monitoring.

Despite there being some anecdotal evidence of the copycat effect occurring in New Zealand, there have been no scientific studies carried out in this country. Nevertheless, the Ministry of Health believes it is prudent to take note of research which has showed consistent trends in England, European countries, Australia, Japan and the United States. It has also been suggested that this effect may be even more pronounced in New Zealand, due to our small population and high media saturation level.

Fictional portrayal of suicide

The section above has referred to non-fiction portrayal of suicide through reporting both in the print media and television news reports. However, portrayals of suicide do also occur in other forms of media that are more commonly associated with entertainment. Fictional portrayals have appeared in television dramas, film, video, and live media such as theatre.

Television and film portrayals of suicide

A majority of the population watch television and take in movies on a regular basis so both television and film has the potential to reach and influence large numbers of people, and especially the young. Television and film can influence attitudes both positively and

negatively in relation to suicidal behaviour. While these media can help present messages about help seeking and positive alternatives to suicide, they can also suggest that suicidal behaviour is a normal part of life. This can be dangerous for vulnerable people.

Evidence on the contagion effects of fictional portrayals on television and film has historically been variable. This may in part be due to the logistical difficulties in researching the impact of television portrayals because statistically suicide and suicide attempts are a rare event. However, more recent research has given greater weight to the need for caution. Although this research is primarily based upon television, the principles around portrayal of suicide and copycat behaviour could be reasonably applied to film, as this medium is similar in scope to television and has the ability to influence a large and varied audience (notwithstanding the ability to classify by age restrictions).

A number of studies in the 1980s which investigated a suicide attempt featured in the British soap *Eastenders* were unable to find any impact on suicidal behaviour (Ellis and Walsh 1986; Fowler 1986; Platt 1987). A German study published in 1988 showed railway suicides among 15–19-year-old males increased up to 175 percent after a television serial showing the railway suicide of a 19-year-old male (Schmidtke and Hafner 1988).

In 1999, a comprehensive study (Hawton et al 1999) demonstrated a significant link between media representation of suicide and suicidal behaviour. The study analysed cases of self-poisoning that presented at accident and emergency departments and psychiatric services in the United Kingdom after the portrayal of a deliberate paracetamol overdose in an episode of the popular television drama *Casualty*. The study found that there was a significant increase in the incidence of self-poisoning in the two weeks following the broadcast, including an increase in the use of the particular drug identified, paracetamol,

as the preferred method, and reflects the need for caution in the fictional portrayal of suicide and suicide attempts.

Other forms of media

Theatrical representations of suicide

The impact of dramatic live theatre is also a medium where fictional portrayal of suicide has been presented. Live drama is a powerful medium of expression that can have an intense impact on the audience. However, there is very little research into the effects of the portrayal of suicide in theatrical performance. A study by Jackson and Potkay (1974) of a one-act play on suicide performed for a college audience showed no demonstrable increase in suicidal behaviour. More recently, some evaluative work has been undertaken in Australia looking at the impact of depictions of suicide (Morgan et al 1998). Morgan et al expressed concern about using drama as a suicide prevention initiative where suicide is portrayed in the actual drama, and suggests drama may be more effective as a suicide prevention initiative by focusing on help-seeking messages rather than suicide per se. The authors have suggested that a number of principles should be followed in these types of dramatic productions. These include: pre-reading and pre-testing, promoting support services (or helping organisations), including positive messages, preparing the audience, providing a transparent rationale for depicting suicide, evaluating, and avoiding impromptu performances.

Internet

The Internet has fast become a worldwide phenomenon for communicating, conducting business, information-gathering and dissemination, and entertainment. Young people, in particular, are

generally very comfortable with the Internet. While the Internet has many obvious benefits it also allows undiscriminating and easy access to potentially harmful information. It is very difficult to limit what information young people have access to in this medium.

There are more than 150,000 references to suicide on the Internet (Baume and Cantor 1997). However, currently there is very little research available into the influence of the Internet on suicidal behaviour, so it is not possible to draw any clear conclusions of its impact at this time. The growth in sites which provide detailed guidance on how to commit suicide, detailed accounts of celebrity suicides, and visuals of people who have died by suicide, nevertheless are a major concern.

See *Contacts for comment and resources on suicide* (page 31) for some sites that have been developed which include research information on suicide and contacts for helping agencies.

Radio

The literature on suicide and the media has not tended to focus on radio broadcasting on its own, which may be due to the difficulties in undertaking research into this medium. Young people, in particular, are regular listeners and there are a number of youth-orientated radio stations in New Zealand. Radio presents information in a variety of different formats from news reporting, advertisements, 'theme' programmes (focusing on a particular issue or personality) and the general comments of the presenter(s).

Many of the principles of responsible reporting covered in this resource can of course be used by radio broadcasters.

Cross-cultural issues in reporting and portraying suicide

Very little research has been carried out on the factors influencing Māori and Pacific suicide, or on the possible affects that media reporting, or fictional portrayal may have on those peoples' behaviour. However, we know that discussion on death (including symbols and patterns) as well as approaches to grieving can differ quite markedly amongst different cultural groups. It is important to bear this in mind when considering the portrayal of suicide in the media or in fiction. While following the suggested guidelines in this booklet will be helpful, it will also be appropriate to consult cultural experts when assessing the portrayal of Māori or Pacific deaths by suicide.

Is there a risk of 'normalising' suicide through media coverage?

In the past suicide was regarded as a taboo subject. However, the last 10 years have seen an increasing amount of New Zealand media coverage of suicide, largely reflecting public concern and because we now have the highest suicide rate among selected OECD countries. See *New Zealand suicide statistics*, page 16.

