New Plymouth injury Safe Trust

Taranaki Suicide Prevention Needs Assessment

August 2008

Prepared by Channa Perry
Safe Community Programme Manager

On behalf of the Ministry of Health (Health & Disability National Services Directorate)

Table of Contents

Acknowledgements

New Plymouth injury Safe Trust would like to thank the following individuals and organisations who contributed to the Taranaki Suicide Prevention Needs Assessment through their participation in interviews or focus groups, or the provision of information and data:

Accident Compensation Corporation
Age Concern Taranaki
Bishops Action Foundation
Central Taranaki Victim Support
Clinical Psychologists
Counsellors
Department of Corrections (New Plymouth Prison)
Eagers Funeral Services
Eltham Veterinary Services
Family/whanau bereaved by suicide or affected by suicide attempt
Family Works
Federated Farmers (Taranaki Branch)
General Practitioners (New Plymouth & South Taranaki)
Hauora Taranaki PHO
HELP Trust
HRC Family Counselling
Lifeline Taranaki
Like Minds Taranaki
Mahia Mai A Whaitara
Manaaki Oranga
Mental Health Service Consumers
Ministry of Health
New Plymouth District Council
New Plymouth Girls High School
New Plymouth Police
New Plymouth Victim Support
Open Home Foundation
Pathways
Peak Health PHO
Problem Gambling Foundation
Progress to Health
Rural Women New Zealand
South Taranaki Community Safe House
South Taranaki Family Counselling Services
South Taranaki Women's Centre
Stratford District Council
Supporting Families
Taranaki District Health Board – Health Promotion Unit
Taranaki District Health Board – Mental Health Services
Taranaki Suicide Project
Taranaki Women's Refuge
Te Rau Pani
Te Whare Puawai O Tangata Trust
Toi Ora
Youth focus group participants
WAVES
Work and Income New Zealand
Youth Transition Services

New Plymouth injury Safe Trust would like to take this opportunity to thank the Ministry of Health (Health & Disability National Services Directorate) who provided funding for the Taranaki Suicide Prevention Needs Assessment.

We would also like to extend our thanks to Dr Carolyn Coggan (Director, Safe Communities Foundation New Zealand) and Maree Young (Researcher/ Evaluator, Health Promotion Unit, Taranaki District Health Board) for their time and expertise in peer reviewing this report.

Disclaimer

This report has been prepared by Channa Perry, Programme Manager for New Plymouth injury Safe Trust, under contract to the Ministry of Health (Health & Disability National Services Directorate). The views of the author, or New Plymouth injury Safe, do not necessarily represent the views or policies of the Ministry of Health. While every effort has been made to ensure the accuracy and comprehensiveness of this document, New Plymouth injury Safe gives no indemnity as to the correctness of the information or data supplied.

Executive Summary

Suicide, and suicide attempts, represent a significant public health issue in New Zealand. Each year more New Zealanders die as a result of suicide than are killed in road traffic accidents. Research has shown that multiple risk factors are linked to suicide, ranging from individual factors (genes, personality) through to macro-social factors (unemployment, poverty, media influence). It is often an accumulation of these risk factors that leads to suicidal behaviour among certain at-risk population groups. These risk factors also increase the rate of mental health problems among those who are exposed to them, in turn leading to greater risk of suicide. Mental health disorders are a factor in up to 70% of suicides and suicide attempts.

At an individual level, it can be difficult to predict suicide. However, research suggests that taking a comprehensive and intersectoral approach to suicide prevention at the population level is an effective way of reducing rates of suicide and self-harm. The New Zealand Suicide Prevention Strategy (2006-16), and the recently published New Zealand Suicide Prevention Action Plan (2008-12) provides a strategic framework to guide and coordinate suicide prevention at the national and local level.

If this national strategic guidance is to be translated into action at the local level an understanding of the local context with respect to suicide and suicide prevention is essential. Knowing the extent of the problem and who is most at risk will help us target our limited resources most effectively to those at most need. Identifying existing suicide prevention interventions that are supported by sound research evidence will reduce duplication when future services are developed as well as providing a valuable springboard for the development of new local initiatives. Highlighting gaps and opportunities for future action will ensure that future local planning will result in comprehensive and coordinated services and initiatives.

The purpose of this Needs Assessment was to provide local data and evidence to inform and support individuals, organisations and networks across the Taranaki region to take a strategic approach to planning, development , coordination and implementation of suicide prevention at the local level. Information was collected from a number of different sources including existing literature on suicide and self-harm, available statistical data on suicide and self-harm and a number of key informant interviews and focus groups with a range of stakeholders. The stakeholders included mental health service providers, consumers, family/whanau bereaved by suicide, community representatives, Maori representatives and organisations/services that had a role to play in suicide prevention and postvention support.

The Needs Assessment identified four groups at risk of suicide in Taranaki – young males (particularly Maori), older males (non-Maori), farmers and mental health service consumers. These groups are considered to be at higher risk as a result of quite varying factors that are different for each group. Thus the approaches to addressing these factors will need to be quite distinct in order to target the needs of each group.

In the case of self-harm, the findings of the stakeholder consultation conflicted with hospitalisation statistics. Stakeholders identified young females (15-24 years) as being at greatest risk of self-harm while Taranaki DHB hospitalisation statistics suggested rates were higher among 25-44 year old females (i.e. the kind of self-harm that was serious enough to warrant hospital admission). However, it should be noted that when *national* data is

considered, females aged 15-24 years have the highest rate of hospitalisation for self-harm compared to any other population group in New Zealand.

In terms of existing service provision a number of local initiatives were identified as being 'effective' by current research. A number of other local initiatives, that would be defined as 'promising' by research in this area, were identified. None of the initiatives identified within Taranaki would be considered as 'unsafe' or 'harmful' according to the evidence base. These existing effective interventions are examples of 'good practice' that can provide a sound starting point for future development. Opportunities to extend the role of existing services and initiatives to improve support to those at risk of suicide and their family/whanau were also identified.

A number of gaps were identified during the Needs Assessment, linked either to the needs of specific population groups or to the absence of particular services. Those groups identified as having specific unmet needs were young people, older people and those living in rural communities. In terms of service provision, a broad range of service needs were identified. These ranged from a need for greater awareness raising and information sharing through to improvements in primary care services and better follow up support for those who have made a suicide attempt. A need for improved coordination of local suicide prevention efforts and community-based training was also highlighted.

As a result, the Needs Assessment proposes a number of recommendations. These include general recommendations aimed at improving the coordination of suicide prevention in Taranaki, as well as more specific recommendations that propose a public health approach to meeting the needs of specific population groups. The first step in taking these recommendations forward would be through the establishment of a multi-sectoral group that can prioritise the findings and develop a plan of action for the future. This would provide the starting point for Taranaki to translate the New Zealand Suicide Prevention Strategy (2006-16) into meaningful and effective action at the local level.

Channa Perry
Safe Community Programme Manager
New Plymouth injury Safe Trust
August 2008

Background

New Plymouth injury Safe Trust represents a coalition of seven organisations with a shared interest in injury prevention and community safety within the New Plymouth District. The organisations who are part of the New Plymouth injury Safe coalition are Accident Compensation Corporation (ACC), Department of Labour, Kidsafe Taranaki Trust, New Plymouth District Council, New Plymouth Police, Taranaki District Health Board (Health Promotion Unit) and Tui Ora Ltd.

The organisations within New Plymouth injury Safe Trust are each committed to a shared vision of community safety:

New Plymouth District, a safe community without the burden of injury

The coalition was formed in 2001 when representatives from five local organisations came together to explore how they could better align and coordinate their injury prevention priorities and activities. The group commissioned their first community-based injury prevention needs assessment in 2001, which involved the analysis of local and national injury statistics and extensive consultation with local stakeholders. The coalition made a commitment to repeat the community-based injury prevention needs assessment every five years and a second needs assessment was carried out in 2006. Around the same time the coalition formalised their structure in 2006, registering as a charitable trust.

In 2005 the coalition made a successful application to Safe Communities Foundation New Zealand (SCFNZ) that resulted in New Plymouth District being designated as an International Safe Community based on the World Health Organisation (WHO) framework for safe communities. Criteria for becoming an accredited Safe Community of the WHO Safe Community Network include having an infrastructure governed by a cross-sectoral group and running long-term sustainable programmes that cover both genders, all ages and all environments. These programmes typically focus on intentional as well as unintentional injury.

Suicide prevention is one of four injury prevention priority areas identified by New Plymouth injury Safe Trust in their Strategic Plan (2008-11). To gain a greater understanding of the problem, and to identify opportunities for the development of coordinated and sustainable approaches to suicide prevention, the Trust applied to the Ministry of Health (Health & Disability National Services Directorate) for funding to carry out a suicide prevention needs assessment.

Although New Plymouth injury Safe Trust's area of interest is predominantly the New Plymouth District, a decision was made by the group to conduct a needs assessment across Taranaki. This reflects the fact that many of the organisations working in the mental health and suicide prevention sector have a regional remit as well as responding to anticipated future developments that may see suicide prevention coordinated at a regional level.

Introduction

Every year approximately 500 New Zealanders die by suicide; more than the number who die in road traffic crashes. Around five times as many people will be hospitalised as a result of self harm or suicide attempt.[1] Suicide disproportionately affects young people aged 15-24 years, with suicide being the second most common cause of death for this age group. However, since reaching a peak in 1996, the youth suicide rate has declined by 25%. Approximately 80% of suicides now occur in the 25 years and over age group, with the highest suicide rate in the 25-44 year age group.[2]

A closer look at the statistics reveals a number of trends that demonstrate disparities in the prevalence of suicide among different population groups. Those who live in the most deprived areas of New Zealand have higher rates of suicide and hospitalisation for suicide attempts that those living in the least deprived areas. There are also gender disparities with more males dying by suicide than females.

These trends are exacerbated for Maori, with Maori males having higher rates of suicide and hospitalisation for suicide attempts compared with non-Maori males. A significant number of Maori suicides occur in the under-35 age group. While this may reflect the socio-economic inequalities faced by Maori, in countries like New Zealand it is common for indigenous peoples to have poorer health even when socio-economic position is considered. While suicide rates have declined since 1998 for all groups, evidence shows that the improvements over this period have not eliminated the difference between Maori and non-Maori suicide rates.

With suicide rates reflecting patterns of inequalities in the broader determinants of health, the reduction of health inequality is a key objective of the New Zealand Suicide Prevention Strategy 2006-16. The importance of responsiveness to Maori through accessible, effective and appropriate interventions is also acknowledged. In particular, the strategy calls for a "collaborative approach to suicide prevention, co-ordinated across government agencies and integrated across the public and private sectors"[3].

To support the implementation of the national Strategy, the Associate Minister for Health recently published the New Zealand Suicide Prevention Action Plan 2008-2012.[4] The Action Plan is made up of two companion documents: *The Summary for Action* and *The Evidence for Action*. Together the Strategy and Action Plan set out to guide and coordinate suicide prevention at the national and local level. In particular, the Action Plan provides more detail about how the high level goals of the Strategy will be achieved, describing the actions that will be required across the range of sectors involved in suicide prevention.

It should be noted that the New Zealand Suicide Prevention Action Plan 2008-12 is intended primarily as a guide for government and non-government agencies involved in

---

[1] Associate Minister of Health. 2006. *The New Zealand Suicide Prevention Strategy 2006-16.* Wellington, New Zealand

[2] Beautrais AL, Collings SCD, Ehrhardt P, et al. 2005. *Suicide Prevention in New Zealand: A contemporary perspective.* Wellington: Ministry of Health

[3] Associate Minister of Health. 2006. *The New Zealand Suicide Prevention Strategy 2006-16.* Wellington, New Zealand. p.6

[4] Ministry of Health. 2008. *New Zealand Suicide Prevention Action Plan 2008-1012: The Summary for Action and The Evidence for Action*. Wellington: Ministry of Health

planning, funding and delivery of suicide prevention initiatives. It is not intended to be a detailed prescription for how specific suicide prevention initiatives should be carried out at a local level. However, the New Zealand Suicide Prevention Strategy acknowledges that for implementation to have maximum effect the active involvement of local communities is essential[5]. It recommends a community-wide approach that encourages community members to play an active role in the development and implementation of local suicide prevention activities.

Thus the Taranaki Suicide Prevention Needs Assessment sets out to compliment the Action Plan by identifying opportunities for improved collaboration and co-ordination of suicide prevention activity at the local level. New Plymouth injury Safe Trust hope that this needs assessment will ultimately form the basis for the development of a community-wide suicide prevention plan for Taranaki.

Purpose

The purpose of the Needs Assessment is to provide local data and evidence to inform and support individuals, organisations and networks across the Taranaki region to take a strategic approach to planning, development and implementation of suicide prevention at the local level. The needs assessment also sets out to identify opportunities for improved co-ordination and collaboration across the suicide prevention sector. The *New Zealand Suicide Prevention Action Plan 2008-12* has been used as the framework for the Needs Assessment process and the development of any recommendations for future action at the local level.

Objectives

The Taranaki Suicide Prevention Needs Assessment had the following objectives:

- To identify rates of self-harm and suicide among different population groups in Taranaki using routine quantitative data sources
- To identify population groups at greatest risk of self-harm and suicide through community consultation with key stakeholders
- To undertake a mapping of existing services and activities that contribute towards the prevention of self-harm and suicide
- To identify gaps in existing service provision and explore opportunities for future service development
- To identify opportunities for improvements in the co-ordination of local suicide prevention initiatives
- To provide recommendations to inform the development of a strategic and co-ordinated approach to suicide prevention across Taranaki

[5] Associate Minister of Health. 2006. *The New Zealand Suicide Prevention Strategy 2006-16.* Wellington, New Zealand

Chapter 1: Data and Methods

1.0 Overview

The information presented in this report was obtained from three main sources:

- Research literature and other documentation relating to suicide prevention in New Zealand
- Available statistical data on suicide and self-harm in Taranaki
- Stakeholder consultation with key individuals and groups in Taranaki with an interest in self-harm and suicide prevention

1.1 Literature Review

At the beginning of the Needs Assessment, a brief literature review was carried out. The literature review included published research papers, reports, policy documents and other written information relating to suicide and self-harm within Taranaki and across New Zealand.

Relevant literature was identified by searching academic databases, particularly the University of Auckland's Injury Prevention Research Centre and the University of Otago's Injury Prevention Research Unit, as well as the Suicide Prevention Information New Zealand (SPINZ) resources and research catalogue. Other documents were identified during the community consultation process (e.g. project reports, organisational policies and procedures). The New Zealand Suicide Prevention Strategy 2006-16, the New Zealand Suicide Prevention Action Plan 2008-12 and the Ministry of Health Public Health Intelligence Monitoring Report *Suicide Facts 2005-6 data* were also key sources of information.

The literature search focused predominantly on the following areas:

- Identification of populations at most risk of self-harm and suicide
- Evidence of effective interventions for prevention of self-harm and suicide
- National policy, strategies and actions to address suicide prevention

The main section of the literature review is presented in Chapter 4 and focuses on effectiveness of suicide prevention interventions and the needs of specific population groups. However, findings from the literature review are also presented throughout the report to support, inform and expand upon the official statistics and the findings of the stakeholder consultation.

1.2 Suicide and Self-Harm Statistics

To determine the incidence of suicide and self-harm injuries in Taranaki, information was obtained from the following data sources:

- Public Health Intelligence (Suicide Facts 2005-6 data)
- New Zealand Health Information Services (NZHIS)

These data sources were selected because they were readily accessible and could be accommodated within the budget for this needs assessment.

Differences in the standard populations used for age standardisation by Public Health Intelligence and NZHIS should be noted. NZHIS uses Segi's World population and Public Health Intelligence uses the WHO World Standard population. The charts presented in this report are all based on raw data supplied by NZHIS and have therefore used Segi's world population for calculation of age-standardised rates.

1.3 Stakeholder Consultation

The stakeholder consultation set out to obtain respondents' views and experiences in relation to the following three areas:

- Population groups in Taranaki that are at greatest risk of self harm and suicide
- Services within Taranaki that have a role to play in promoting mental health, preventing suicide and providing postvention support
- Areas of need that could be met through future service development or improved co-ordination and collaboration between existing services

The following steps were undertaken to identify and consult with key stakeholders:

Step 1 – Identify key stakeholders:

Stakeholders were identified in a number of ways. These included contacts recommended by members of New Plymouth injury Safe Trust (NPiS), the Taranaki Suicide Project (TSP) and Bishops Action Foundation (who organised the local ASIST - Applied Suicide Intervention Skills Training – programme). Agencies and individuals were selected with the aim of obtaining a cross-section of viewpoints and experiences related to self-harm and suicide. Stakeholders included mental health service providers, consumers, family/whanau bereaved by suicide, community representatives, Maori representatives and organisations/services that had a role to play in suicide prevention and postvention support. Additional key informants were often identified during key stakeholder interviews and these were followed up and also invited to participate in an interview.

Step 2 – Develop an interview schedule:

An interview schedule was developed following informal discussions with some members of the Taranaki Suicide Project. To streamline the collection and analysis of the data the seven goals of the New Zealand Suicide Prevention Strategy 2006-16 were used as the overarching framework for the questionnaire. A researcher based within the Taranaki District Health Board peer reviewed the questionnaire and consent process, and some amendments were made. (See Appendix 1-3: Information Sheet, Consent Form and Questionnaire for Stakeholder Interviews/Focus Groups). Although the full questionnaire was used for most interviews, it was adapted and shortened in some cases where participant time was limited and/or it was more appropriate to focus on a specific area or topic. It was also amended for telephone interviews as these were generally carried out when participants had little time and it was necessary to be more focused.