While this media coverage has helped generate public awareness of this problem, the increased level of reporting may mean vulnerable people are at risk of seeing suicide as a normal human behaviour. Vulnerable people are those who may not be 'thinking straight' because they may be suffering from a range of mental health problems (such as depression, schizophrenia, alcohol and drug abuse) or are experiencing severe grief. Some suicide researchers have found that even so-called neutral reporting of suicide may be

followed by an increase in the rate of suicide, due to a subtle acceptance that suicide is a normal course of action when faced with an emotional crisis (Goldney 1986).

Studies by Littman in Canada and Goldney in Australia have concluded that young people model their behaviour on what is presented to them as a normal response to difficulties in life (Littman 1985; Goldney 1986, 1989). Dramatic or graphic reports therefore, may have an impact. Professor Goldney suggests the media try to avoid inadvertently normalising suicide.

How the media can minimise the risk of 'copycat' suicide

The association between publicity and suicide raises complex questions around the right of the media to present factual information and the potential increase in suicide risk that such publicity may create. For instance, concerns have been raised that this resource could be construed as an attempt to curtail freedom of the media. However, the Ministry of Health has a responsibility to inform the media and the public about the findings of research which may impact on the health of New Zealanders.

At the end of the day, media organisations must weigh up for themselves the balancing of freedom of the press with the need to minimise risks of suicide among more vulnerable members of the community.

See *Considerations when reporting or portraying suicides* (page 23) for suggestions on how to report and portray suicide.

PART 2: Facts about Suicide

While it is important that the media try to report suicide as safely as possible it is also equally important that the media use current, accurate, and reliable information when writing or presenting an article about suicide. The following information can be used for this purpose.

Causes and prevention

The factors which lead a person to wanting to end their life are complex. It is not known exactly why some people choose suicide and others do not.

Why is New Zealand's rate of suicide increasing?

There are many factors which may have some level of influence in New Zealand. Possible explanations include increasing rates of depression and alcohol and drug abuse, rising rates of violence including child and sexual abuse, cultural alienation, changes in family structure and society as a whole, reduced influence of religion, greater acceptance of euthanasia, increased reporting and portrayal of suicide in the media, high unemployment, and trends towards a more risk-taking and individualised society.

It is probable that all these factors have some level of influence and that an interplay of social, psychological, and biological factors are responsible for the increased rates of suicide.

Risk factors

Research from the Canterbury Suicide Project in Christchurch suggests that people who have died by suicide or made a serious

suicide attempt often have shared circumstances such as:

- they have some underlying psychological distress or mental illness
- they display some recognisable mental health or adjustment difficulty prior to the suicide attempt
- immediately prior to the suicide attempt they face severe stress or a life crisis, which often centres around the breakdown of an emotional or supportive relationship
- they come from disturbed or unhappy family and childhood backgrounds
- they come from socially and educationally disadvantaged backgrounds.

Research from this study has also found that approximately 90 percent of people who commit suicide or make suicide attempts will have had one or more recognisable psychiatric disorders at the time such as:

- depression (about three-quarters)
- alcohol, cannabis, and other drug abuse (over a third)
- significant behavioural problems such as conduct disorder and antisocial behaviours (about a third).

Protective factors

While there is strong research evidence on risk factors for suicidal behaviour, further research is required on the value of a range of protective factors against suicidal behaviour. However, a range of factors appear to have the capacity to protect people who might otherwise be at risk of suicide. These include coping skills, feelings of self-esteem and belonging, connections to family or school, secure

cultural identity, supportive family/whānau, hapū and iwi, responsibility for children, and social support.

When does suicide occur?

- Most suicide is sporadic, and although there may be pointers to it which seem obvious in retrospect, more often than not it is unpredictable.
- Suicide rates are higher in the spring and summer.
- People in custody are at a higher risk of suicide than the general population.
- When people are discharged after receiving in-patient treatment for a psychiatric problem they are at a higher risk of suicide. While in hospital they are also at a higher risk of suicide.
- About 5 percent of all suicides among young people occur as part of a cluster. Suicide can occur in clusters within a local area. This may happen when some people in a community identify with the distress of the victim who has died by suicide. Often they may have had similar problems and may be the same age or ethnic group as the victim.

Prevention

Just as there is no one cause of suicide there is no one answer. Rather, suicide prevention efforts should include a range of activities which aim to influence the factors and events shown to increase the possibility of suicide.

Such efforts should include:

- preventing problems such as mental health problems, family violence, sexual abuse, alcohol and drug abuse and so on from occurring in the first place

- assisting people who have problems or difficulties which could lead to suicidal behaviour
- assisting people who have either attempted suicide or who are suicidal.

The *New Zealand Youth Suicide Prevention Strategy* has been developed as a national strategic response to the particular problem of youth suicide in New Zealand (see *Contacts for comment and resources on suicide* on page 31).

Common myths about suicide

Myth One:

People who threaten or attempt suicide are just attention-seeking.

Although a few individuals may attempt suicide to seek attention, the type of attention they are wanting is help. Typically, a suicide attempt is a last resort and is used by people to alert others that they are in an intolerable situation and cannot cope. All threats of suicide must be taken seriously. The attention they get may well save their lives.

Myth Two:

If people really want to commit suicide, nothing they read in magazines or see on TV will convince them otherwise.

In most cases people are ambivalent about actually dying. Rather, they may be looking for ways of removing the distress or pain they are experiencing. People who feel suicidal are often looking for messages which may condone or support their action.