Step 3 – Conducting interviews:

Interviews were mainly carried out face-to-face at a location chosen by the participant. A number of small group interviews were carried out, mainly involving professional groups at existing team meetings. Community-based focus groups were held in Hawera, Stratford and New Plymouth to which community members who had previously attended ASIST training were invited (a focus group was also arranged for Opunake but no-one attended). Two youth focus groups were also held. The NPiS Programme Manager carried out all interviews and focus groups, apart from the youth focus groups. One of these was run by a youth worker and the other by a young person themselves using a slightly adapted questionnaire (see Appendix 4 – Youth Focus Group Questionnaire). Some interviews were carried out over the telephone and two respondents requested that they fill in and return the questionnaire in paper format.

A total of 29 face-to-face interviews, nine telephone interviews, three group interviews and five community focus groups were held. An additional two paper questionnaires were completed.

1.4 Data Analysis

Suicide and self-harm hospitalisation data was sourced from New Zealand Health Information Service and supplied in Microsoft Excel format. The data was analysed and charts created using Excel software.

A general inductive approach was used for analysis of the qualitative data from the interviews, focus groups and questionnaires. Each transcript was read individually with key patterns and themes coded by the researcher and grouped into different categories. Additional information gathered during the consultation (e.g. from information leaflets about particular services) was also included within the relevant category. To facilitate this process, the data collected during the consultation was analysed using the seven goals of the New Zealand Suicide Prevention Strategy 2006-16 as an 'organising construct'. The use of an organising construct has been recommended as an effective means of providing meaning and structure to the disparate themes typically identified during qualitative analysis.[6]

Following the thematic analysis, the data was broadly categorised under the following headings:

- Definitions of self-harm
- Population groups at risk of self-harm / reasons
- Population groups at risk of suicide / reasons
- Mental health promotion services/activities
- Care for those experiencing mental disorders associated with suicidal behaviour
- Care for those who make non-fatal suicide attempts
- Reducing access to means of suicide
- Media reporting and portrayal of suicide
- Support for families/whanau/others affected by suicide

[6] Fredriksson L. 1999. *Modes of relating in a caring conversation: a research synthesis on presence, touch and listening.* Journal of Advanced Nursing, 30;5:1167-1176

- Expanding and sharing suicide prevention evidence and information
- Suicide prevention training
- Local suicide prevention partnerships/coalitions
- Current service provision
- Gaps in service provision
- Issues for specific population groups

1.5 Validity of Data

A number of issues exist relating to the validity and accuracy of data used in this needs assessment. Some of these issues are fundamental to the use of quantitative and qualitative data in general, where as others are related to the issue of self-harm and suicide specifically. It is important that these issues are highlighted and noted before considering the data findings.

1.5.1 Self-harm hospitalisation data

The hospitalisation rate for intentional self-harm used in this report is defined as the rate of first admission (inpatient or day patient) for an intentional self-harm event, using the International Statistical Classification of Diseases 10th Revision, Australian Modification System.[7] Thus these figures represent unique 'events' of self-harm, rather than people being hospitalised following a self-harm event. It is possible, therefore, that a single person can contribute to numerous self-harm events. Similarly, where an individual is re-admitted to hospital for the same self-harm event, this will be counted only once (at first admission).

However, regional differences exist between reporting practices and patient management that makes direct comparison of differences between DHBs difficult. For example, while those individuals who present at an Emergency Department and are admitted will be included in the data, definitions of 'admitted' vary between District Health Boards. Taranaki DHB defines a patient as admitted once they have been in the Emergency Department for 3 hours following initial assessment.

It should also be noted that, for a variety of reasons, actual cases of self-harm inevitably exceed those recorded in hospitalisation data. Self-harm has the potential to be misclassified, largely due to misreporting by patients when they receive treatment.[8] In particular, research has shown that individuals at risk of completed suicide may be especially prone to obscure the causes of their injuries leading to potential misclassification of self-harm at the point of hospitalisation. Furthermore, those individuals who present at a General Practitioner (or other primary care service) and are not admitted to hospital will not be included in the data.

---

[7] National Centre for Classification in Health. 2002. *The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification (ICD-10AM)*. Sydney: National Centre for Classification in Health

[8] Connor KR, Langley J, Tomaszewski K & Conwell Y. 2003. *Injury Hospitalisation and Risks for Subsequent Self-Injury and Suicide: A National Study from New Zealand*, American Journal of Public Health, 93:1128-1131

Indeed, research has shown that self-harm is considerably under-reported, with some estimates suggesting only 1 in 600 injure themselves sufficiently to need hospital treatment.[9] Therefore it could be argued that self-harm hospitalisation figures are just the 'tip of the iceberg' in terms of the actual extent of self-harm in the population.

1.5.2 Suicide data

A determination of suicide can only be made by a coroner following an inquest and will be based upon there being sufficient evidence, either explicit or implicit, that the injury was self inflicted and that the person intended to kill himself or herself. In some cases it may take many years before an inquest is heard, particularly if other factors surrounding the death need to be investigated first. In these cases a provisional classification of suicide may be made prior to a coroner's verdict. These provisional deaths will be included in the suicide data released for a particular year but may be subject to change at a later date depending on the outcome of the inquest.

For a number of reasons, suicide may be under-reported and the reliability of official rates is subject to error through variations in defining and reporting cases. For example, lack of evidence about intention may cause some suicide deaths be reported as road traffic deaths or other form of non-intentional injury-related death.

Research shows that the number of attempted suicides is considerably higher than the number of completed suicides. Figures based on public hospital discharges for intentional self-harm amount to approximately 10 times the number of suicides, with females outnumbering males by about two to one.[10] It should of course be noted that distinguishing self-harm from attempted suicide is often problematic. Not all cases of self-harm are suicide attempts just as it is possible that some reported suicides were cases of self-harm that were not intended to be fatal.

However, as with self-harm, it should be noted that the actual number of suicides likely exceeds the reported number.

1.5.3 Stakeholder Consultation

The collection and analysis of qualitative data obtained through interviews and focus groups is subject to a number of validity issues. These include limitations in the ability to determine the extent to which issues discussed in interviews or focus groups reflect the views of the wider community. Similarly, statistical measures of the prevalence of particular problems (e.g. minor self-harm or suicidal ideation) within the community cannot be made accurately using such methods. Potential selection bias may arise from the fact that those who choose to participate in interviews and focus groups have a strong interest (and strong views) on the topic. Time and other restrictions may prevent other individuals and groups, with equally valid viewpoints, from taking part. Thus it is possible that the findings from the stakeholder consultation do not accurately represent the views of the wider community.

---

[9] Babiker G & Arnold L. 2003. *The Language of Injury: Comprehending Self Mutilation*. British Psychological Society, UK

[10] O'Dea D and Tucker S. 2005. *The Cost of Suicide to Society*. Wellington: Ministry of Health

Furthermore, as with any research, the subjectivity and viewpoint of the researcher can limit the effectiveness of the methods in exploring particular issues or bias the interpretation and presentation of the results. The effects of this can be minimised through the use of a rigorous peer review process. Requests were made to two researchers (Dr Carolyn Coggan and Maree Young) to peer review the needs assessment report prior to publication.

To increase validity, a process of triangulation was used to cross check the data collected during the community consultation. Triangulation serves to strengthen a study by combining methods and data, using both quantitative and qualitative approaches, to control bias and establish valid propositions. The process involves assessing and comparing findings using different methods of data collection or by using the same methods with different individuals or groups.[11] Data from the community consultation was subject to data triangulation (where data is collected at different times and places, and from different groups). The use of a mixed methodology approach to the overall needs assessment allowed theory triangulation (using more than one theoretical approach, each with its own methodological strength and weakness).

[11] Denzin NK. 1988. The Research Act: A Theoretical Introduction to Sociological Methods, 3rd Ed. Englewood Cliffs. NJ: Prentice Hall

Chapter 2: Suicide in Taranaki

2.0 Suicide – An overview of the evidence

Research has identified several population groups that are at high risk for suicide and suicide attempt. These include young people (aged 15-24 years); Maori children and young people; children and young people in welfare care; those who have made previous suicide attempts; those in custody or in prison; those who are gay, lesbian or bisexual; and those who are socially isolated.[12] The higher suicide rates for these groups reflect the general patterns of health inequalities within the New Zealand population. Ethnicity, gender and geographic location of residence are all related to health inequalities.[13]

Research also demonstrates that a number of factors, ranging from individual (e.g. genes, personality) through to macro-social factors (e.g. unemployment rates) are involved in the development of suicidal behaviours. Most often it is an accumulation of these risk factors that leads to suicidal behaviour among at-risk population groups.[14]

As well as directly contributing to suicidal behaviours, risk factors can contribute indirectly by influencing an individual's susceptibility to mental health problems. Indeed mental health disorders are a factor in up to 70% of suicides and suicide attempts.[15]

The impact of exposure to risk factors, and the extent to which these actually contribute to suicidal behaviour, is influenced by contextual factors such as cultural issues, the media climate and the availability of suicide methods in the environment.[16]

The existence of multiple factors contributing to suicide means that a coordinated and multisectoral approach to suicide prevention is essential.

2.1 Suicide - Official Statistics

This section presents statistical data supplied by the New Zealand Health Information Service. Suicide rates in Taranaki are compared with those of other DHBs and trends in the Taranaki data over time are also explored. To identify those population groups at greatest risk, national data as well as regional data is used. This is because the relatively small numbers of suicides at a regional level make generalizations about risk difficult. For example, where less than 5 suicide deaths have occurred in a particular population subgroup, the calculation of a robust suicide rate cannot be made and a zero figure is given. This does not necessarily mean no suicides occurred in that population group.

---

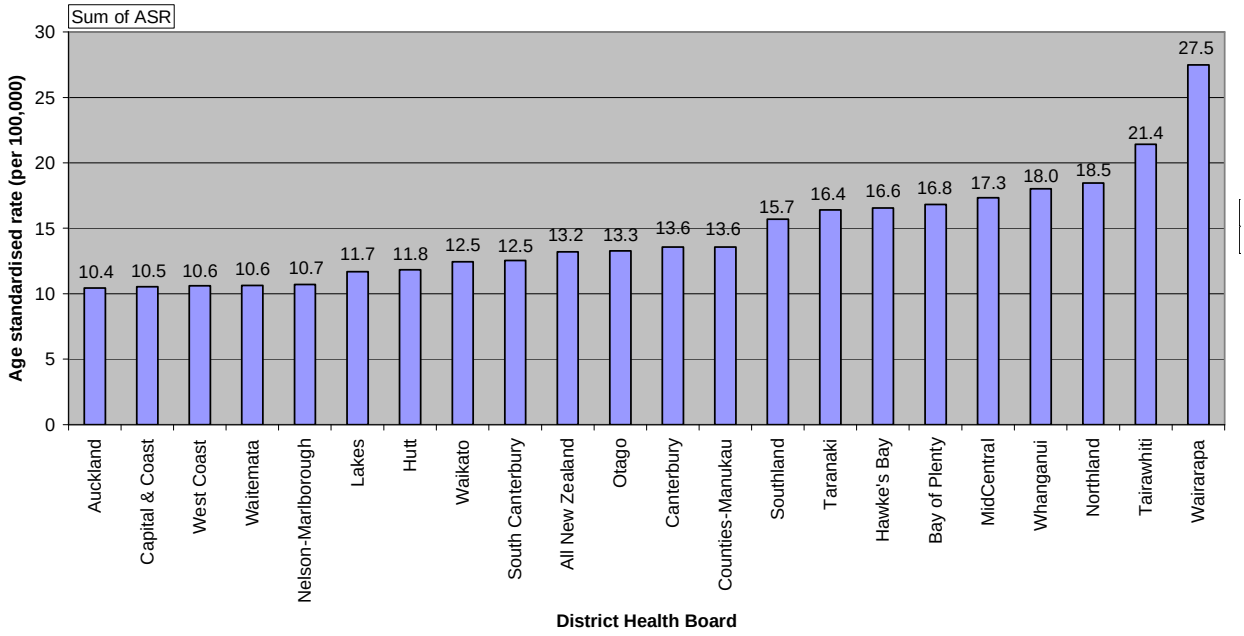
[12] Beautrais AL, Collings SC, Ehrhardt P, et al. 2005. *Suicide Prevention: A review of evidence of risk and protective factors, and points of effective intervention*. Wellington: Ministry of Health
[13] Ministry of Health. 2002. *Reducing Inequalities in Health.* Wellington: Ministry of Health
[14] Ministry of Health. 2008. *New Zealand Suicide Prevention Action Plan 2008-12: The Evidence for Action.* Wellington: Ministry of Health
[15] Beautrais AL, Collings SC, Ehrhardt P, et al. 2005. *Suicide Prevention: A review of evidence of risk and protective factors, and points of effective intervention*. Wellington: Ministry of Health
[16] Ministry of Health. 2008. *New Zealand Suicide Prevention Action Plan 2008-12: The Evidence for Action.* Wellington: Ministry of Health

Identification of those population groups at greater risk of suicide is explored more fully in the stakeholder consultation findings. As well as identifying at-risk populations in Taranaki that are concealed in the quantitative data (e.g. occupation groups) the consultation provides some insight into why certain population groups in Taranaki are considered to be at greater risk of suicide.

2.1.1 National Comparisons of Suicide Data

Figure 1 (below) shows suicide deaths in 2003–2005. These were summed across three years to provide sufficient numbers to calculate robust rates and protect confidentiality. The highest rate of suicide in 2003–2005 was recorded in Wairarapa DHB (27.5 suicides per 100,000 population) and the lowest rate was recorded in Auckland DHB (10.4 suicides per 100,000). The Taranaki rate sits slightly above the national average of 13.2 per 100,000 at 16.4 per 100,000.

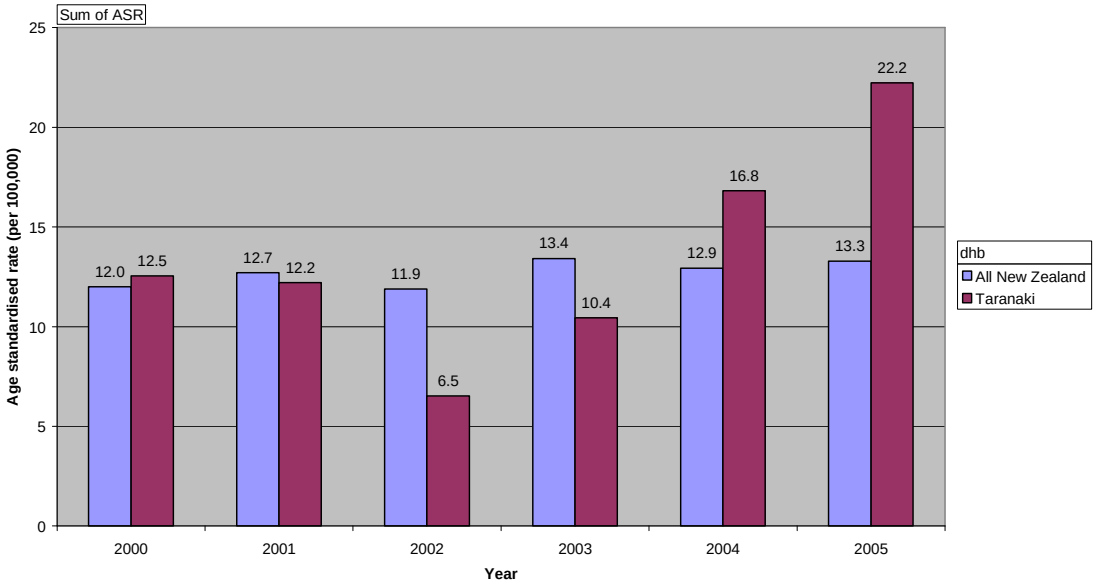
Figure 1: Suicide death rates by District Health Board (2003-2005)



2.1.2 Taranaki Suicide Data – Trends over time

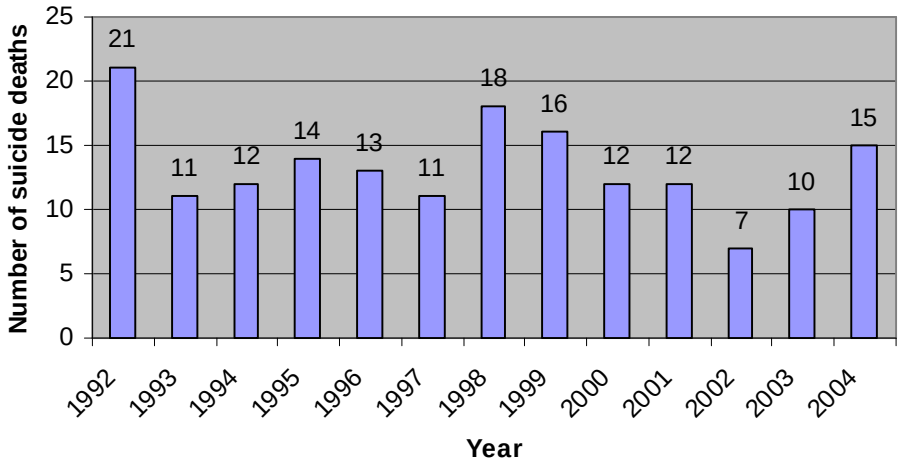
Figures 2 (below) shows changes in the suicide death rate over a 6-year period for Taranaki compared with the national average. The suicide death rate for Taranaki increased from 6.5 per 100,000 in 2002 to 22.2 per 100,000 in 2005. During the same period the national average rate of suicide deaths remained relatively stable, between 11.9 and 13.4 per 100,000. However, it should be noted that the *actual* number of deaths by suicide each year in Taranaki are relatively low and small changes in numbers of deaths from one year to the next have a marked effect on the suicide rate.

Figure 2: Suicide death rates per year – Taranaki and New Zealand (2000-2005)



This effect on rates is highlighted by looking at *actual* numbers of suicide deaths (Figure 3). These figures are broken down by Territorial Local Authority (TLA) from 1992 – 2004. Apart from 1992, 1996 and 2000 the number of suicides in New Plymouth District was below 10 per year. In South Taranaki District the number has not exceeded 9 per year and in Stratford the number has not exceeded 3. (Actual figures for 2005 were not supplied).