Myth Three:

Most suicides occur without warning.

Although the final act of suicide may seem sudden or spontaneous, the majority of people have a long history of problems and have displayed clear warning signs prior to their attempt.

Myth Four:

All people who are suicidal are depressed.

While depression is common among people who make serious suicide attempts (about 75 percent), not everyone who is suicidal or commits suicide will be depressed.

Myth Five:

Suicide is painless.

Many methods of suicide are very painful. People are frequently physically disabled by suicide attempts, often quite seriously. Fictional portrayals of suicide do not usually display the reality of that pain.

Myth Six:

Asking or talking about suicide with a suicidal person increases the risk of suicide.

Asking people directly if they are suicidal will often lower their level of anxiety and give them an opportunity to discuss their feelings and thoughts which can lower the risk of suicide. This communication is an opportunity to make an initial assessment of how serious someone is about committing suicide.

Myth Seven:

Effective help for suicidal people comes only from mental health professionals with extensive training and experience in this area.

All people who interact with suicidal people can assist them with emotional support and encouragement. Further, while counsellors and mental health professionals are more likely to provide the expert help needed, they rely heavily on family and friends to provide a network of support.

Myth Eight:

Once a person is suicidal, he or she will be suicidal forever.

For many people, feeling suicidal will be a limited or transient experience. With the right assistance and support, they will probably recover and have a life unhindered by suicidal thoughts and behaviour.

Warning signs of suicidal behaviour

Most people who commit suicide have given warning signs beforehand. Unless it is known what to look for, they can be easily missed.

Help should be sought where a person:

- threatens suicide
- talks about wanting to die
- uses drugs or alcohol recklessly
- shows sudden changes in behaviour, appearance, and mood
- appears depressed and sad

- expresses feelings of hopelessness and helplessness
- has become very hostile and uncommunicative
- engages in other risky behaviour (for example, dangerous driving)
- has an unexpected reduction of academic performance
- withdraws from friends, family, and activities.

These signs may be more serious if the person also has:

- previously attempted suicide
- had a recent bereavement or suicide of a friend or family member
- had a recent relationship break-up
- recently got into trouble with the law
- a history of depression or other mental health problem.

New Zealand suicide statistics

Using statistics: a note of caution

- Deaths by suicide are subject to a coroner's inquiry, and can only be officially deemed suicide once an inquest is complete. In many cases the coroner will complete the inquest up to six months to a year following the death meaning that publication of the statistics can be delayed for up to 18 months after the end of the calendar year.
- Because suicide is a relatively rare event in statistical terms, rates of suicide can vary markedly from year to year. Any interpretation of trends requires an examination of rates over several years.

- Data on the rates of suicide for geographical regions and cities may be of little value for reporting comparisons because of the low numbers, and hence highly variable suicide rates. For example, where populations are small, the rate of suicide can be greatly inflated by only one or two deaths. This is also the case for ethnicity comparisons.
- Due to changes in the classification of ethnicity since September 1995, it is not possible to compare pre-1995 Māori and non-Māori suicide numbers or rates with later years. This is also the case for Pacific data.
- Attempted suicide data are derived from public hospital inpatient and daypatient treatments of attempted suicide. Those cared for in hospital but not admitted (including accident and emergency clients), and those cared for by primary care services or community care services are not reported. For this reason the actual rate of attempted suicide is likely to be much higher than reported in the official statistics.
- Age-standardised rates are adjusted for differences in age structures of populations being compared. An age-standardised rate shows what the rate would have been if the population had the same age structure as a standard population. The standard population used in this case is Segi's world population.

How common is suicide in New Zealand?

Note: The latest available data in this publication for all ages are for 1996, while for youth (15–24), 1997 provisional data are referenced.[2]

- In 1996, suicide comprised 2.9 percent of male and 0.8 percent of female deaths from all causes.
- There were 428 male deaths and 112 female deaths as a result of suicide in 1996.
- Over the last 100 years there have been two peaks in the rate of male suicide, one in the 1930s and the other in the 1990s. The 1930s peak was due to increases among men (aged 25–64) and older men (65+) and the current peak is due to increases among young men (20–24).
- From 1945 to the mid-1960s, there was a drop in the overall rate of suicide.
- The female rate was relatively stable in the 100 years prior to the 1980s, when the rate increased slightly.
- Between 1977 and 1996, the age-standardised suicide rate in New Zealand increased from 11.3 deaths per 100,000 to 13.8 deaths per 100,000. The increased rate during this period was substantially accounted for by an increase in the number of males dying by suicide.
- Male suicide rates increased steadily from 1977 (16.2 deaths per 100,000) to 1996 (22.2 per 100,000), while total female suicide rates were consistently much lower and more stable (6.6 deaths per 100,000 in 1977; 5.8 per 100,000 in 1996). More recently, rates for females aged 15–24 years have increased (see *Suicide and young people*, pages 21–22).

[2] A factsheet with the 1997 provisional youth suicide statistics is available from the Ministry of Health, PO Box 5013, Wellington or the Web site www.moh.govt.nz/youthsuicide.html.

International comparisons

- In 1995, New Zealand had the highest youth suicide rate in the 15–24 year age group of selected OECD countries[3].
- Suicide trends differ across cultures. For example while New Zealand has a high young male suicide rate, China has a high female suicide rate.
- Comparing international statistics is inherently problematic given that different methods are used to classify suicide, and because the classification of suicide is, to some degree, culturally determined.