Figure 3: Total Suicide Deaths in Taranaki (1992-2004)

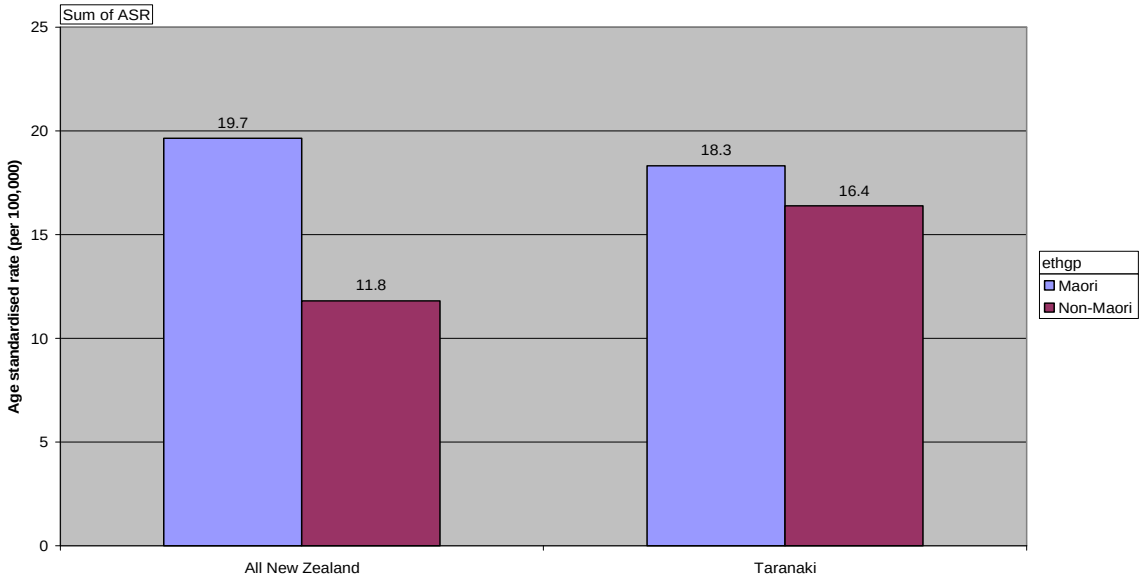


2.1.3 Taranaki Suicide Data – Population groups at greatest risk

Ethnicity and Suicide

The national three-year moving average age-standardised rate of suicide for Maori was 19.6 deaths per 100,000 in 2003-2005. In Taranaki the rate was slightly below average at 18.3 per 100,000 (Figure 4). As the chart below shows, the rate of suicide for non-Maori was significantly above national average in 2003-2005 (16.4 per 100,000 in Taranaki compared to 11.8 per 100,000 nationally).

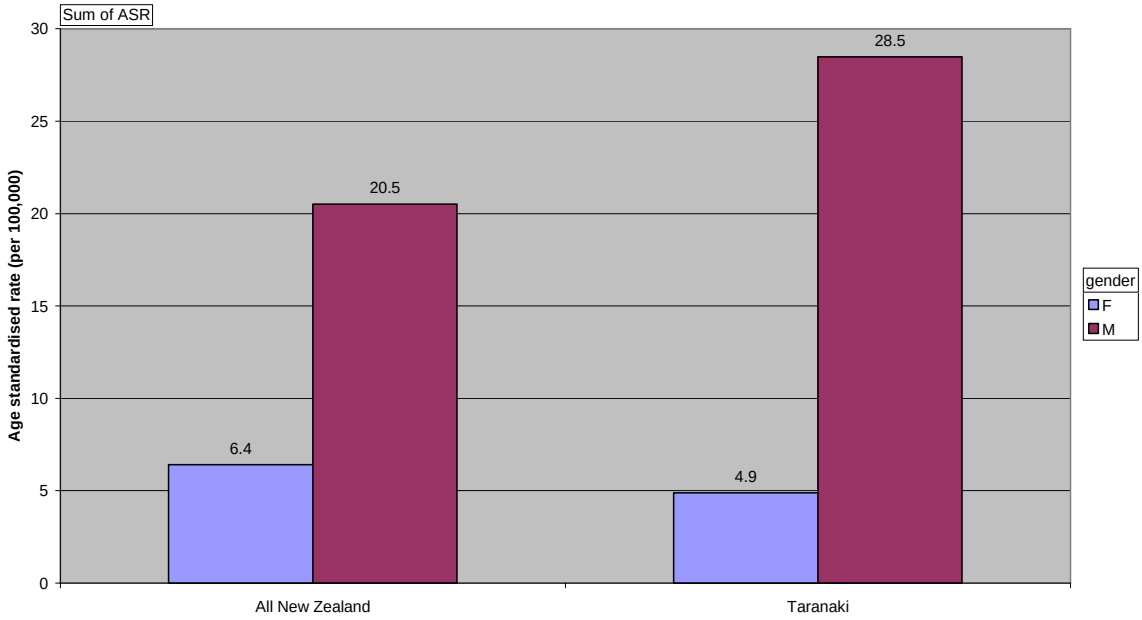
Figure 4: Suicide Death Rates by Ethnicity – Taranaki and New Zealand (2003-2005)



Gender and Suicide

The national three-year moving average age-standardised rate of suicide for males was 20.5 per 100,000 population in 2003-2005 compared to 6.4 per 100,000 for females. In Taranaki this difference was more marked with a significantly higher than average male suicide rate (28.5 per 100,000) and slightly lower than average female rate (4.9 per 100,000). (Figure 5).

Figure 5: Suicide Death Rates by Gender – Taranaki and New Zealand (2003-2005)



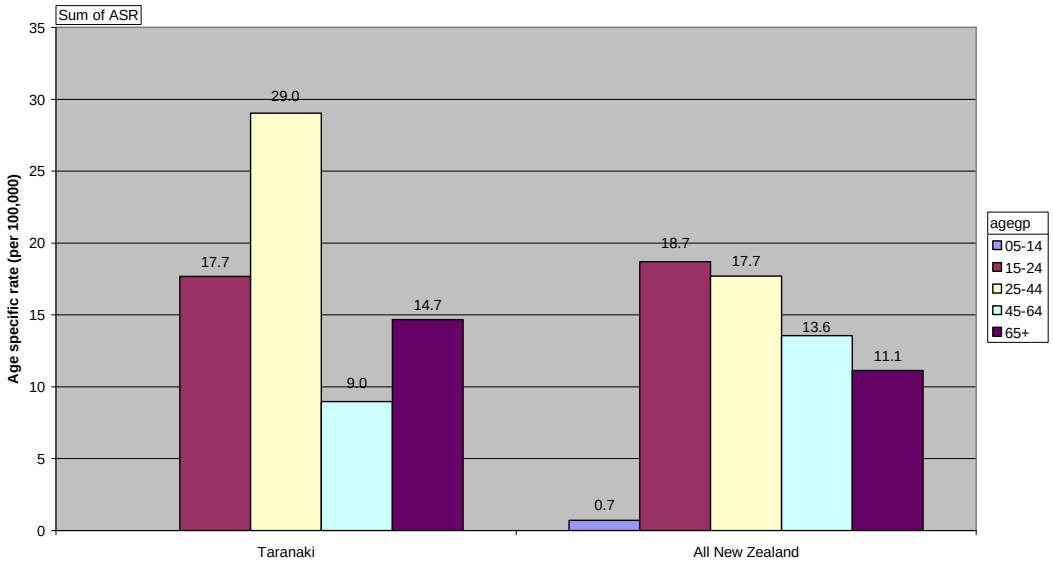
Life-Cycle Stage and Suicide

National data shows that the suicide rate for those in the life cycle stage of 15-24 years has declined by 33.5% since the peak in 1995-1997. Meanwhile the rate for the life-cycle stage of 45-64 years has increased from 11.9 per 100,000 population in 200-2002 to 13.7 per 100,000 population in 2003-2005[17].

In Taranaki the suicide death rate by life-cycle stage differs somewhat from the national average figures. The suicide rate for the 15-24 year and 45-64 year age groups are below the national average figure while the rates for 25-44 years and 65+ are significantly above the national average. For example, in 2003-2005 in Taranaki the suicide rate for the 25-44 year ago group was 29.0 per 100,000 compared to 17.7 per 100,000 nationally (Figure 6).

[17] Ministry of Health. 2007. *Suicide Facts: 2005-2006 data.* Wellington: Ministry of Health

Figure 6: Suicide Death Rates and Life-Cycle Stage – Taranaki and New Zealand (2003-2005)

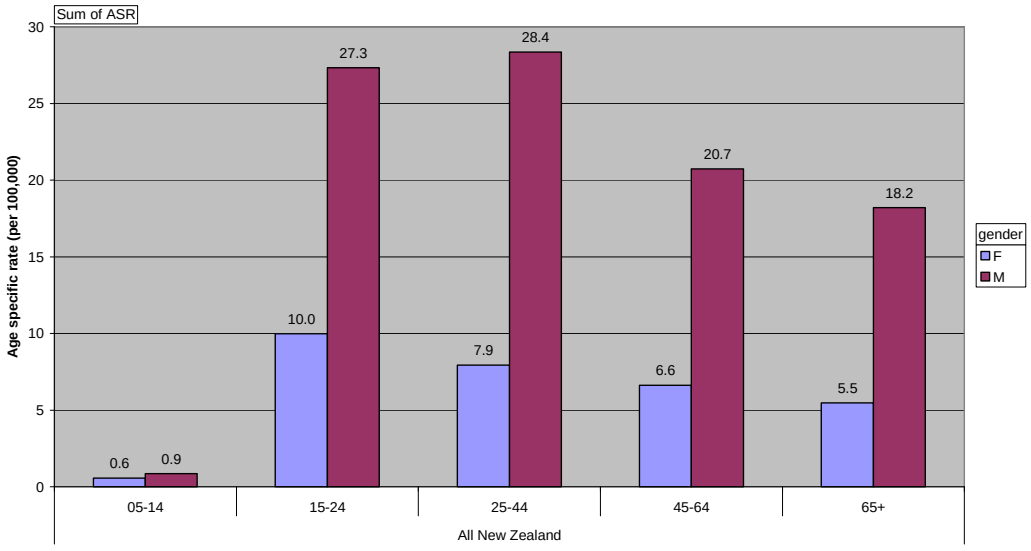


However, as has already been noted, the relatively small numbers of suicide deaths in Taranaki mean that caution should be exercised when interpreting such data. This is particularly the case when looking at regional figures that are broken down by life-cycle stage where the numbers of suicide deaths within in each age group are even smaller.

As national figures are based on *all* suicide deaths in New Zealand (around 500 deaths per year) the calculated age specific rates can be considered more robust. Figure 7 and 8 (below) uses national data to show differences in age specific suicide rates according to gender and ethnicity.

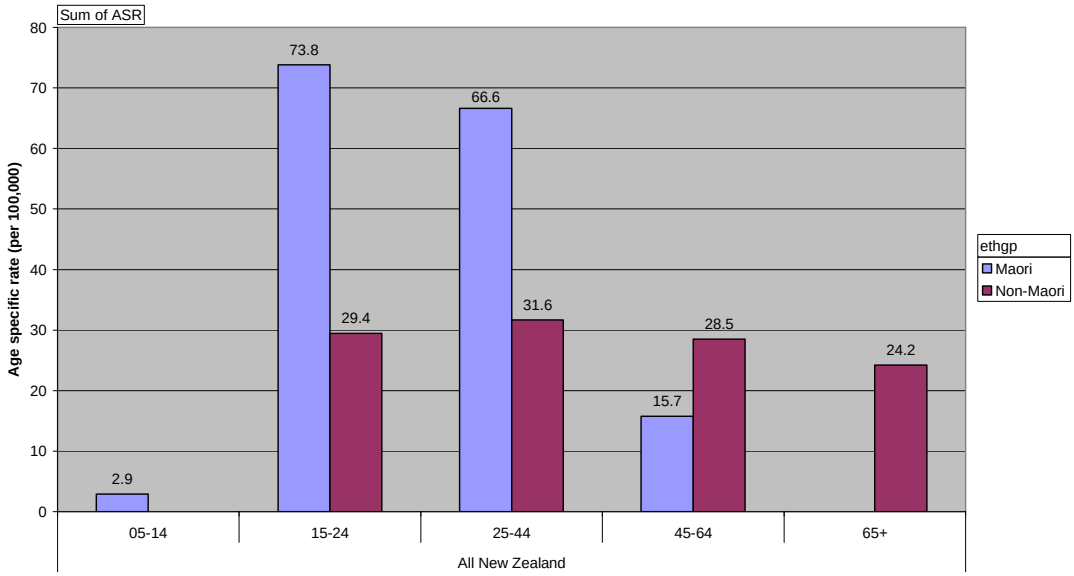
Life-Cycle Stage and Gender

Figure 7: Suicide Death rate and Life-Cycle Stage by Gender – New Zealand (2003-2005)



Life-Cycle Stage and Ethnicity

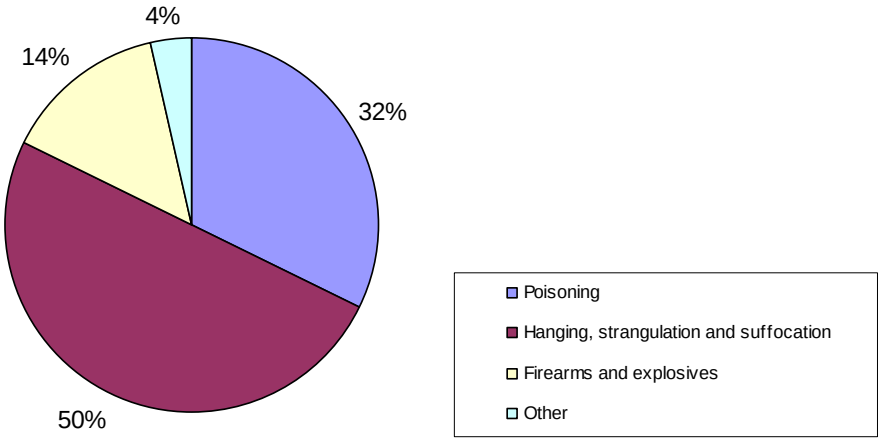
Figure 8: Suicide Death Rate and Life-Cycle Stage by Ethnicity – New Zealand (2003-2005)



2.1.4 Taranaki Suicide Data – Causes of death for suicide

Figures for causes of death for suicides in Taranaki for the five year period 2000-2004 show that the main cause of death for suicide was hanging, strangulation or suffocation (50%) followed by poisoning (32%) and firearms (14%). 4% of suicide deaths were caused by 'other' methods (including cutting or piercing instruments, jumping from a high place and other unspecified means). (Figure 9).

Figure 9: Causes of death for suicide in Taranaki (2000-2004)



2.2 Suicide - Findings of Stakeholder Consultation

2.2.1 Population groups at greatest risk

A number of population groups in Taranaki were repeatedly identified during the consultation as being at higher risk of suicide:

- Young males (particularly Maori)
- Middle aged or older males (non-Maori)
- Farmers
- Mental health service users and/or those suffering with depression

2.2.2 Reasons for suicide

These population groups were identified as being at greater risk of suicide for a number of reasons:

Young males (particularly Maori):

Reasons cited for this group being at greater risk of suicide included a lack of support systems, difficulty articulating feelings, poor coping skills, poverty, family/relationship problems and cultural identity issues (for Maori). Many respondents commented that although young women also faced some of these issues, they were more likely to have a support system with others who they could talk to about their problems. Women were also seen as being more likely to access help whereas issues of pride, particularly among Maori males, prevented them seeking help. This age group, both Maori and non-Maori, was also described as having a more reckless attitude towards life that put them at higher risk. As one respondent stated:

> *"They're reckless, don't care. They don't think to the future".*

Middle-aged and Older males (non-Maori):

Risk factors for this group included loneliness, isolation, relationship breakdown and difficulties associated with unemployment or retirement (e.g. feeling a failure). Those living alone, following divorce or death of a spouse, and without friends or a social support network were seen as being at particular risk. This group was described typically as 'staunch' and unlikely to seek help or talk about how they feel. Several respondents commented that when such individuals decided to end their lives they were "very serious" and were likely to choose methods that had a high chance of being fatal.

Farmers:

This group were seen as being at risk of isolation due to their rural location and the nature of their work. The independence and self-reliance of farmers was seen as a key reason for not seeking help if they faced difficulties, particularly among those living alone.

Farmers were seen as facing additional risks related to the impacts of environmental issues, particularly the weather, and financial problems that arose as a result. The relatively high levels of debt that are part of the farming business often compound these financial difficulties. The stressful nature of farming, in terms of long hours and hard physical work over many months of the year, was seen as responsible for potential seasonal variations in the suicide rate among this group. The long and unsocial hours associated with farming were also seen as reasons for farmers not accessing help through their GP or another support service. A number of respondents also commented on the suicide of three males employed in the agricultural support sector in South Taranaki. The stress of shift work, end-of-season exhaustion and seasonal variation in employment were suggested as possible issues that put this occupational group at greater risk.

Rural Women (South Taranaki) recently raised concerns relating to suicide in the farming community with Taranaki Federated Farmers and a remit on the issue was put forward at their AGM. This was taken to the Federated Farmers national conference in July 2008 and an agreement was made to formally support Rural Women NZ who are calling for improved follow up care for people in rural communities who have been diagnosed with stress and depression.

Research into work-related suicide has suggested higher rates of suicide among certain occupations, including farming, although findings among studies are not consistent. One New Zealand based study, looking at suicide deaths between 1991 and 1996, found that higher rates of suicide were found among trades workers and agriculture and fishery workers.[18] Researchers have suggested that certain occupations, such as farming, are characterised by a number of potential triggers for depression (e.g. work strain) and access to carry out the suicidal act (e.g. access to firearms).

Mental health consumers:

Users of the mental health system were seen as being at greater risk of suicide as a result of their mental health disorders, particularly those diagnosed with severe mental illness such as schizophrenia and bipolar disorder. Some respondents commented that some mental health consumers attempt suicide in a desperate attempt to get the help they need from mental health services. Those with untreated depression (who may or may not be mental health consumers) were also identified as being at high risk of suicide. As already noted, 70% of suicides and suicide attempts are carried out by people with a pre-existing mental health disorder.

[18] Langley J, Stephenson S. 2001. *Suicide and Occupation in New Zealand*. Journal of Occupational Health and Safety – Australia and New Zealand, 7: 363-370

Chapter 3: Self-Harm in Taranaki

3.0 Self-Harm – An overview of the evidence

The Royal Australian and New Zealand College of Psychiatrists define intentional self-harm as a behaviour, not an illness. They state that self-harm can include self-poisoning and overdoses, minor injury as well as potentially dangerous and life threatening forms of injury but does not include body piercing, unusual sex or the recreational use of drugs and alcohol[19]. People self-harm to cope with distress or to communicate that they are distressed. It is a serious problem as it can lead to disability or death and is reflective of the serious emotional distress being experienced by the individual at the time of the injury.

Recorded rates of hospitalisation for intentional injury in New Zealand show that females, Maori (as opposed to non-Maori), those in the life-cycle stage of 15-24 years and those residing in the most deprived areas (quintile 5) have the highest self-harm hospitalisation rates[20]. Self-harm is most common among younger people, accounting for approximately 10% of hospitalisations of young people aged 15-19 in New Zealand. The majority (92%) of these hospitalisations are for self-poisoning. Research also shows that women more commonly take overdoses than men. These factors combined make self-poisoning through overdose the most common form of self-harm in New Zealand.[21] These population subgroup trends are further compounded by the influence of socio-economic factors with increased self-harm hospitalisation rates found in areas of higher deprivation[22].

Although not all individuals are suicidal when they self-harm, an awareness of self-harm and its links with suicide is an important aspect of suicide prevention. New Zealand based research has shown that significantly increased age- and sex- adjusted relative risks for suicide are associated with previous hospitalisation for self-injury, injuries of undetermined causes and assault. Research findings also indicate that identifiable subgroups of individuals hospitalised for injuries are at marked risk of serious suicidal behaviour, suggesting the potential of targeted suicide prevention for these individuals.[23]

3.1 Self-Harm - Official Statistics

The data presented in this section mainly utilises self-harm hospitalisation data for 2006 sourced from the New Zealand Health Information Service (NZHIS). The data allows comparison between Taranaki District Health Board (DHB) and other DHBs across New Zealand. The data also highlights those subgroups of the population most likely to be hospitalised for self-harm. Self-harm hospitalisation data for the period 2000-2006 allows trends over time to be shown.

---

[19] The Royal Australian and New Zealand College of Psychiatrists. 2005. *Self-harm: New Zealand Treatment Guide for Consumers and Carers*. RANZCP, Wellington: New Zealand

[20] Ministry of Health. 2007. *Suicide Facts: 2005-2006 data.* Wellington: Ministry of Health

[21] The Royal Australian and New Zealand College of Psychiatrists. 2005. *Self-harm: New Zealand Treatment Guide for Consumers and Carers*. RANZCP, Wellington: New Zealand

[22] Ministry of Health. 2007. *Suicide Facts: 2005-2006 data.* Wellington: Ministry of Health

[23] Connor KR, Langley J, Tomaszewski K & Conwell Y. 2003. *Injury Hospitalisation and Risks for Subsequent Self-Injury and Suicide: A National Study from New Zealand*, American Journal of Public Health, 93:1128-1131

A degree of caution should be exercised when interpreting the statistical data in this chapter. As already noted, hospitalisations for self-harm represent unique 'events' of self-harm as opposed to numbers of 'people'. Thus, a single person may contribute numerous self-harm events. Meanwhile, recording systems within individual DHBs can affect the way self-harm is recorded, and indeed whether certain cases of self-harm are recorded at all. These differences mean that direct comparison between DHBs is unreliable.

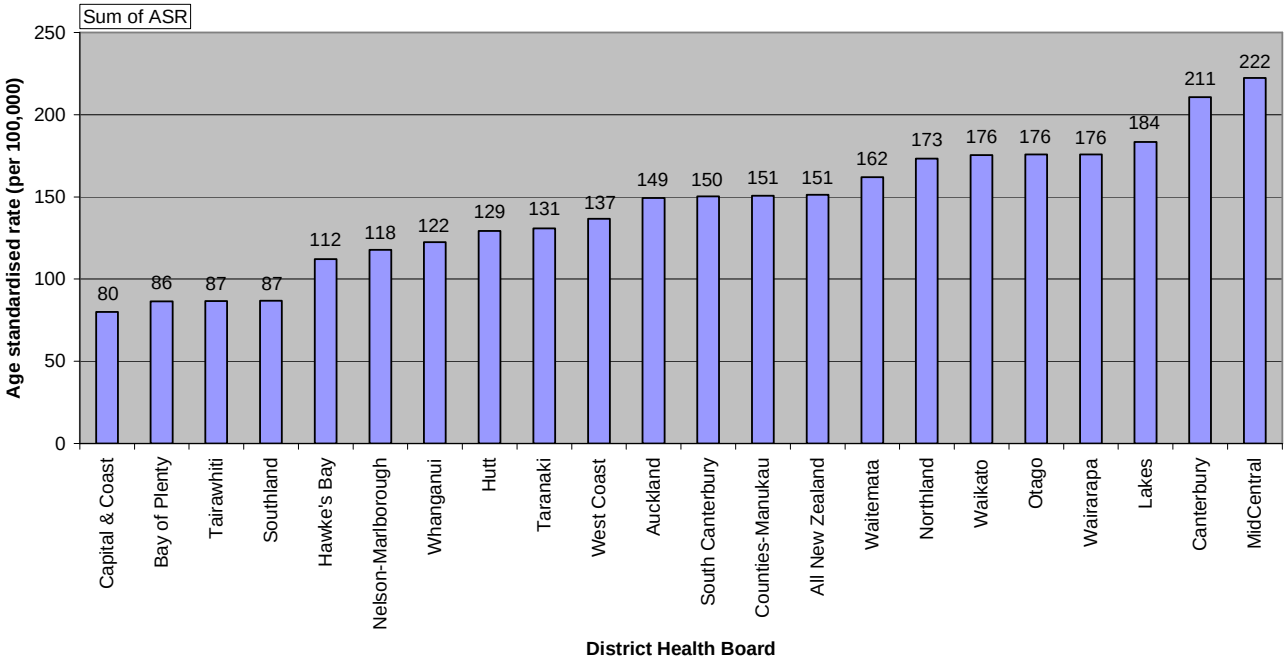
Similarly, the hospitalisation data focuses only on those events of self-harm that were serious enough to warrant hospitalisation. Therefore, it is possible that the data reflects a greater tendency of certain population subgroups to carry out serious self-harm that requires hospital treatment. It is possible that a greater rate of self-harm exists among other groups but it is less severe and/or some individuals choose not to seek hospital treatment.

Thus the use of data sources other than routinely collected hospital data can be of value in capturing the extent of the problem among those individuals and groups who do not seek hospital treatment but who may well use other health or support services. Similarly alternative sources of data can also give some insight into why self-harm is more evident among certain population groups. The findings of the stakeholder consultation go some way to addressing these issues by highlighting the extent of self-harm among certain groups in the community.

3.1.1 National Comparisons of Intentional Self-Harm Hospitalisation Data

The hospitalisation rate for intentional self-harm in Taranaki in 2006 was 131 per 100,000 population. This figure sits slightly below the national average figure of 151 per 100,000. The highest rate in 2006 was Mid Central (222 per 100,000) and the lowest was Capital & Coast (80 per 100,000) (Figure 10).

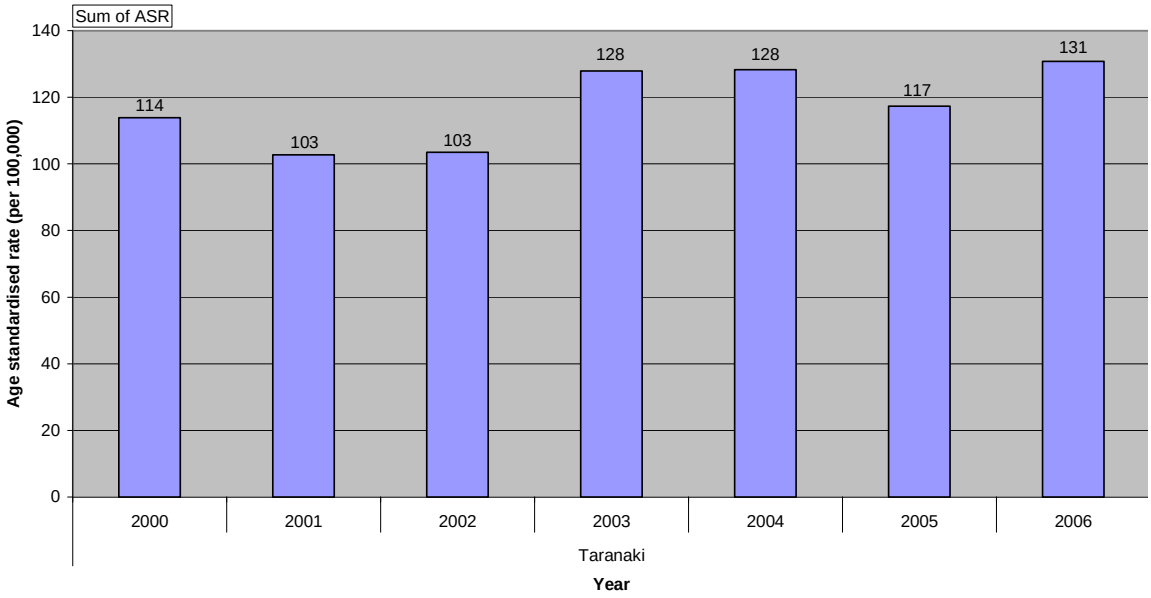
Figure 10: Intentional Self-Harm Hospitalisation Rates by District Health Board (2006)



3.1.2 Taranaki Self-Harm Hospitalisation Data – Trends over time

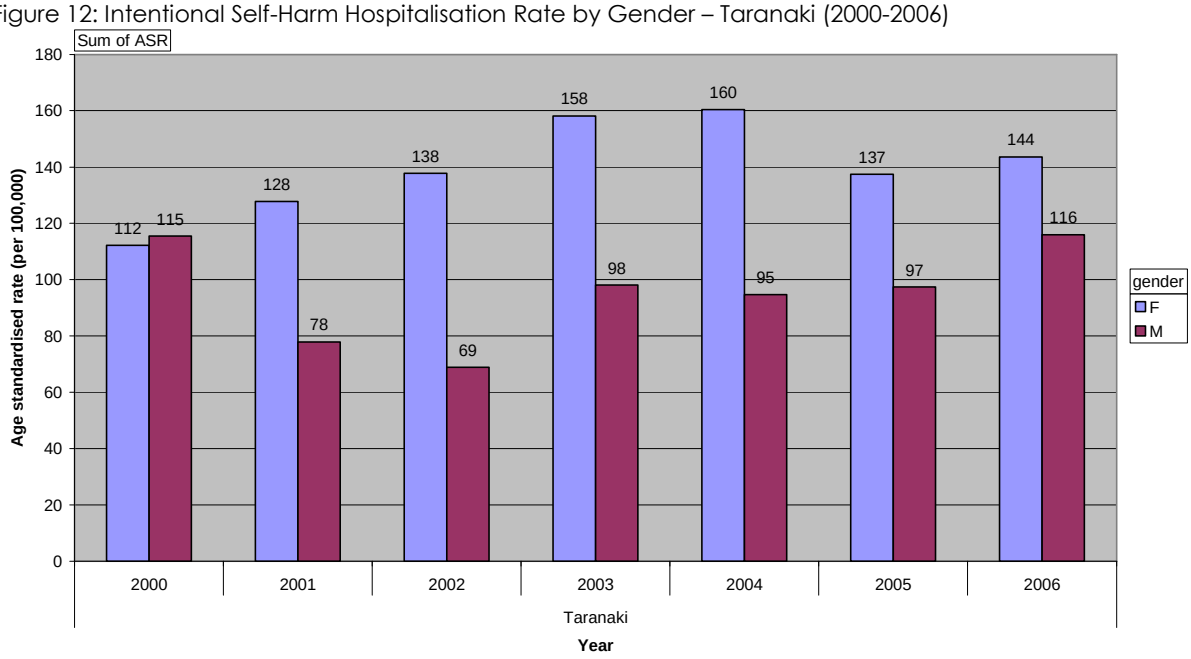
Since 2000 until 2006 the self-harm hospitalisation rate has remained fairly stable (Figure 11). The rate was at its lowest in 2001 and 2002 (103 per 100,000) and its highest in 2006 (131 per 100,000). However, the potential for changes in DHB recording and reporting processes over this time period means that such trend data may be unreliable.

Figure 11: Intentional Self-Harm Hospitalisation Rates – Taranaki (2000 – 2006)



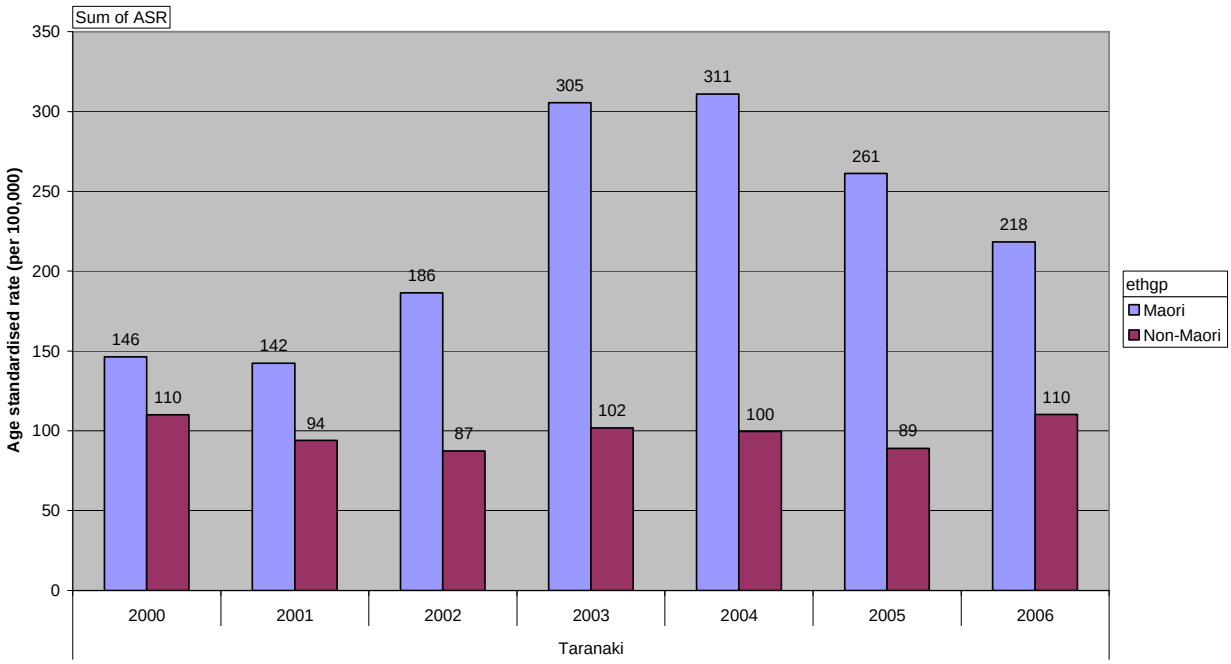
Apart from 2000 the intentional self-harm hospitalisation rate has been significantly higher for females than for males. The female rate peaked at 160 per 100,000 in 2004 while the male rate reached a peak in 2006 at 116 per 100,000. (Figure 12)

Figure 12: Intentional Self-Harm Hospitalisation Rate by Gender – Taranaki (2000-2006)



The intentional self-harm hospitalisation rate follows a similar trend for Maori with rates peaking in 2004 at 311 per 100,000 (compared to 100 per 100,000 for non-Maori in the same year). The rate for Maori fell to 218 per 100,000 in 2006 (around double the rate for non-Maori) (Figure 13).

Figure 13: Intentional Self-Harm Hospitalisation Rates by Ethnicity – Taranaki (2000 – 2006)



3.1.3 Population groups at greatest risk of self-harm

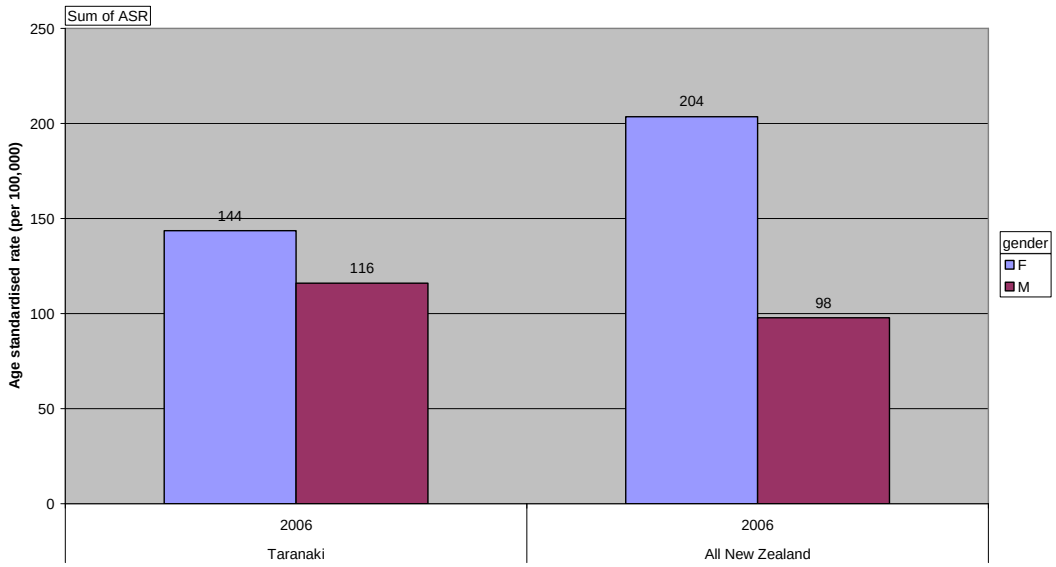
National data shows that the sub-groups of the New Zealand population with the highest intentional self-harm hospitalisation rates in 2006 were females, Maori (as opposed to non-Maori), those in the life-cycle stage of 15-24 years, and those residing in the most deprived areas (quintile 5)[24]. These findings are generally reflected in Taranaki although some interesting variations can be seen.