Suicide and gender

- The male: female ratio for suicide in 1996 was 3.8:1.
- While the rate of suicide is much higher for males, more women attempt suicide.
- One reason for the gender difference in the rates of suicide may be due to males choice of more lethal methods of suicide such as firearms and hanging. Females use methods such as self-poisoning and therefore are much more likely to be found and given life-saving treatment.

[3] OECD countries compared were New Zealand, Finland, Australia, Canada, USA, Norway, France, Denmark, Sweden, Germany, Japan, UK, and the Netherlands.

Suicide and ethnicity

Note: Due to changes in the classification of ethnicity since September 1995, it is not possible to compare pre-1995 Māori and non-Māori suicide rates with later years. This is also the case for Pacific data.

- In 1996, there were 71 Māori male suicide deaths and 24 Māori female suicide deaths, compared to 357 non-Māori male and 88 non-Māori female suicides.
- In 1996, there were 17 Pacific male suicide deaths, 3 of which were aged between 15 and 24 years. There was one female Pacific suicide death for that year.
- For the 11 years from 1984 to 1994, the number of Māori male suicides increased from 17 to 31 deaths, while Māori female suicides showed more of an increase, from 5 to 12 deaths.

Attempted suicide

- There were 1324 male and 2015 female hospitalisations (inpatient and day patient) for intentional self-inflicted injury in 1996/97.[4] Of these 405 males and 684 females were aged 15–24 years.
- There were 185 Māori male and 248 Māori female public hospitalisation discharges for intentional self-inflicted injury in 1996/97.

[4] The hospitalisation data presented here refer to the fiscal year from July 1996 to June 1997, not the calendar year.

Suicide and young people

1977–96 figures

- From 1977 to 1996, the number of youth suicides in New Zealand doubled, from 70 (1977) to 143 (1996). Males had the largest increase in terms of numbers, but females had a higher percentage increase.
- From 1977, the total rate of youth suicide (15–24 years) doubled, from 12.3 per 100,000 to 26.1 per 100,000 in 1996.
- Suicide rates for males 15–24 years almost doubled, from 20.3 per 100,000 in 1977 to 39.1 per 100,000 in 1996.
- Suicide rates more than tripled for 15–24 year old females from 4.2 per 100,000 in 1977 to 14.3 per 100,000 in 1996.

1997 figures

- In 1997, 142 people aged 15–24 years died by suicide. Of these, 113 were male and 29 were female.
- The total rate of youth suicide (15–24 years) in 1997 was 26.1 per 100,000.
- The rate of youth suicides for males (15–24 years) in 1997 was 40.9 per 100,000.
- Among females (15–24 years), the rate in 1997 was 10.8 per 100,000.
- Child suicide (under the age of 15 years) is rare in New Zealand. In 1997, there were eight deaths in the 10–14 year age group.
- Suicide is the second leading cause of death (behind motor vehicle deaths) for young people aged 15–24 years.

Māori youth suicide

- The rate of Māori youth suicide in 1997 was 33.9 per 100,000 aged 15–24, which was significantly higher than the non-Māori rate of 24.2 per 100,000.
- In 1997, the Māori male youth suicide rate was the highest recorded youth rate at 51.1 per 100,000 compared to non-Māori males at 38.5 per 100,000.

For further information on suicide statistics contact

New Zealand Health Information Service

tel (04) 801-2700 or fax (04) 801-2769

PART 3: Practical Advice, Contacts, and Resources

Considerations when reporting or portraying suicides

The following considerations should be borne in mind when reporting or portraying suicide in the media. They have been based on the best available research. Some of these considerations may not be practical or relevant for including in very short, factual newspaper, television and radio reports. However, all media personnel need to be aware of the issues involved in reporting and portraying suicide in the media.

- **Consider whether the number of stories you are publishing or broadcasting about suicide is repetitive in terms of news relevance.** Repetitive and ongoing coverage, or prominent coverage of suicide tends to promote and maintain a preoccupation with suicide for those at risk, especially young people. This preoccupation appears to be associated with suicide contagion, particularly if the suicides occurred in the same community.
- **Try to include reliable information and knowledgeable commentators when you do report about suicide.** Facts and common myths about suicide are provided in *Part 2: Facts about suicide* (page 10) and a list of reliable sources of further information or comment is provided below under *Contacts for comment and resources on suicide* (page 31).
- **Aim to present suicide as a poor choice for resolving a crisis or deep despair.** Sometimes media reports inadvertently present suicide as a 'rational' means of dealing with personal problems,

for example, 'John committed suicide after the break-up of a relationship.' This type of reporting may suggest suicide is a potential solution to a problem for vulnerable people. If practical, stories or reports on suicide should include positive and realistic suggestions for seeking help, such as talking to a friend, family member, or helping professional.

- **Avoid simplistic explanations for suicide.** Suicide is an act of a troubled or depressed person. Most people who commit suicide have a long history of problems, and both media and commentators should avoid conveying that final precipitating crisis event as the only cause of a given suicide.
- **Promote awareness of the strong relationship between mental health problems, especially depression, and suicide risk.** About 90 percent of people who commit suicide or make serious suicide attempts will have had one or more recognisable psychiatric disorders, the most common being depression. Therefore, educating the public about the potential significance of mental health problems (particularly depression and schizophrenia) and suicidal behaviour may assist in ensuring that those experiencing problems receive timely and appropriate referral and help.
- **Avoid inadvertently glorifying suicide or those who commit suicide.** Suicide can sometimes be presented as romantic, heroic, alluring, or a normal act. Doing so can suggest to vulnerable people that suicide is a good choice. News coverage is less likely to contribute to suicide contagion when reports of community expressions of grief (for example, public eulogies, flying flags at half mast, and erecting permanent public memorials) are minimised. Such actions may contribute to suicide contagion by suggesting that society is honouring the suicidal behaviour, rather than mourning the person's death.

- **Take particular care when reporting suicides or suicidal attempts by celebrities.** It is prudent to take a cautious approach when reporting celebrity suicide. These suicides may have a greater influence on young people because of the imitative associations young people tend to make with celebrities. Therefore, when a suicide report involves a young persons' idol, such as a music or sports star, extra care is required. It is important that when a public figure suicides, care is taken to report all the facts such as use of drugs and prior mental health problems. Minimal coverage of the suicide method used is particularly advised.
- **Acknowledge the deceased person's problems as well as their positive aspects.** Empathy for family and friends often leads to a focus on reporting the positive aspects of a suicide victim's life. For example, friends or teachers may be quoted as saying, 'she was a great kid' or 'he had a bright future', and avoid mentioning the troubles and problems that the person may have been experiencing. If the deceased person's problems are not acknowledged, as well as their positive characteristics, suicide can appear attractive to vulnerable people – especially those who rarely receive positive reinforcement.
- **Present positive role models.** Report stories of people who have felt despair or distress but sought help to overcome their difficulties rather than attempted or committed suicide.
- **Never report 'how-to' descriptions of suicide.** Describing or depicting the details of the method of suicide is strongly discouraged as this may lead to imitation of the suicidal behaviour by another at-risk person. For example, reporting that a person died of an overdose may not be harmful, but providing details of the number and type of pills taken could be.

- **Provide information on where to go for help.** Accurate numbers of local help services, or mental health referral telephone services could be included.
- **Be aware that people bereaved by suicide are themselves at higher risk.** People who have suffered a death by suicide of a family member, and either approach reporters to tell their story or are approached by the media, are vulnerable and working through grief and related issues. Media professionals are reminded that people bereaved by suicide are themselves at higher risk of suicidal behaviour than the rest of the population.
- **Consider the effect of the placement of the story in the newspaper on at risk people who may read the story.** Research (Phillips 1982; Ganzeboom and de Haan 1982; Kopping et al 1989; Ishii 1991; Yoshida et al 1991) has shown that placing a story about suicide on the front page of a paper may contribute to suicide contagion.
- **Avoid the word 'suicide' in the headline.** Research by Phillips (1992) has shown that the use of the word 'suicide' in headlines may be associated with copycat suicides.
- **Refrain from using photographs and visuals with suicide stories.** Photographs or dramatic visuals should not be used. Photographs of a funeral, the deceased person's bedroom, a rope in a noose, or the site of the suicide may increase the risk of copycat suicides (Phillips et al 1992).

Codes and legislation on reporting of suicide

There are several codes and Acts of Parliament which restrict how suicide can be reported in the media. These are detailed in the *Appendix* (page 41).

Suicide calls to the media: What to do?

Media organisations are sometimes contacted by suicidal people. This may happen without warning in the early hours of the morning on talkback radio, after for example, a television news item on suicide or a newspaper feature article. These calls can be distressing to deal with. There are steps reporters and announcers can take to assist such callers:

- Be calm and understanding.
- If the call is on air, put the caller on to your producer, or put some music on and talk to them off air.
- Assess the urgency of the situation. Someone may call who has already begun a suicide attempt. It is essential to realise that they want help. Ask whether they have already harmed themselves (for example, ask, *'Do you have anything with you which you might harm yourself with?'* This is a good way of finding out if they have done so). If they have call an ambulance (or get a colleague to call). Then:
  - **keep the person talking**
  - **make sure you express concern for the person's safety and that you want to be sure the person is all right**
  - **make it clear that your main concern is the person's life, that you are not going to take any chances with it, and you are not going to disconnect them**
  - **ascertain whether they are on their own. If so, whether a close friend or family member should be contacted.**
- Suggest to your caller that they contact their local mental health service or general practitioner (you may have to find a telephone number for them). You could also ask your caller for their permission to contact an emergency service on their behalf. You

will need to get their name and address to do this. A range of specific *Help lines and services* are listed on page 39.

- Do not promise to fix things – it's fine to agree to assist them to get some help, but do not set yourself up as the person who can resolve problems.
- Emphasise that there are professionals who may be in a better position to help them than you.
- Remember that you are not responsible for anything the caller might do, or threaten to do.

Such calls can be particularly distressing, especially when they are unexpected. Make sure you talk to someone that day about the call for your own health and wellbeing. If you have been particularly upset by a call, you may find it helpful to talk to a professional, such as a counsellor.

Advice for commentators

The following advice is for those who may be asked by the media for comment about suicide.

'No comment' does not mean no story.
Refusing to speak with the media does not prevent coverage of a suicide; rather, it precludes an opportunity to influence what will be contained in the report. Nevertheless, you should not feel obliged to provide an immediate answer to difficult questions. However, be prepared to provide a reasonable timetable for giving such answers or be able to direct the media to someone who can provide the answers.

All parties should understand that researched evidence exists to support a concern that news coverage and fictional depiction of suicide may contribute to the causation of suicide.
People's attempts to minimise suicide contagion through the media can be easily misinterpreted and be perceived as restricting the freedom of the press. Take the time to explain the carefully established, scientific basis for the concern about suicide contagion and how the potential for contagion can be reduced by responsible reporting.