Gender and Self-Harm

While the intentional self-harm hospitalisation rate for males in Taranaki was similar to the national rate in 2006, the rate for females in Taranaki was significantly below the national average (144 per 100,000 in Taranaki compared to 204 per 100,000 nationally). Despite this, the self-harm hospitalisation rate for females was still higher than that for males in 2006. (Figure 14).

[24] Ministry of Health. 2007. *Suicide Facts: 2005-2006 data.* Wellington: Ministry of Health

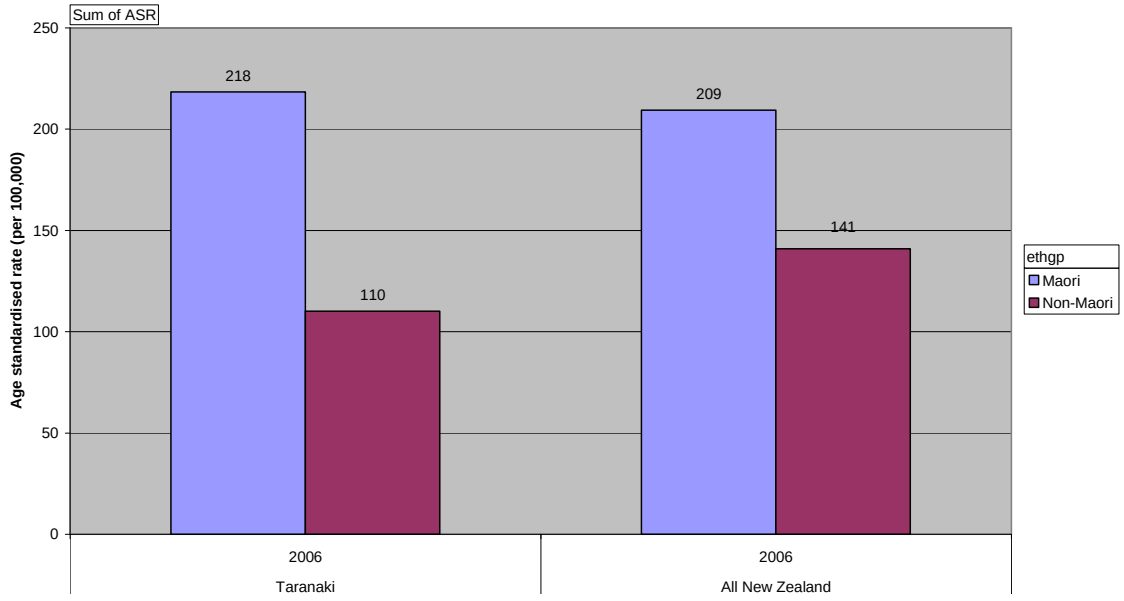
Figure 14: Intentional Self-harm Hospitalisation Rates by Gender – Taranaki and New Zealand (2006)



Ethnicity and Self-Harm

The rate of hospitalisation for self-harm for Maori in Taranaki reflects national rates (218 per 100,000 in Taranaki compared to 209 per 100,000 nationally). The rate of hospitalisation for self-harm for Maori in Taranaki is twice that for non-Maori. (Figure 15).

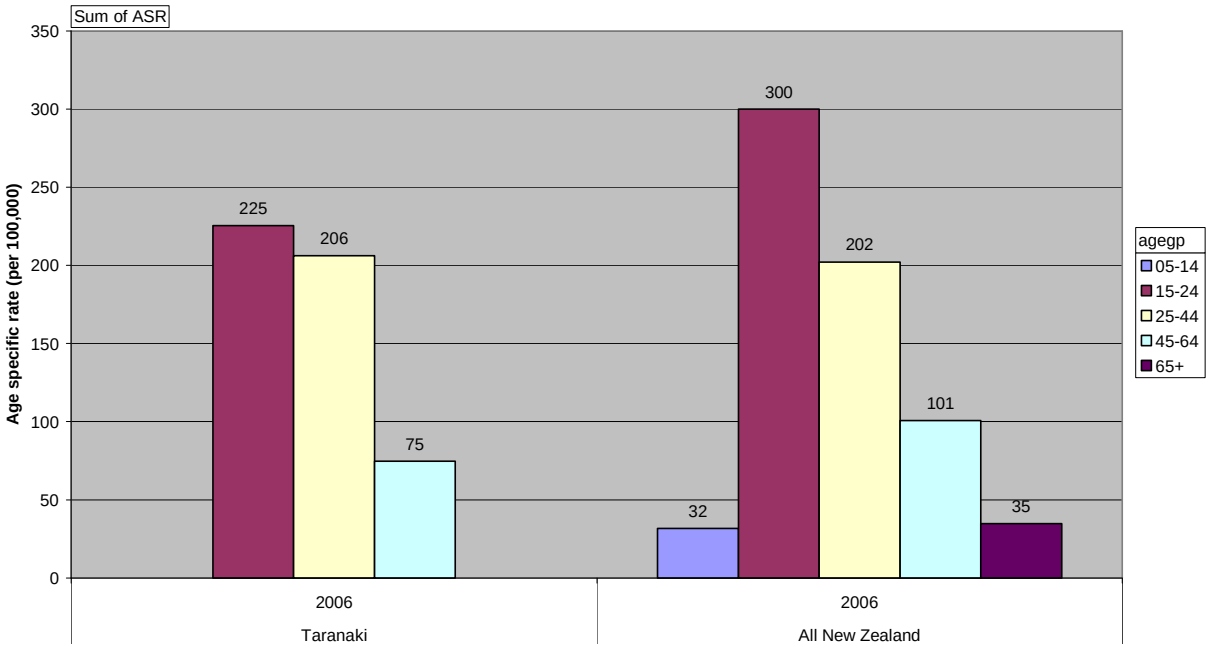
Figure 15: Intentional Self-Harm Hospitalisation Rates by Ethnicity –Taranaki and New Zealand (2006)



Life-cycle stage and Self-Harm

As with national data, the life-cycle stage with the highest rate of hospitalisation for self-harm in Taranaki is the 15-24 year age group. However, the hospitalisation rate for this group in Taranaki is lower than the national average and only slightly higher than the rate for 25-44 year olds. Rates for 0-14 years and 65+ years are recorded as zero because actual hospitalisation numbers in these age groups were too low for reliable age specific rates to be calculated (Figure 16).

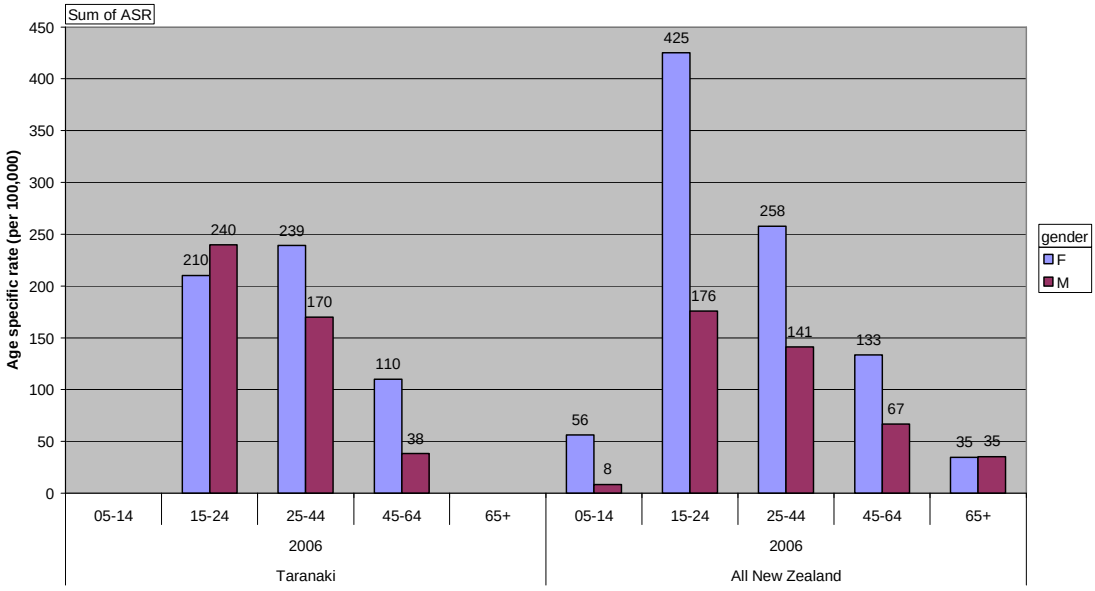
Figure 16: Intentional Self-Harm Hospitalisation Rates by Life-Cycle Stage – Taranaki and New Zealand 2006)



Life-Cycle Stage and Gender

As already noted in figure 5, the intentional self-harm hospitalisation rate for females in Taranaki in 2006 was significantly below the national rate. When the data is broken down by life-cycle stage it gives more insight into the variations between Taranaki and national average rates. Most noticeable is that the self-harm hospitalisation rate for females in the 15-24 year age group is slightly lower than that for males where as nationally it is more than double the male rate. In Taranaki the subgroup with the highest self-harm hospitalisation rate are females aged 25-44 years and males aged 15-24 years, in contrast to national data where females aged 15-24 years have rates well in excess of any other age group. (Figure 17).

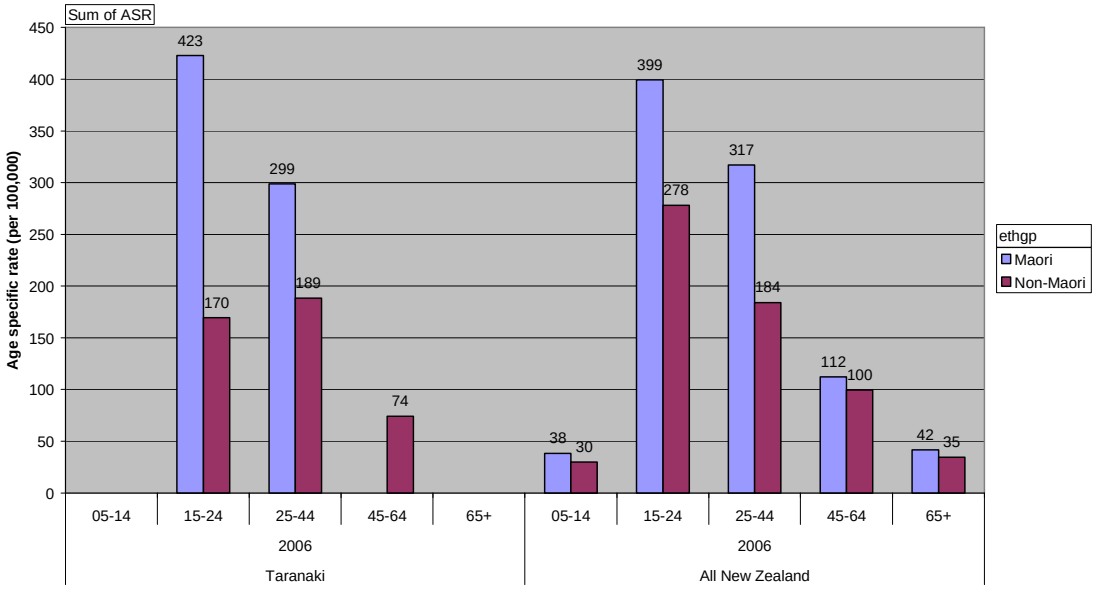
Figure 17: Intentional Self-Harm Hospitalisation Rates by Life-Cycle Stage and Gender – Taranaki and New Zealand (2006)



Life-Cycle Stage and Ethnicity

The intentional self-harm hospitalisation rates for Maori in Taranaki were similar to national average rates in 2006 for the 15-24 year and 25-44 year age group. For the age groups 5-14 years, 45-64 years and 65+ years a zero rate is given, as actual hospitalisation numbers were too low for a reliable age-specific rate to be calculated. (Figure 18).

Figure 18: Intentional Self-Harm Hospitalisation Rates by Life-Cycle Stage and Ethnicity – Taranaki and New Zealand (2006)



3.2 Self-Harm - Findings of Stakeholder Consultation

3.2.1 Definitions of Self-Harm:

What became apparent through the stakeholder consultation was that definitions of self-harm varied immensely. When asked about the extent of self-harm in the community it was very common for respondents to state: "It depends what you mean by self-harm". While some respondents focused on definitions that included self-injurious behaviour such as cutting and burning, others included eating disorders (anorexia, bulimia), alcohol and drug abuse, smoking and reckless sexual behaviour.

For the purposes of the Needs Assessment, respondents were informed of the definition of self-harm provided by the New Zealand Suicide Prevention Strategy[25]:

"Deliberate self-harm, which refers to behaviours that may or may not result in serious injury, but are not intentionally fatal" (Pg.3)

3.2.2 Extent of Self-Harm in the community

All respondents interviewed agreed that rates of actual self-harm exceeded recorded hospitalisation rates although the extent of this was not known. Many of the respondents had contact with clients or family/friends who self-harmed but did not seek medical treatment. Reasons given for not accessing treatment included the stigma and shame felt by self-harmers, lack of knowledge about what help is available and difficulty accessing treatment. It was also suggested that self-harm often resulted only in minor injury so medical treatment, particularly hospitalisation, would not be sought.

Some respondents were concerned that the rate of self-harm was actually increasing, particularly among young people at secondary school (especially girls). A key reason given for this was that self-harm was becoming less of a stigma and more socially acceptable among this age group. Some respondents working with young people of secondary school age suggested that self-harm had become part of a particular youth sub-culture (referred to by some as "Emo's") where self-harming had become one of the ways in which young people could identify with, or become accepted, by the group. The open self-harm behaviour carried out in a group situation was seen by some as less risky than 'hidden' self-harm carried out in private. As one respondent stated:

> *"It's not the ones who are self harming as part of a group that I'm worried about. I get more concerned about those who are self-harming in private".*

Some respondents believed self-harm was more prevalent among young women who were already 'at risk' and facing problems such as family violence and abusive relationships. Others felt that all girls were at risk of self-harm, particularly as a result of the widespread bullying made possible through communication technology (text, email, blogging, web-based chatrooms etc). Speaking about text bullying on respondent stated:

[25] Associate Minister of Health. 2006. *The New Zealand Suicide Prevention Strategy 2006-16.* Wellington, New Zealand

"Rumours and gossip can be vicious and it is instant, reaching more girls. The impact on girls' lives can be devastating".

Young people who took part in the consultation also felt that, for a number of reasons, self-harming was quite common among young people. Some of the young people stated that self-harm was becoming more open among young people. It was not clear from the youth focus groups whether self-harm rates among young people were actually rising or whether there was more awareness of the issue due to young people being more open about it. As one young person stated:

"I used to think I was the only one, but heaps of kids do it"

3.2.2 Population groups at greatest risk

The stakeholders identified two main population groups as being at greatest risk of intentional self-harm. These were young women aged 14-25 years and those across all age groups with existing mental health disorders, particularly borderline personality disorder.

The identification of young females as a high-risk group is supported by national self-harm hospitalisation data. As Figure 8 in Section 2.2.3 of this report shows, females aged 15-24 years are the subgroup of the New Zealand population with the highest intentional self-harm hospitalisation rate in 2006. This contrasts with self-harm hospitalisation data for Taranaki which shows women aged 25-44 years as having the highest hospitalisation rate for self-harm. This could reflect more serious self-harm among this age group within Taranaki although the potential for inaccuracies in the data and differences in DHB recording processes should also be considered.

3.2.4 Reasons for self-harm

The stakeholders identified two main reasons for self-harm. The first of these was typically described as "attention seeking" where the self-harm behaviour was carried out by the individual to signal for help, particularly from mental health services. Some respondents suggested that mental health consumers who carried out serious self-harm did so in a desperate attempt to get the help that they needed.

The other main reason given for self-harm was that it was used by some as a coping strategy for dealing with stress, particularly among those without family support and poor coping skills.

"For some it is a habitual ritual performed under stress, a coping strategy for stress. For some it's attention seeking, or a desperate cry for help. But they don't access services due to shame or they are already mental health clients so don't seek additional help".

Comments from young people focused mainly on self-harm as a coping strategy to deal with emotional pain or numbness:

"Feeling immediate pain to take away emotional stress and pain"

"People do it to feel 'something' "

Some young people commented that self-harm was more prevalent among young people who were experiencing 'problems' where as others thought all young people were at risk:

"People with problems are more susceptible to it"

"People who are quiet and bottle up emotions, and people who are excluded and don't fit in"

"It happens among every aspect of the community. There are many that show off but others keep it quiet. Boys don't tend to talk about it. There are groups of people – social circles – that support self-harm"

Chapter 4: Suicide Prevention in Taranaki

4.1 Data Sources

This chapter presents three main sources of information:

- An overview of New Zealand **research evidence** relating to effectiveness of suicide prevention interventions and the specific needs of different population groups
- Main findings from the **stakeholder consultation** relating to existing suicide prevention services and activities in Taranaki
- Main findings from the **stakeholder consultation** relating to identified gaps in service provision, unmet needs of particular population groups and opportunities for future service development

Research Evidence:

The research evidence presented in the Section 4.2 includes current evidence of *effective suicide prevention initiatives* as well as evidence related to *meeting the needs of different population groups*. The overview of effective suicide prevention initiatives uses a recent review carried out by Beautrais, Fergusson & Coggan (2007)[26] as the framework and largely utilizes the research evidence from this review. The overview of evidence relating to the needs of specific population groups uses the framework and summary of evidence provided by *The New Zealand Suicide Prevention Action Plan (2008-12): The Evidence for Action*.