Commentators should not tell reporters what to report or how to write or present stories about suicide.
If the nature and apparent mechanisms of suicide contagion are understood, the media are more likely to present the news in a manner that minimises the likelihood of such contagion. Instead of dictating what should be reported, you should explain the potential for suicide contagion associated with certain types of reports and should suggest ways to minimise the risk of contagion.

Think carefully about what is said and reported about suicide.
Given the potential risks, both parties should seek to minimise the risks of harmful news coverage by carefully considering what is to be said and reported about suicide. Suicide is a complex issue. Make an effort to get informed so your comments will not serve to increase the myths and misinformation about suicide.

Take the opportunity to mention the support available.
For example, mayors and school principals when asked for comment, could in addition to expressing the community's concern, mention the local support networks available for both people feeling suicidal and their friends and family. See *Help lines and services* (page 39) and *Information on local suicide prevention initiatives* (page 37) for contacts.

General advice on how to help

A person showing any signs of suicidal behaviour can be helped by:

Calm and open listening

Do not expect to solve the problems, just listen. Do not be afraid to talk about suicide or the problems that have caused the suicidal behaviour. Problems do not get worse by talking about them.

Indications of care and concern

If a person confides that they have been thinking about suicide, telling and showing care and concern is essential. There should be no agreement to keep their suicidal thoughts a secret.

Professional help

Any person who is finding life difficult should be told that there are professionals who can provide expert advice. The person should be helped to access the professionals.

All threats must be taken seriously

Listeners should not try to change the subject or ignore threats because they are scared. This may look as if you do not care.

Listeners should not offer simple advice

Those thinking about suicide will feel their problems are major and cannot be solved right now.

Not being told that they're selfish to consider suicide when their life is so good

This will make them feel guilty as well as depressed.

Not being told 'suicide is the easy way out'

There is nothing easy about suicide.

Contacts for comment and resources on suicide

The following contacts and resources may be helpful for providing informative advice on suicide.

Information on suicide and its prevention

- **SPINZ (Suicide Prevention Information New Zealand)**
  SPINZ is a new service provided by the Mental Health Foundation and the Centre for Youth Health, South Auckland Health. The service provides advice and information to the community on youth suicide and youth suicide prevention. As well as maintaining a Web site, the service will respond to written requests for information.
  Web site: www.spinz.org.nz
  tel (09) 630-8573
  fax (09) 630-7190
  e-mail: spinz@mentalhealth.org.nz

- **Ministry of Health**
  PO Box 5013
  Wellington
  tel (04) 496-2000
  fax (04) 496-2340

  The Ministry of Health is responsible for overseeing the implementation of the New Zealand Youth Suicide Prevention Strategy. You can access information about the Strategy through the Ministry of Health Web site www.moh.govt.nz/youthsuicide.html

- **Mental Health Foundation of New Zealand**
  PO Box 10-051
  Auckland
  tel (09) 630-8573
  fax (09) 630-7190
  Web site: www.mentalhealth.org.nz
  e-mail: resource@mentalhealth.org.nz

  The Mental Health Foundation disseminates resource material and information about mental health and mental illness including suicide. In addition to providing workshops and training programmes they can also provide advice to others when resources or information related to mental health are being developed.

- **Health Funding Authority**
  National Office
  PO Box 10-485
  Wellington
  tel (04) 495-9293
  fax (04) 495-9285

  The Health Funding Authority funds health services across New Zealand including youth health, mental health, and health promotion services.

  ***Media Handbook: A resource for journalists and sub-editors reporting on mental illness* (1998).** This document provides information to assist media in reporting on mental illness. The publication provides factual information on mental illness, contacts and recommended literature. Available from Huia Publishers, Wellington.

- **New Zealand Youth Suicide Prevention Strategy**
  The *New Zealand Youth Suicide Prevention Strategy: In Our Hands, Kia Piki te Ora o te Taitamariki,* published in March 1998, was developed to reflect the need for a broad-based approach and range of activities to respond to the problem of suicide among youth in New Zealand. In 1995, New Zealand had the highest rates of suicide by OECD comparisons (for statistical information on youth suicide in New Zealand see *New Zealand suicide statistics*, page 16 and our Web site: www.moh.govt.nz/youthsuicide.html).

  The strategy implementation is the responsibility of an inter-agency committee on youth suicide prevention. A Ministerial committee also oversees the work of the inter-agency committee. The Ministry of Health is the lead agency for overseeing the leadership, co-ordination and communication of the strategy. A number of projects have been developed under the strategy which are the responsibility of various agencies. Initiatives include the development of a range of guidelines to help those who work with young people to recognise and manage suicidal behaviours (eg, guidelines for primary health care providers, schools, Police and social workers). Other initiatives include information for parents and young people on how to recognise suicidal behaviour and how to seek help and community-based programmes to develop young peoples' skills and also to provide information to communities on suicide (see SPINZ service listed above) and how to develop local suicide prevention approaches.

  A selection of key resources developed as part of the strategy include:

  ***The New Zealand Youth Suicide Prevention Strategy: In Our Hands, Kia Piki te Ora o te Taitamariki* (1998).** The overall strategy is made up of two separate but interconnecting strategies presented within the same document. *In Our Hands* is the general population strategy and *Kia Piki te Ora o te Taitamariki* has been developed for Māori.

In Our Hands presents a series of goals and objectives which range from promoting resilience factors such as strengthening and supporting families, to ensuring people have the skills to identify and help someone who is suicidal, through to supporting those who have been bereaved by suicide. Available from the Ministry of Health.