Findings of Stakeholder Consultation:

The main findings of the stakeholder consultation presented in Section 4.3 and 4.4 were based on questions the stakeholders were asked about existing suicide prevention activities as well as service gaps and opportunities for future service development in Taranaki (see Appendix 1 for the Stakeholder Questionnaire). The questions were framed around the seven goals of the New Zealand Suicide Prevention Strategy 2006-16:

- **Promote mental health and wellbeing, and prevention of mental health problems**
- **Improve the care of people who are experiencing mental disorders associated with suicidal behaviour**
- **Improve the care of people who make non-fatal suicide attempts**
- **Reduce access to means of suicide**
- **Promote safe reporting and portrayal of suicidal behaviour by the media**
- **Support families, whanau, friends and others affected by a suicide or suicide attempt**
- **Expand the evidence about rates, causes and effective interventions**

[26] Beautrais AL, Fergusson D, Coggan C et al., 2007. Effective strategies for suicide prevention in New Zealand: a review of the evidence. The New Zealand Medical Journal, 120:1251 http://www.nzma.org.nz/journal/120-1251/2459/

4.2 Suicide Prevention in Taranaki – The Evidence Base

4.2.1 Overview

Consideration of existing research evidence is important as it enables us to identify whether existing suicide prevention initiatives in Taranaki are likely to be effective and appropriate. Evidence in this area can also be used to inform future planning of suicide prevention activities to ensure that limited resources in this area are targeted most effectively to the groups that need them most.

The evidence that is summarised in this section focuses on effective (as well as less effective) suicide prevention interventions as well as the specific needs of different population groups at risk of self-harm and suicide.

Some examples of effective evidence-based interventions that are currently taking place in Taranaki were highlighted during the stakeholder consultation. These are presented alongside the evidence as local examples of good practice. Relevant information from the stakeholder consultation that could be used to inform the future development of evidence-based suicide prevention interventions in Taranaki is also presented throughout this section.

It should be noted that greater detail about the local examples of good practice referred to in this section is provided in Section 4.3 (Suicide Prevention in Taranaki – Existing Service Provision) which presents the main findings of the stakeholder consultation. Chapter 6 goes on to map some of these existing initiatives, along with a number of proposed future evidence-based actions, against the New Zealand Suicide Prevention Action Plan (2008-12).

Evidence of effective interventions

A recent study carried out by Beautrais, Fergusson, Coggan et al. (2007)[27] reviewed effective strategies for suicide prevention in New Zealand and classified these based on the following hierarchy of evidence:

- *Initiatives for which strong evidence of effectiveness exists* (Initiatives have been evaluated using a randomized trial design and there is consistent evidence of programme efficacy)
- *Initiatives that appear promising* (Some evidence of effectiveness exists but it is not sufficient enough or consistent enough to classify findings as strong)
- *Initiatives for which no evidence of effectiveness exists but which may be beneficial in suicide prevention* (Initiatives that are believed to be beneficial in suicide prevention by providing a context for encouraging positive health and wellbeing, but for which no direct evidence of suicide-specific programme effectiveness exists)
- *Initiatives for which evidence of harmful effects exist* (Concerns have been raised regarding their safety and there is reason to believe they may risk increasing rates of suicidal behaviour)

[27] Beautrais AL, Fergusson D, Coggan C et al., 2007. Effective strategies for suicide prevention in New Zealand: a review of the evidence. The New Zealand Medical Journal, 120:1251 http://www.nzma.org.nz/journal/120-1251/2459/

Evidence related to meeting the needs of different population groups

Evidence relating to effective interventions is further enhanced by considering research evidence that highlights the needs of particular population groups, how these needs are best met and what can be done to strengthen protective factors among different groups. *The New Zealand Suicide Prevention Action Plan (2008-12): The Evidence for Action* provides a useful summary of the evidence relating to the needs of different population groups. It is important that the needs of different population groups are considered alongside evidence of effective interventions to ensure that the benefits of different interventions are accessed equitably. Differences in access to certain services can reinforce inequalities and mean that benefits in terms of suicide rates are not realised among all groups. For example, evidence-based suicide prevention initiatives in primary care will have a limited impact on those groups who already have low access to primary care services (e.g. Maori, young people).

4.2.2 Initiatives for which strong evidence of effectiveness exists

Training for medical practitioners

Evidence has shown that providing medical practitioners in primary care with training to enable them to better recognize and treat depression has been shown to result in improved treatment of patients with depression and lower suicide rates. Quality improvement initiatives, collaborative care programmes and nurse case management programmes in primary care settings have also been shown to improve the identification and management of depression.

Although those GPs interviewed felt that they had a good awareness of depression and knew what to look for, it is possible that GPs and other primary care professionals (e.g. practice nurses) could benefit from training in this area. When asked about training, some GPs felt that it was either unnecessary or that introduction of a training programme would be challenging as GPs were subject to many other requests to participate in training and development. One GP pointed out that quality improvement work on depression had already taken place through their GP peer group and that GPs generally were generally very aware of depression. One GP pointed out that it was not the lack of training that was a problem, but rather the short time available in a practice setting to make a reliable diagnosis of depression.

Restriction of suicide methods

Evidence from New Zealand, and other countries, suggests that reducing access to means of suicide can reduce the rate of suicide by that method. These findings are based on the outcomes of various initiatives including reducing access to domestic gas; firearms control; reducing carbon monoxide emissions from vehicles; restricting availability of pesticides and analgesics; installing barriers at sites that have become popular for suicide and restrictions on prescribing drugs which are toxic in overdose.

Local examples of initiatives that have are taking place to reduce access to means of suicide include an information sharing agreement between Taranaki DHB Mental Health Services and the Police to identify whether clients at risk of suicide own firearms and to have them removed if necessary. Another example is the use of close control prescribing

to limit the quantity of medication that can be collected by clients who are considered to be at risk of suicide.

Gatekeeper education

Evidence exists to support programmes which focus on enhancing the skills of community, organisational, and institutional gatekeepers (e.g. clergy, those who work in schools, prisons, welfare centres, etc.). Successful programmes have focused on training community gatekeepers to identify mental health problems and encourage early mental health intervention and promote help seeking. Such programmes also focus on increasing protective factors such as social connectedness and improving coping skills.

An example of a similar initiative in the Taranaki area is the delivery of the Living Works ASIST (Applied Suicide Intervention Skills Training) organized by the Bishops Action Foundation. This programme sets out to equip community gatekeepers with the skills needed to identify when someone is at risk of suicide, and to support that person to access appropriate help. A number of community-based service providers, particularly those who did not deliver mental health care as their core business, felt that training in suicide prevention would be useful. Those who attended the ASIST training found it very useful in supporting their day-to-day work. A common concern raised about the ASIST programme was that the cost (even when heavily subsidized locally) remained a barrier to some people (especially volunteers and community members who had to pay for the course themselves) and that there was a need for more follow and support for those who had attended the training.

4.2.3 Initiatives that appear promising

Providing support after suicide attempts

A small number of interventions that focus on enhancing treatment and support for people who have made previous suicide attempts have been shown to reduce risk of repeated suicidal behaviour. These interventions focus on providing relatively simple interventions as part of the follow-up care to people discharged from hospital following a suicide attempt. Examples include sending letters to people after discharge, employing counsellors to coordinate follow up services and giving patients a 'green card' to allow swift emergency access to mental health services.

One example of a local project providing support after suicide attempt is the Taranaki DHB Whakawhanaungatanga Self-Harm Collaborative project which has a couple of targets relating to follow up of patients discharged after self-harm/suicide attempt. One of these targets is for patients, their whanau/significant others and relevant care services to be provided with a written copy of a follow-up care plan. The other target is for 90% of people presenting to services following self-harm/suicide attempt to be provided with a follow-up appointment at an appropriate continuing-care service within 48 hours and to be contacted if they do not attend. Taranaki DHB faced a number of challenges in meeting this target during the pilot project. Although the target was not met the number of patients issued with a care plan and provided with follow-up appointments did increase. The Whakawhanaungatanga Self-Harm & Suicide Prevention Collaborative project phase II is about to start, this will build on progress made from phase I and will look at a number of strategies for addressing the targets.

Pharmacotherapy for mental illness

Mental illness being highly prevalent among those who die by suicide and research shows that treating mental illness effectively and providing long term mental health care and support are major approaches to preventing suicide. Some treatments for specific mental illnesses have been shown to reduce suicidal behaviour, namely long-term therapy with lithium for people with bipolar disorder or severe depression, and the use of certain antipsychotic medications by people with psychotic illnesses, including schizophrenia.

The use of pharmacotherapy for mental illness was not examined in this needs assessment. However, it should be noted that a need has been identified for proactive follow-up of those who have been diagnosed with depression and prescribed antidepressant medication, particularly for those living in rural parts of South Taranaki.

Psychotherapy and psychosocial interventions for mental illness

A number of therapies; including cognitive behavioural therapy (CBT), interpersonal behavioural therapy (IPT), dialectical behavioural therapy (DBT) and some forms of problem solving therapy; have been shown to reduce suicidal behaviour. Studies have shown that such therapies can reduce suicidal behaviour alone or in combination with medication.

The needs assessment highlighted that a pilot project, involving the use of dialectical behavioural therapy (DBT), was taking place locally. Anecdotal evidence suggests this has had positive outcomes for those with borderline personality disorder.

Public awareness education and mental health literacy

Improving public knowledge about mental health and suicidal behaviour may contribute to suicide prevention by changing public recognition and attitudes towards mental illness. For example, programmes to increase public awareness and understanding of depression may lead to better recognition and treatment seeking among those with depression. However, research has shown that while it is relatively easy to change attitudes with such programmes it tends to be more difficult to turn attitudinal change into behavioural change (e.g. increased use of antidepressants). Evidence also suggests that awareness campaigns that target clearly defined specific subgroups are more effective than generic population-based programmes, which are largely ineffective.

One example of a local programme that increases public awareness and mental health literacy is the Like Minds, Like Mine programme run by Like Minds Taranaki. This is part of a national programme that began in 1997. Like Minds Taranaki run a number of strategies as part of the programme that include working with the media, advising on local policy initiatives, developing projects and programmes to reduce stigma and discrimination and taking the lead in local mental health literacy campaigns (e.g. Mental Health Awareness Week, Stress in Rural Communities road show). The Like Minds, Like Mine programme has been shown to be effective in changing the New Zealand public's awareness of and attitudes to mental illness.[28] Toi Ora also hold a contract to deliver a

[28] Vaughan G. 2004. Like Minds, Like Mine. In S Saxena and PJ Garrison (eds). 2004. Mental Health Promotion: Case Studies From Countries. Switzerland: World Health Organization

Like Minds, Like Mine programme aimed at reducing stigma and discrimination among Tangata Whaiora.

Screening for depression and suicide risk

Various programmes that screen for mental illness (such as depression) and suicide risk have been developed and are typically used in institutional settings (e.g. prisons, schools) or in primary care settings. While initial evaluation has been promising, there is a need for further evaluation to determine which tools identify risk most accurately and how they might be used most cost effectively.

One third of those local GPs questioned routinely use a recognized, evidence-based screening tool with patients who they felt might have depression. The remaining GPs either did not use them at all or used them only very rarely when a diagnosis was inconclusive. One GP highlighted that the tool he used had been recommended to all practices by Taranaki DHB. Those GPs who used a screening tool felt that they were very reliable and helped identify depression in those borderline cases that might be missed by routine questioning.

Crisis centres and crisis counselling

These services offer crisis counselling to callers who are suicidal and encourage them to seek assessment and treatment from mental health services although very few of them have actually been evaluated. Some studies have shown that telephone helplines may be effective in reducing callers' psychological distress, sense of hopelessness and suicidal behaviour.[29][30]

Lifeline Taranaki is a telephone helpline that provides crisis counselling across Taranaki 24 hours a day, 7 days a week. Lifeline Taranaki uses local volunteers and, where possible, calls are answered by local people. Where this is not possible (e.g. due to lack of volunteers) calls are diverted to the Lifeline centre in Auckland. Other telephone helplines available locally include Youthline, the Alcohol and Drug Helpline and a Rape Crisis helpline.

School based competency promotion and skill enhancing programmes

Following concerns about the risks associated with didactic suicide awareness programmes in schools, researchers now recommend the use of skill-enhancing, competency-promoting programmes within schools instead. These programmes focus on 'protective factors' such as enhancing self-esteem and coping skills. Evaluations to date have shown that such programmes have been associated with reduced suicidal behaviours among students[31].

The Waiora Wellness Centre based at New Plymouth Girls High School is a good example of a local school-based initiative that seeks to enhance the skills and competencies of its students. The centre runs a number of group activities, in partnership with other

[29] Kalafat J, Gould M, Harris Munfakh J, et al. 2007. An evaluation of crisis hotline outcomes Part 1: Non-suicidal crisis callers. Suicide and Life-Threatening Behaviour 37: 322-337

[30] Gould MS, Kalafat J, Harris Munfakh J. 2007. An evaluation of crisis hotline outcomes: Part 2 – suicidal callers. Suicide and Life-Threatening Behaviour 37: 338-52

[31] Eggert LL, Thompson EA, Herting JR, Nicholas LJ. Reducing suicide potential among high risk youth: Tests of a school-based prevention program. Suicide Life Threat Behav. 1995;25:276-96

organisations, which seek to build self-esteem and resilience among students. The group programmes also aim to strengthen peer support networks among groups of girls to foster positive relationships and reduce bullying. Another school-based programme – the Health Promotion Unit's Peer Support programme - uses a peer support model to provide a listening and referral service to young people. Students from 5 secondary schools have received Marae-based training to provide them with the skills needed to support other students at school with a range of health and social issues.

A number of other skill-enhancing, competency-promoting programmes for young people are also run in community settings (i.e. non-school based) across Taranaki. These include the WAVES youth health service (whose programmes include group activities that aim to build self-esteem and confidence), the Health Promotion Unit's Hauora Rangatahi programme (which builds community development and advocacy skills of rangatahi) and individual courses and activities (such as teen self-esteem courses) run by local Women's Centres.

Encouragement of responsible media coverage of suicide

Research evidence has shown that some styles of media reporting and portrayal of suicidal behaviour may increase suicide rates by encouraging 'copycat' suicides and normalising suicide as a response to adversity.[32] Research suggests that vulnerable people are particularly at risk of suicidal behaviour following media coverage of suicide, particularly where explicit reports about the method of suicide are provided.[33] As a result, New Zealand has developed media guidelines for reporting and portraying suicide. However, to ensure that media reporting on mental health issues is informed by factual and accurate information it is important that collaborative relationships with the media continue to be built at both local and national level.

The needs assessment found that local media (notably local newspapers) are following media guidelines and not reporting on suicide. Although some people interviewed felt that the media were being irresponsible by *not* reporting on suicide, current evidence supports a continuation of the suppression of suicide reporting. Despite this there may be opportunities to work with local media to increase public understanding of depression, increasing awareness of effective interventions and encouraging people experiencing depression to seek help. In terms of building positive relationships with local media, Like Minds Taranaki work closely with the media as part of their delivery of the national Like Minds, Like Mine programme. They encourage positive, non-discriminatory reporting of mental health issues through the award of an annual journalism scholarship to journalism students who choose to write about mental health issues.

A remaining challenge in the area of media coverage of suicide is the influence of the Internet; particularly as research studies have shown links between the Internet and suicide. For example, Internet message boards may provide a powerful vehicle for bringing self-injurious adolescents together. However, some researchers have argued that the Internet could also offer a potential means of suicide prevention and may make reaching certain groups (e.g. young people) easier. Possible approaches include the

[32] Associate Minister of Health. 2006. The New Zealand Suicide Prevention Strategy 2006-16. Wellington: Ministry of Health

[33] Hunter Institute for Mental Health. 2001. Response Ability, Resources for Journalism Education. Commonwealth of Australia: National Suicide Prevention Strategy

contribution of professional comments to message boards that contain comments on suicide.[34]

Support for family, whanau and friends bereaved by suicide

Rates of suicidal behaviour show a 2-6-fold increase among family members of those who die by suicide or make suicide attempts suggesting that targeted support at families/whanau bereaved by suicide may prevent suicidal behaviour in this group. Evidence of effective programmes are very limited although promising initiatives include active outreach at suicide scenes (to encourage those involved to seek treatment), professional group intervention programmes for adults and psychologist-led group-based intervention for bereaved children. The importance of accessible, timely and accurate information (e.g. written information, information provided by support services) has been highlighted.

Current initiatives that are specifically aimed at family and whanau bereaved by suicide include Victim Support (short-term) and the Bereaved by Suicide support group (long-term). Research evidence recommends that where services are provided by the voluntary sector, volunteers should be support by training, supervision and audit to ensure their safety and the safety of those who they are supporting.[35] Victim Support volunteers who were interviewed stated that they had received the generic volunteers training (which briefly covered suicide), ASIST (Applied Suicide Intervention Skills Training) and other occasional training sessions (e.g. training on legal issues provided by a local Funeral Service). In terms of information provision, local resources include Jo Nicholl's book (On The Way to Healing) and the information resource library held by the Bereaved by Suicide group.

4.2.4 Initiatives for which no evidence of effectiveness exists but which may be beneficial in suicide prevention

Improving control of alcohol

Strategies to improve control of alcohol at the national, regional or district level may have an impact in reducing suicidal behaviour by decreasing the risk of acute alcohol intoxication (which is linked with impulsive suicide attempts).

New Plymouth District Council have recently developed a District Alcohol Strategy that seeks to coordinate a range of enforcement and education activities aimed at reducing the harm caused by alcohol in the New Plymouth District. The strategy is currently open for community consultation. The needs assessment did not identify any similar strategies operating in Central or South Taranaki districts.