Kia Piki te Ora o te Taitamariki: Strengthening Youth Wellbeing is a similar strategy but with a Māori community development approach which focuses on promoting resilience factors such as cultural identity and belonging. Available from the Ministry of Health.

***A Review of the Evidence: In Our Hands, The New Zealand Youth Suicide Prevention Strategy* (1998), by Annette Beautrais.** This document summaries the international evidence on effective suicide prevention interventions which supports *In Our Hands,* the general population component of the New Zealand Youth Suicide Prevention Strategy. Available from the Ministry of Health.

***A Review of the Evidence: Kia Piki te Ora o te Taitamariki, The New Zealand Youth Suicide Prevention Strategy* (1998), by Keri Lawson-Te Aho.** This document summarises the international evidence about indigenous youth suicide and applies these to a Māori context. This evidence and consultation with Māori underpins *Kia Piki te Ora o te Taitamariki,* the Māori-specific component of the New Zealand Youth Suicide Strategy. Available from the Ministry of Health.

***Helping Troubled Young People – A Guide for Parents* (1998).** Pamphlet for parents and caregivers of young people, which provides advice on how to recognise and respond to signs of distress. Available from the Ministry of Youth Affairs.

***Te Āwhina i Ngā Rangatahi e Raru nei* (1999).** A Māori-specific resource for parents, caregivers, and whānau of rangatahi. It offers Māori ideas on how they can encourage and support their rangatahi, as well as seeking additional support for themselves and their whānau. Available from the Ministry of Youth Affairs.

***SPIN* (1998).** A resource for young people which presents real-life situations in cartoon form that can lead to depression, encourages help seeking, and suggests where to get help. Produced by the Mental Health Foundation and commissioned by the Ministry of Youth Affairs. Available from the Ministry of Youth Affairs.

***Young People at Risk of Suicide – A guide for schools* (1998).** This guide focuses on identifying young people who are in a state of emotional distress and may be at risk of harming themselves by attempting suicide. Produced by the National Health Committee and the Ministry Education. Available from the Ministry of Education.

***Guidelines for Detection and Management of Young People at Risk of Suicide in Primary Care* (1999).** Produced by the Royal New Zealand College of General Practitioners (RNZCGP) for public health nurses, general practitioners, and practice nurses. Commissioned the Ministry of Youth Affairs and available from the RNZCGP.

***A Practical Guide to Coping with Suicide* (1999).** This guide offers straightforward information and advice for community workers and lay people about preventing and dealing with suicide. Produced by and available from the Mental Health Foundation.

Full details on government initiatives under the New Zealand Youth Suicide Prevention Strategy are available from the Ministry of Health or its Web site (see page 31).

Major studies and research units on suicide in New Zealand

- **The Health Research Council,** PO Box 5541 Auckland. The Health Research Council has a directory of experienced health researchers by topic, including suicide. Tel (09) 379-8227, fax (09) 377-9988.
- **Canterbury Suicide Project (Principal Investigator, Dr Annette Beautrais),** Christchurch School of Medicine, PO Box 4345, Christchurch. Tel (03) 372-0408, fax (03) 372-0405, e-mail: suicide@chmeds.ac.nz
- **The Christchurch Health and Development Study (Director, Dr David Fergusson),** Christchurch School of Medicine, PO Box 4345, Christchurch. Tel (03) 372-0406, fax (03) 372-0405.
- **Injury Prevention Research Centre Auckland.** University of Auckland, Private Bag 92-019, Auckland. Tel (09) 373-7999, fax (09) 373-7503, e-mail: injury@auckland.ac.nz
- **Injury Prevention Research Unit Dunedin.** University of Otago. PO Box 913, Dunedin. Tel (03) 479-8342, fax (03) 479-8337.

Statistical information on suicide may be obtained from:

- **New Zealand Health Information Service (NZHIS)**
  PO Box 5013
  Wellington
  tel (04) 801-2700
  fax (04) 801-2769
  Web site: www.nzhis.govt.nz

  NZHIS collects hospital inpatient and death information. It publishes annual reports and is able to provide specific information upon request subject to a charge.

Information on local suicide prevention initiatives may be available from:

- **SPINZ (Suicide Prevention Information New Zealand)**
  tel (09) 630-8573
  fax (09) 630-7190
  e-mail: spinz@mentalhealth.org.nz.
  Web site: www.spinz.org.nz
- **Community mental health services** *(see listings in your local telephone directory under Hospital and Health Services)*
- **Public health services** *(see listings in your local telephone directory under Hospital and Health Services)*
- **Safer communities councils** *(see listings in your local telephone directory or approach your local authority)*
- **Specialist Education Services**
  PO Box 12-188
  Thorndon
  Wellington
  tel (04) 499-2599
  fax (04) 460-0834
  Web site: www.ses.org.nz

Consumer perspectives may be sought through:

- **New Zealand Schizophrenia Fellowship Inc**
  PO Box 593
  Christchurch
  tel (03) 366-1909
  Web site: www.sfnat.org.nz

- **Wellington Mental Health Consumers Union**
  PO Box 6228
  53 Courtenay Place
  Wellington
  tel (04) 801-7769
- **Manic Depressive Society Inc**
  PO Box 25-068
  Christchurch
  tel (03) 366-5815
- **Manic Depression Information Trust**
  PO Box 37-829
  Parnell
  Auckland
  tel (09) 827-7027
- **Community mental health services [may also have information on local consumer groups]** *(listed under Hospitals and Other Health Service Providers in the front of your local telephone directory)*
- **Youth Suicide Awareness Trust**
  PO Box 3369 or PO Box 1692
  Auckland Wellington
  CLEAR Toll Free 0508 CHOOSE LIFE
  0508 246-673
- **Bereaved by Suicide support groups** *(check your local telephone directory or contact your local community mental health service, also through the telephone directory)*

Help Lines and Services

It can be very helpful to end a story on suicide with a list of help lines. Media professionals are strongly encouraged to consult carefully with the contacts suggested above on the issue of which help lines are appropriate in different kinds of stories.

Broadcasters need to be particularly careful to consult on the appropriateness of broadcasting telephone lines for particular stories. The services require advanced notice of the use of their telephone number for stories on suicide or depression to ensure an adequate number of qualified staff are available to take calls. Options can include:

Help lines

- Youthline (0800 376-633)
- Lifeline *(refer to front of your local telephone directory)*
- Samaritans *(under S in your local telephone directory)*

Services for emergencies

- Psychiatric emergency services
- Community mental health services
- General practitioner
- Emergency department of the local hospital

General support services

- Community mental health services
- School counsellor
- General practitioner

- Specialist Education Services
- Lesbian and gay support counselling services
- Iwi and other Māori health/counselling services
- Sexual abuse counselling services
- Family counselling services
- Alcohol and drug services
- Other specialist counselling service such as bereavement services, family counsellors, whanau support services, refugee support services etc)
- Victim support
- Samaritans/Lifeline/Youthline

General information for the public on mental health

- The Mental Health Foundation of New Zealand

Anyone seriously concerned about an individual's immediate safety should:

- remain with them until appropriate support arrives
- remove any obvious means of suicide (guns, medication, cars, knives, rope etc)
- contact the nearest hospital or psychiatric emergency service.

Appendix: Codes and legislation on the reporting of suicide

There are a number of codes and Acts of Parliament which restrict the level and manner in which suicide can be reported or portrayed.

The Broadcasting Act 1989

Section 4 states that every broadcaster (television and radio) is responsible for maintaining in its programmes, standards which are consistent with the observance of good taste and decency and the maintenance of law and order. They are also required to comply with any approved code of broadcasting practice issued by the Broadcasting Standards Authority. If a complaint to the Broadcasting Standards Authority is upheld, the broadcaster may be ordered to refrain from broadcasting for a specified time.

The Code of Broadcasting Practice

Section V7, regarding the Portrayal of Violence, states that close-up detail indicating how suicides and hangings may be accomplished must not be shown. Furthermore, in dealing with factual material about suicides in New Zealand, programmers should be mindful of the provisions of the Coroner's Act which forbids the disclosure of a method of suicide, except with the express permission of the Coroner concerned.

Making a complaint

Television and radio

To lodge a complaint about a television or radio broadcast, a complainant should first write to the broadcaster who transmitted the broadcast. If not satisfied with the broadcaster's response, then a **formal complaint** can be lodged with the Broadcasting Standards Authority.

To be regarded as a formal complaint, a complaint should:

- refer to a programme which has been broadcast, be in writing, be addressed to the broadcaster concerned and include the words 'Formal Complaint'
- identify which of the standards referred to in the codes of broadcasting practice, or the Broadcasting Act (refer to the codes or Act for details) appear to have been breached
- give details including the name, date and time of the programme and the station or channel, and
- include a clear statement of the reasons for your objection (if, for example, your complaint is based on the portrayal of how suicides may be accomplished, you should cite the words spoken or actions shown and explain why you consider those words or actions breach that standard).

Anyone can make a complaint about reportage of issues in any forms of media. There are different avenues of complaint and standards, depending on the medium concerned.

Print media

If the contents of a print media article raise concerns, a complaint should first be made to the editor of the publication concerned. If unsatisfied with the response the complainant can then write to the following address, including a clipping of the article concerned:

The Secretary
New Zealand Press Council
PO Box 10-879
The Terrace
WELLINGTON

Note: A code of practice has been published by the New Zealand Press Council. For copies write to the above address.

The Coroners Act 1988

- If there is reasonable cause to believe that a death was self-inflicted, but an inquest has not been completed, no one is permitted to make public any particulars relating to the manner in which the death occurred without the coroner's permission.
- Where an inquest has been completed, and the coroner has found that the death was self-inflicted, only the name, address, and occupation of the person concerned and the fact that the coroner has found the death to be self-inflicted may be reported unless the coroner authorises the publication of further details. The coroner may decide to authorise the release of further details of a self-inflicted death if they are of the opinion that publication of the details may reduce the chances of the occurrence of other deaths.

- Where details of a self-inflicted death have been published in a report by the Police Complaints Authority, or the Commissioner of Police under the Police Complaints Authority Act, they may be further reported without the authority of the coroner.
- Anyone who publishes or permits to be published any information in breach of the Coroners Act is liable on summary conviction to a fine of up to $5000 in the case of a body corporate, or up to $1000 in any other case. (In addition to a prosecution and fine, it will in some circumstances be possible for an injunction to be obtained preventing the publication or broadcast.)

Your contact numbers for resource professionals and groups

These pages are for you to add contact details for people who are able to provide advice regarding suicide.

Service:	
Contact Person(s):	
Phone:	
After hours:	
Address:	
e-mail	**Fax:**

Service:	
Contact Person(s):	
Phone:	
After hours:	
Address:	
e-mail	**Fax:**

Service:	
Contact Person(s):	
Phone:	
After hours:	
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e-mail	**Fax:**

Service:	
Contact Person(s):	
Phone:	
After hours:	
Address:	
e-mail	**Fax:**

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