[34] Sisack M, Varnik A, Wasserman D. 2005. Internet Comments on Media Reporting of Two Adolescents' Collective Suicide Attempt. Archives of Suicide Research, 9:87-98. International Academy for Suicide Research

[35] Ministry of Health. 2008. New Zealand Suicide Prevention Action Plan 2008-12: The Evidence for Action. Wellington: Ministry of Health

Community-based mental health services and support services

Although community-based mental health teams form part of mainstream mental health care delivery they have undergone relatively little evaluation. However, studies have suggested that they are associated with fewer suicide deaths, less dissatisfaction with care and improved compliance with treatment. One area of community-based mental health care that has been associated with reducing suicidal behaviour is the development of clear protocols for assessment, treatment and follow-up of those who present at emergency departments with suicidal ideation or suicide attempt.

The Taranaki DHB Whakawhanaungatanga self-harm and suicide prevention collaborative is part of a national pilot initiative that implements New Zealand's best practice guidelines for the assessment and management of people at risk of suicide. Developing clear protocols for assessment, treatment and follow-up of those who present at emergency departments or other service following self-harm/suicide attempt is at the core of this project. During the initial pilot stage of the project the DHB met their targets around assessment but faced some challenges in meeting discharge and follow-up targets. The project is ongoing and processes for overcoming previous challenges are being identified.

Family support for families facing stress and difficulty

Improvements in family wellbeing and health care that serve to reduce risks of childhood and adolescent adjustment disorders may have an impact in reducing suicidal behaviour among young people. Programmes include family support and home visitation programmes that seek to improve home environments, prevent maternal depression and optimize outcomes for children born into dysfunctional family environments.

A broad range of family support programmes operate across Taranaki including Family Works (family counselling, social work services, parenting courses etc.), Mahia Mai A Whaitara (social work services and other family support), Manaaki Oranga (maternal mental health programme), Pike Te Ora and Plunket (home visiting services for families with young children), Women's Centres (parenting programme, drop in service, child care etc.), Pregnancy Help Inc (advice and practical support for pregnant women) and Women's Refuge/Taranaki Safe House (for those escaping family violence)

4.2.5 Initiatives for which evidence of harmful effects exists

School-based programmes that focus on raising awareness about suicide

Little evidence about the effectiveness of didactic school-based suicide awareness/peer support programmes exists[36]. Some studies have even expressed concern that such programmes, with or without youth peer support for suicidal young people, may be unsafe for certain vulnerable individuals[37].

[36] Beautrais A, Fergusson D, Coggan C, Collings C, Doughty C, Ellis P, Hatcher S, Horwood J, Merry S, Mulder R, Poulton R, Surgenor L. Effective strategies for suicide prevention in New Zealand: a review of the evidence. J New Zealand Med Assoc. 2007:120:1251

[37] Gould MZ, Greenberg T, Velting DM, Shaffer D. Youth Suicide risk and preventive interventions: A review of the past 10 years. J Am Acad Child Adolescent Psychiatry. 2003;42:386-405

There are currently no school-based suicide awareness/peer support programmes running in Taranaki. It should be noted that during this needs assessment a significant number of individuals highlighted the need to talk about suicide to young people in schools. However, research suggests that such an approach risks inadvertently normalising suicidal behaviour or promoting imitation and should therefore be avoided[38].

Public health messages about suicide and media coverage of suicide issues

There is no evidence that public health messages about suicide are beneficial. Indeed concerns have been expressed that such messages may actually normalize suicide rather than prevent it. While concerns remain that public health messages about suicide may have a negative effect it is recommended that that public health messages do not form part of a suicide prevention strategy.

No use of public health messages to raise awareness of suicide were identified during this needs assessment. A small number of respondents felt that suicide should be talked about more openly, and that the media should play a role in advertising these messages. However this action is not supported by the evidence.

No-harm and no-suicide contacts

Research shows that the use of no-harm or no-suicide contracts is widespread in mental health settings despite there being no evidence to support their effectiveness. Concerns have been expressed about their safety, in particular the risk that they may create a false sense of security in the therapist or may anger patients.

This needs assessment did not elicit the use of no-harm contracts in mental health settings although questions about their use were not asked.

One GP stated that she used a 'safety contract' when she had concerns that a patient may become suicidal after they left the surgery. The contract would involve the patient agreeing to contact the GP if they began to feel unsafe. A similar approach is recommended within the ASIST (Applied Suicide Intervention Skills Training) programme, referred to as a 'Safeplan'. These plans are intended as a short-term measure to keep the individual safe until they can seek professional help. Safeplans typically include safety contacts, an agreement to not use drugs/alcohol and a link to resources. They may also include risk specific actions such as disabling a potential suicide plan (e.g. removing medication or firearms from the home).[39]

Recovered or repressed memories therapies

Concerns have been expressed about recovered memory therapies and a possible link with increased rates of self-harm and suicide attempt.

The needs assessment did not identify any use of recovered or repressed memory therapies in Taranaki.

[38] Aseltine RHJ, DeMartino R. An outcome evaluation of the SOS Suicide Prevention Program. Am J Public Health. 2004;94:446-51

[39] Ramsay RF, Tanney BL, Lang WA et al, 2004. Suicide Intervention Handbook. Living Works/Lifeline

4.2.6 Evidence related to meeting the needs of different population groups

Maori

Maori suicide is largely confined to those aged under 35 and rates within this age group are generally higher than for non-Maori. Similarly the Maori hospitalisation rate for intentional self-harm is one-and-a-half times that for non-Maori.

The majority of Maori receive most of their healthcare from general population services and, given the high rate of suicidal behaviour among Maori, it is essential that general population services, providers and systems are re-orientated to meet the needs of Maori.[40] In line with *He Korowai Oranga: The Maori Health Strategy (2002*), the whanau should be recognised as the principal source of strength, support, security and identify for Maori. In terms of healthcare planning and development, the Taranaki DHB (Maori Health Team) are leading the local implementation of the Maori Health Strategy in Taranaki.

While alienation from one's own culture has been linked to suicide, the strengthening of cultural identity through increased access to Maori language, family network, community structures, customs and traditions has been suggested as a protective factor for suicide.[41] Recent research has supported associations between cultural identity and suicide attempt among Maori, suggesting that strong cultural identity may be a protective factor against suicide.[42] A number of local projects that have been set up with the aim of strengthening cultural identity were highlighted during the needs assessment. These included the Health Promotion Unit's Waka Ama project, that aims to raise awareness of Maori culture and promote positive cultural identity, and the Hauora Rangatahi programme, a community development project working with rangatahi in Opunake.

Children and young people

Young people aged 15-24 years have the highest suicide rate for females, and the second highest rate for males.[43] The experience of adversity during childhood, including experience of abuse, family breakdown, family violence and parental mental illness, increases the risk of later suicidal behaviour. Other factors, such as depression, alcohol abuse and certain personality traits also increase the risk of suicide.[44]

Young people aged 16-24 years are the least likely of any age group to visit a health service for a mental health reason.[45] Research with young people has identified a number of barriers to accessing primary health care including cost, access issues, embarrassment and cultural appropriateness. Young people are more likely to use

[40] Ministry of Health. 2002. *Reducing Inequalities in Health*. Wellington: Ministry of Health
[41] Lawson Te Aho K. 1998. *A Review of Evidence: A background document to support Kia Piki te Ora o te Taitamariki: New Zealand Youth Suicide Prevention Strategy.* Wellington: Te Puni Kokiri
[42] Coupe NM. 205. Whakamomori Maori Suicide Prevention. PhD Thesis. Massey University, Palmerston North, New Zealand
[43] Ministry of Health. 2008. *New Zealand Suicide Prevention Action Plan 2008-12: The Evidence for Action.* Wellington: Ministry of Health
[44] Beautrais AL, Collings SC, Ehrhardt P, et al. 2005. *Suicide Prevention: A review of evidence of risk and protective factors, and points of effective intervention.* Wellington: Ministry of Health
[45] Oakley Browne M, Wells JE, Scott KM (eds). 2006. *Te Rau Hinengaro: The New Zealand Mental Health Survey.* Wellington: Ministry of Health

primary health care services when they are targeted, youth friendly and provided in a physically separate setting (e.g. school or youth health centre). During the needs assessment examples of local services that use such a model were highlighted. These included the 'WAVES' youth health centre and the New Plymouth Girls High School 'Waiora Wellness Centre', both based in New Plymouth.

Older people

Although older people have the lowest rates of suicide and hospitalisation for self-harm (apart from those aged 5-14 years) their suicide attempts tend to be more lethal, due to their frailty, isolation and a more common use of more lethal methods. As mood disorders play a significant role in suicidal behaviour in this group it has been suggested that improved detection and treatment of depression through opportunistic screening within primary care should be the most important focus for working this group.[46]

Population-level interventions shown to be effective with this group include exercise and social support through befriending. Local initiatives highlighted during this needs assessment included the Friends Plus visiting scheme and Sport Taranaki's Green Prescription exercise programme.

Gay, lesbian, bisexual, transgender and intersex people (GLBTI)

Recent research suggests that people of non-heterosexual orientation are at increased risk of developing mental disorders and have higher rates of suicidal behaviour.[47] Suggestions for this increased risk include the social discrimination and stigma they experience which can lead to social isolation and victimisation. As a result, GBLTI people may face obstacles accessing health services which makes appropriate training for health professionals about the key issues faced by this population very important.

The Ministry of Social Development has established a policy function to raise awareness and commitment among other government agencies to address the issues affecting GLBTI people. Other national initiatives include the Out There Queer Youth Development Project (Department of Internal Affairs) and the Transgender Inquiry (Human Rights Commission).

Refugees and Migrants

Refugees and migrants may face discrimination and negative public attitudes that increase risk of mental disorder and suicide.[48] Past traumatic experiences, separation from family, cultural and social isolation, and a drop in socio-economic status are particular risk factors.

Approaches that promote good mental health includes increasing public support for cultural diversity, increasing access to English language education and community social support programmes that allow immigrants and refugees to meet with others of the same ethnicity. One service that provides information, advice and support to migrants

[46] Beautrais AL, Collings SC, Ehrhardt P, et al. 2005. *Suicide Prevention: A review of evidence of risk and protective factors, and points of effective intervention.* Wellington: Ministry of Health
[47] Fergusson D, Horwood LJ, Ridder E et al. 2005. *Sexual orientation and mental health in a birth cohort of young adults.* Psychological Medicine 35:971-981
[48] Ellis P, Collings S. 1997. *Mental Health in New Zealand From a Public Health Perspective.* Wellington: Ministry of Health

and refugees was identified during the needs assessment. This was Settlement Support, based in New Plymouth, which provides advice and support, as well as a number of local information seminars and courses for migrants and the general community.

Pacific peoples

The suicide rate for Pacific peoples is lower than that for the population as a whole, although Pacific peoples have higher rates of suicide plans and attempts than all other ethnic groups, with this being highest among New Zealand-born Pacific peoples.[49]

There is strong stigma associated with suicide among traditional Pacific communities which may prevent some individuals from disclosing suicidal thoughts or seeking help. Approaches that have been suggested as being most effective for Pacific peoples include those that strengthen protective factors and reduce risk to risk factors for suicide, and developing interventions that build on family and social support systems (e.g. church networks).[50]

People with disabling physical health conditions and long-term impairments

People with chronic and debilitating conditions, including multiple sclerosis, HIV and cancer, have a higher risk of suicidal behaviour as a result of depression and other factors associated with their disability (e.g. pain, social isolation). Approaches to reducing risk in this group include more focus on the detection and treatment of depression by health and disability professionals who are working with this population group.[51]

The Taranaki Disability Information Centre was identified as a local information and support service that has been set up to meet the needs of disabled people in Taranaki. The group has good links with the disability and health care sector through its monthly networking meetings and could be well place to play a role in advocating on behalf of the mental health needs of people with physical disability and long-term impairment.

[49] Oakley Browne M, Wells JE, Scott KM (eds). 2006. *Te Rau Hinengaro: The New Zealand Mental Health Survey.* Wellington: Ministry of Health

[50] Simmons DJ, Voyle et al. 1997. *Community-based approaches for the primary prevention of Non-Insulin Dependent Diabetes Mellitus.* Diabetic Medicine 14(7): 516-526

[51] Kishi Y, Robinson R, Kosier J. 2001. *Suicidal ideation among patients with acute life-threatening physical illness: Patients with stroke, traumatic brain injury, myocardial infarction and spinal cord injury.* Psychosomatics 42(5): 382-390

4.3 Suicide Prevention in Taranaki – Existing Service Provision

4.3.1 Promoting Mental Health and Wellbeing, and preventing mental health problems

A large number of services that were seen to promote mental health were identified. Some of these services had a clear remit to carry out mental health promotion, such as Like Minds Taranaki and Toi Ora. Other services, while not having mental health promotion as their core business, were seen to play an important role in promoting mental health through the support they provided for those with particular needs (e.g. counselling and advisory services).

The services most commonly mentioned included:

Mental Health Promotion & Reducing Discrimination

Like Minds Taranaki - Services include education, peer support, advocacy, raising awareness of mental health issues, reducing discrimination and influencing policy development. They run the Like Minds, Like Mine programme, part of a national initiative aimed at reducing stigma and discrimination associated with mental illness. They led a recent partnership initiative – Stress in Rural Communities – that involved a series of roadshows held in 9 rural communities across Taranaki to raise awareness of mental health issues and support services. Like Minds Taranaki have just received funding from the Ministry of Health to set up a local mental health website which will contain information on mental health problems and services.

Toi Ora – Working towards reducing the stigma and discrimination that Tangata Whaiora may experience and developing strategies to minimise harm caused by discrimination.

Taking the First Step – A multi-agency partnership project, led by Like Minds Taranaki, which has been established to help people with mental health issues and disability to access employment. The project has led to the publication of a guidebook for job seekers with health issues that includes help with finding a job, information on emotional wellbeing, a guide to employer subsidies and information about employees' rights.

Counselling & Advisory Services

Problem Gambling Foundation – Provides free, professional, confidential counselling services to people who want to control their gambling and to people affected by another person's gambling. Promotes responsible gambling through health promotion (education and development) and health protection (developing regulation and standards). A number of respondents commented that problem gambling (particularly using pokie machines) was an issue in Taranaki and was possibly linked with suicide. This link is backed up by research findings that suggest those who develop problem

gambling behaviours are vulnerable to developing depression and responding to life stresses with suicidal behaviour.[52]

Professional counselling and psychotherapy services - These usually charge a fee on a sliding scale or provide other assistance with fees. Counselling services include:

- Family Works - counselling and therapy for children, adolescents, adults, groups and families
- HRC (Hawera Rape Crisis) Family Counselling Services - general counselling, stress management, family therapy, relationship counselling, loss/grief counselling, anger management etc. Also provides counselling for victims of rape and sexual abuse
- South Taranaki Counselling Service- provides counselling/psychotherapy services to the South Taranaki area
- Employee Assistance Programme (EAP) – many larger employers offer free confidential counselling sessions through their EAP programme. For example, the PPCS meat processing plant in Hawera will cover the costs of 4 sessions of counselling or courses with HRC Family Counselling Services for employees

Specialist Advisory Services – A number of specialist advisory services were identified as contributing towards mental health promotion including *Settlement Support* (information and support service for migrants, refugees and their families), *Budget Advisory Services* (advice and support to help with household budget management) and the Taranaki Disability Information Centre (information and support for people with disabilities).

Services for Children & Young People

WAVES – A youth health, advice and counselling service based in New Plymouth. Many respondents described this as an excellent service that provided a safe a non-judgemental place for youth to access help. Many also described it as the only service of its kind for youth in Taranaki and felt that the service needed to be expanded. Along with youth friendly health services, WAVES offers a number of group activities (art, hip hop, self esteem courses, etc.) and therapy sessions with a clinical psychologist. The services are free of charge.

Waiora Wellness Centre (New Plymouth Girls High School) – The centre, based in a separate building on the school site, employs a fulltime nurse and two guidance counsellors as well providing access to other health professionals and welfare agencies. The centre, the first of its kind in Taranaki, takes a holistic approach to meeting the often complex needs of the school's students. As well as providing a counselling and health care service, the centre runs a number of group based programmes available to all students that focus on building self-esteem, resilience and coping skills as well as strengthening cultural identity among Maori students.

HELP Trust "IT'S OK TO ASK 4 HELP" Peer Support Programme (ceased early 2008) – A peer support programme set up to encourage young people to learn help seeking behaviour. The programme was run in several Taranaki secondary schools and used trained ambassadors to distribute yellow 'call for help' cards to all students. At times of crisis students could use the cards as a means of asking for help from someone they trust. A

[52] Problem Gambling Foundation of New Zealand. Fact Sheet: *Problem Gambling and Suicidal Behaviour*, January 2007. Auckland. www.pgfnz.org.nz

number of respondents felt that there was a very real need for a programme such as this to run in schools and wanted to see the programme re-established.

Youth Transition Service – This service works with at-risk youth, aged 15-18 years, with the goal of supporting them to access training, education and employment. The service provides a mentoring role, developing plans with young people and then coaching them through the steps to achieve their goals. The service focuses on building resilience and independence in the young people they work with.

Hauora Rangatahi programme (Health Promotion Unit) – A participatory project supporting a group of Opunake High School students to engage with their local community, identify issues for local rangatahi and to develop community projects to respond to the issues. The project aims to strengthen community development, promote health and wellbeing and to foster a strong sense of cultural identity among local rangatahi.

Taranaki Secondary Schools Peer Support Programme (Health Promotion Unit) – This project involves students from 5 Taranaki high schools who are selected by their peers to attend a 3 day camp at a Marae to develop peer support skills. The students provide a listening and referral service to other students at the school on a wide range of health and social issues.

Waka Ama Project (Health Promotion Unit) – This project runs in 5 local high schools and is open to all students. It aims to increase awareness of Maori culture among non-Maori, and to promote positive cultural identity among the rangatahi that participate.

Central and South Taranaki Youth Trust – Employs a full-time social worker who supports young families. The social worker has a very small caseload that allows intensive support work to take place. The police also have a full-time position based within the Trust. Work closely with other agencies to support young people and their families in South Taranaki.

Big Brother, Big Sister – A peer-mentoring programme for at-risk youth run by Police Youth Aid

Services that Support and Strengthen Families

Family Works (Presbyterian Support Central) – Provides social work services, counselling and therapy services and a range of courses including life skills and parenting courses. The service offers subsidized and free counselling services depending on income and circumstances.

New Plymouth Women's Centre – The centre offers a drop-in centre, crèche, massage and a number of low cost courses (self defence, parenting etc). The centre is run by volunteers.

South Taranaki Women's Centre – The centre provides free pregnancy testing and sexual health advice, free legal advice and various courses (parenting, self esteem, etc.)

Taranaki Women's Refuge – Provides support to those experiencing family violence across Taranaki. Women's Refuge provides safe housing in times of crisis although around

80% of the support takes place in the family home. Also plays a role in educating the community on domestic violence.

South Taranaki Community Safe House – Provides safe and supported emergency accommodation for women and children in South Taranaki affected by family violence. The Safe House is run by the multi-agency South Taranaki Family Violence Networking Group. The needs of women and children using the centre are often very complex and include psychological, social and economic issues. The service is accessed through HRC.

New Plymouth Safer Centre – provides counselling and support to victims of sexual abuse and rape in North Taranaki. Also provides services to sexual offenders and their families (e.g. rehabilitation/treatment programmes).

HRC (Hawera Rape Crisis) – provides counselling and support to victims of sexual abuse and rape in South Taranaki

Pregnancy Help Inc. – Based in Stratford, but providing a service across Taranaki, the organisation provides information, advocacy and support, drop-in sessions, pregnancy testing, parenting support and donations/loans of clothing and baby equipment. All services are free.

4.3.2 Improving the care of people who are experiencing mental disorders associated with suicidal behaviour

Three general types of service provision for people with mental illness were identified. The main type of service provision that respondents mentioned were contracted mental health services. The core business of these services is mental health care, although the level of support they provide varies from acute inpatient care through to community based support and recovery programmes. The other two services that were identified were community and primary care health services (whose core business if often not mental health care but who play an important role in supporting those with mental illness) and a range of NGO's (Non-Government Organisations) and other organisations.

Contracted Mental Health Services

Taranaki District Health Board (TDHB) Provider Arm services:

(Many respondents referred to TDHB services as mainly focusing on the "top 3%" i.e. the 3% of our population who have the most serious mental health disorder).

TDHB Acute Services:

- Inpatient Mental Health Services (Te Puna Waiora at Taranaki Base Hospital) – admission via a Psychiatrist
- Crisis team – 24-hour, seven day per week fully mobile regional crisis response service. Described by many respondents as an essential service but under pressure and stretched too thinly. Those GP's interviewed were highly

complimentary of the service and use it as the first point of contact for any patients deemed a suicide risk.

- Acute Home-Based Treatment team – home-based assessment and treatment to clients experiencing a severe mental health crisis. A number of respondents indicated that this service was valued because it offered an alternative to hospital admission for those who wanted to stay at home
- Elderly Mental Health Services – specialist assessment and treatment for over 65's with a serious mental illness, includes a six bed inpatient programme and multi-disciplinary community mental health team

TDHB Community/Other Services:

- Alcohol and Drug Service – assessment and treatment for those with co-existing alcohol and/or drug and psychiatric disorders
- STEP Residential Alcohol and Other Drugs (AOD) Programme
- Early Intervention First Psychosis service
- Outpatient services
- Child & Adolescent Mental Health Services (CAMHS) Community Service – assessment, treatment and therapy service for young people aged up to 18 years. Again this was described as a service for those with the most serious mental health issues having very strict criteria for service access. The service also employs a self-harm nurse (currently on maternity leave) who works with young people who are self-harming
- Maternal Mental Health service – short and medium term support for pregnant and perinatal clients with severe postnatal depression and puerperal psychosis
- Family/Whanau Advisor – provides strategic advice to DHB on policy matters, provides staff training and supports families/whanau as required
- Support groups including Carer Support groups and Concerned Significant Others group (for family/whanau affected by an individuals alcohol or drug problems)
- Dialectical Behaviour Therapy (DBT) – a one-year programme delivered by a psychologist and currently being trialled in Taranaki. A number of respondents commented on the apparent success of this programme in treating people with borderline personality disorder.

Taranaki Consumer Consultants Ltd. Advocacy Peer Support Service - The service offers support, education, information and advocacy. Consumer advocates and peer supporters assist individuals to be active participants in their own recovery.

Te Rau Pani – Provides a Whanau based specialist Kaupapa Maori Mental Health service to Whanau, Hapu and Iwi in Taranaki. Te Rau Pani is a community-based team whose services include cultural and clinical assessment, long and short-term treatment and follow up, health promotion, employment service and Kaumatua support.

Mahia Mai A Whaitara – Utilises a holistic and integrated approach to social work from a Maori perspective. Also runs a Peer Support Service that includes recovery-focused peer counselling, support programmes and advocacy.

Pathways – Supported accommodation, acute home-based treatment (provided by support workers) and mobile support. The service provides early intervention support and works with clients to improve self-management of their mental illness. They take referrals

from primary and secondary care but do not take self-referrals. They have recently employed a specialist worker to work with clients who have alcohol and drug issues.

Manaaki Oranga – Maori health provider offering a maternal mental health programme. Offers specialist support mothers with mental health, drug and/or alcohol issues. Also provides health care and support services for teenage mothers.

Raumano Health Trust, Patea – Maori health provider offering early intervention, child and adolescent support and therapy and kaumatua support.

Te Whare Puawai O Te Tangata Trust – Oranga Ngatahi Physical Health Programme, supported living accommodation for people with high and complex needs (based in Brixton), consumer advocacy, early intervention and treatment service, and meaningful activity programme.

Tu Tama Wahine – Maori Needs Assessment Service Coordination (NASC)

Te Ihi Rangi Trust, Beacon & *Manna* – Providers of respite care services.

Progress to Health – Offer a range of recovery focused programmes including stress management, life skills, work skills and self esteem. Their community worker team provide advocacy and support for people with mental illness tailoring individual plans around education, training, employment and other needs to support recovery.

Supporting Families (SF) – This service aims to promote best quality of life for people with mental illness and their family/whanau and caregivers through provision of information, mediation, advocacy and peer support. The service supports families/whanau to develop the coping skills necessary to manage their relative or friend's mental illness and to support them to become more effectively involved in their care. SF also runs a carers support group. The service is non-profit and community based, and employs one full time fieldworker.

Like Minds Taranaki – Support services for people with mental illness include local support groups. Two support groups in New Plymouth and one in Hawera. A Postnatal Support Group also runs in New Plymouth for those with postnatal depression. These support groups offer friendship and support for people with mental illness.

Community and Primary Health Care Services

Taranaki Primary Connections (Manaaki Oranga) – A primary mental health project that aims to meet the needs of people In Taranaki who have mild to moderate mental health problems. The project is supported by all three Primary Health Organisations (PHOs) in Taranaki. The service takes referrals from GPs; a coordinator carries out an assessment and refers the client on to a counsellor (for which the client received four free sessions).

Mild – Moderate Mental Health Initiative. (Hauora Taranaki PHO (HTPHO) & Ministry of Social Development (MSD) – Aims to provide proactive management of clients with stress related disorders (anxiety, depression and other stress related conditions) that result in the need for a Sickness Benefit. Available to all, regardless of the clients' PHO or GP registration. Referrals to HTPHO come through WINZ caseworkers and/or clients GP and a

referral is then made to Psychological Services who arrange for counselling. Following counselling, Psychological Services provide progress report to GPs and WINZ via HTPHO.

PHO Counselling Project Vouchers – Vouchers for free or subsidized counselling from listed counsellors and clinical psychologists across Taranaki. GPs who are part of a PHO provide vouchers for a limited number of counselling sessions to those with mild-moderate mental health problems, including depression.

GP Depression Scoring/Screening Tools – Some of the GPs interviewed used a depression scoring/screening tools with those patients who presented with symptoms of depression, or whom the GP was concerned that depression may be an underlying issue. Scoring tools used include the Goldberg Depression Inventory (a self-rating depression score) and adaptations of the Edinburgh Depression Scale. The scoring tools included a question on suicide risk, for example "Do you feel that people would be better of if you were dead?" Those GPs who did not use such scoring tools relied on asking the patient questions that would highlight depression symptoms. If this led to concerns about suicide risk they would ask outright if patients were thinking of harming themselves, whether they had made a plan, etc. Some GPs noted that the relationship they had with patients over time meant that they could often spot that something wasn't right when a patient became depressed. All GPs interviewed used the crisis team as their first point of call for a patient who was believed to be at risk of suicide:

> "*If I really thought they were at risk I wouldn't let them out of the practice. I would get the crisis team*"

One GP interviewed used a safety 'contract' with those patients whose risk was not great enough to call the crisis team:

> *"If there is ambivalence, but it is safe for them to leave the practice, I form a contract with them that promises they will call me if they no longer feel safe"*

Whether or not screening tools were used, GPs felt that they had good awareness of depression and knew what to look for:

> "*We're all pretty tuned into it. It just presents in so many ways*"

NGOs, community and other organisations

Lifeline Taranaki – A free confidential telephone counselling service that is available 24 hours a day. Trained volunteers provide a listening service. The service takes many calls from mental health consumers in Taranaki who are advised to call Lifeline out of hours if they need to speak to someone. Calls are made for many different reasons including relationship problems, concerns about financial issues/debt, loneliness, and depression. Calls are occasionally received from people who are suicidal.

Creative Space – An art group for people with disabilities run by the Taranaki Disability Information Centre. Some people who use the group have mental health problems. A number of respondents referred to the group as being hugely successful, and providing somewhere for people to go where they could focus on art rather than their illness or disability. The group is relaxed and non-directive – materials are available and people can choose to use them as they wish.

Green Prescriptions (Sport Taranaki) – A free service promoting access to physical exercise and recreation via GP referral. Referrals include clients with mental illness. Those who use the service are offered an initial assessment and then, if they wish to take part, are referred to a suitable programme. Sport Taranaki provide one to one support, encouragement and ongoing motivation during the programme.

Traditional Maori Healing – The benefits of traditional Maori healing, particularly for Maori experiencing mental illness, were highlighted and it was felt that this should be made more widely available to Maori as a treatment option. Services mentioned were 'Harmony Haven/Puna Aio' and 'Karangaora' although a number of other similar services are available in Taranaki.

Friends Plus – Volunteer visiting and shopping service for older people. Also provides a 'tuck in' home care service for isolated and housebound older people. The importance of social contact for older people living alone was highlighted as an important mental health promotion service for vulnerable elderly people who were at risk of depressive illness.

New Plymouth Prison (Assessment and risk management) – When entering the prison, prisoners are assessed by Forensics. Those with severe mental disorders would be transferred to a prison equipped to deal with this. Less severe mental disorders can be managed short-term in New Plymouth Prison with those at risk of suicide being managed with 15-minute observations. If they continued to remain at risk or their mental disorder worsened they would be transferred to another prison.

4.3.3 Improving the care of people who make non-fatal suicide attempts

Whakawhanaungatanga/Self-Harm and Suicide Prevention Collaborative – A collaborative project between Taranaki DHB Mental Health Services, Emergency Department (Taranaki Base Hospital and Hawera Hospital) and Maori Health. The project aims to bring about significant change in care and outcome for people presenting with suicidality to Emergency Departments, Maori/Mental Health Services and Mental Health Services in New Zealand. Taranaki DHB is one of ten DHBs nationally taking part in the pilot phase of the project which builds on the New Zealand Guideline Group's (NZGG) evidence-based best practice Guideline: The Assessment and Management of People at Risk of Suicide (2003). The pilot project had four targets based on NZGG recommendations and key practice gaps identified by stakeholders:

- Access (90% of people attending EDs, once identified with self-harm of suicidality should have an assessment begin within one hour by a mental health clinician)
- Assessment (100% of people presenting with self-harm or suicidality will have a documented assessment including assessment of psychosocial stressors, a cultural assessment, mental illness screen and subsequent risk assessment within 72 hours
- Discharge (At the time of discharge/transfer the person and their whanau/ significant others will be provided with a written copy of their care plan)
- Follow Up (90% of people presenting to the services with suicidality, or at risk of self-harm, will have a follow up appointment for continuing care within 48 hours of discharge; 90% of people who do not attend that appointment will be contacted, or their significant other will be contacted, within 48 hours)

Key successes of the Collaborative has been the achievement of the target around access, improved relationships and communication across services, attitude changes following staff training and the integration of a newly developed risk assessment tool into routine care. Now that the pilot has ended, the project will continue to run.

However, the project faces some challenges, notably the instability caused by recent management change and restructuring in ED at Taranaki Base Hospital. The development of an appropriate cultural assessment tool has also been an ongoing challenge although the DHB has identified committed Maori representatives who are keen to drive this initiative forward. A newly appointed Project Manager is currently coordinating the collaborative project in Taranaki with guidance and support from New Zealand Guidelines Group and other participating DHBs.

CAMHS Self-Harm Nurse – This position takes referrals of young people, aged up to 18 years, who are self-harming. The Self-Harm Nurse works closely with schools. (Currently unavailable due to staff member being on maternity leave).

4.3.4 Reducing access to means of suicide

The Police, New Plymouth Prison and Taranaki DHB Mental Health Services all have policies and procedures in place to manage suicide risk and reduce access to means of suicide.

However, a typical response from many of the people questioned about reducing access to means of suicide was that nothing could be done. Most respondents felt that if a person was determined to end their life then there was little or nothing that could be done to stop them. However, when provided with an example of an overseas initiative (reduction in pack sizes of over the counter sales of paracetamol in the UK) a number of local examples were highlighted. Examples of initiatives taking place in Taranaki to reduce access to means of suicide include:

Police – All police officers who deal with arrests receive mandated national training that includes suicide awareness, risk assessment and management of people at risk of self-harm or suicide. New Plymouth police cells were upgraded last year to make them suicide-safe (e.g. removal of ligature points). If an arrested person is assessed as being at risk of suicide, or if police records demonstrate a history of self-harm, frequent or continual observation is carried out (depending on level of risk).

New Plymouth Prison – The prison assesses all new prisoners for suicide risk. Assessment utilises previous prison records and other documents to identify risk factors or history of mental illness. Staff are also trained to identify risk factors. If the assessment triggers concerns the prisoner is assigned a case officer and put on a short-term management plan that includes 15-minute observations in a safe 'camera cell'. If necessary, prisoners are given paper clothes and plastic cutlery. These arrangements would be short term and the prisoner would be moved to a better equipped prison if risk was ongoing.

Te Puna Waiora (Taranaki Base Hospital in-patient ward) – Taranaki DHB Mental Health Services have a policy around searching through property when patients are admitted. Potentially dangerous items are removed (e.g. medication, razors). Other practices include stitching of blankets (to prevent ripping and use as ligatures) and management

of at-risk patients with close observations. Taranaki DHB also has a policy around management of firearms and has an information sharing agreement with police. Firearms can be removed from the home if there are concerns around patient safety. Another initiative includes improvements to risk assessment training for staff.

Close Control Prescribing – Mental health professionals or a patient's GP can place those patients considered to be at risk of suicide on daily or weekly prescribing of medication (known as 'close control') to limit the quantity of medication the patient has access to at any one time.

Netting on buildings - Netting has been noticed around some higher buildings in New Plymouth. (It is unknown whether this has been installed as a suicide prevention initiative).

Reducing access to alcohol – Some respondents noted the recent work of the New Plymouth District Council in putting together an Alcohol Strategy for the district. Reducing access to alcohol was seen by some respondents as having an important role to play in preventing self-harm and suicide.

4.3.5 Promote safe reporting and portrayal of suicidal behaviour by the media

Local Newspapers

When asked about the media, this was almost exclusively viewed as local newspapers. Almost all respondents described the reporting and portrayal of suicidal behaviour, by the Taranaki Daily News and North Taranaki Midweek in particular, as responsible. Many stated that they could not recall reading anything about suicide in the papers in recent years.

A small minority of respondents stated that the lack of reporting was, in itself, irresponsible and that more reporting around suicide was necessary to inform those at risk of where to get help. They did not feel that details of individual suicides should be reported, but rather more general suicide awareness coverage so that people knew what to look out for and what support services were available.

Many respondents felt that local newspapers could play a greater role in raising awareness of mental health issues, particularly depression. They also suggested that the newspapers could cover more positive mental health stories, such as celebrating the achievements of local services or the recovery stories of local people.

John Kirwan campaign (part of National Depression Initiative)

Many respondents commented that the John Kirwan adverts shown as part of the National Depression Initiative were having a positive impact in encouraging people to talk about depression. It was also felt such campaigns were a good way of reducing stigma and discrimination. The idea of a similar campaign within Taranaki using local 'celebrities' was suggested. The 'It's Not OK' family violence campaign was often mentioned and it was suggested that local media could play a role in running a local 'It's OK to ask for help' programme focusing on depression and suicide.

WITT Journalism Scholarships

Like Minds Taranaki gives presentations to journalism students about media coverage of mental health issues and award small scholarship payments to WITT journalism students who choose to write on mental health issues as part of their journalism course project.

4.3.6 Supporting families, whanau, friends and others affected by a suicide or suicide attempt

Respondents identified two main kinds of service. Those that respond in the immediate aftermath of a suicide and those that provide longer-term support and care for families, whanau and friends affected by a suicide. Both kinds of services were typically described as focusing on the needs of immediate family/whanau, particularly partners/spouses and parents (in the case of youth suicide or suicide attempt).

All of the services that stakeholders identified provided some kind of support following a *suicide* (often referred to as 'postvention' support). A number of respondents pointed out that while there was service provision available for families/whanau bereaved by suicide, there was very little support for those affected by a suicide *attempt*. One respondent summed this up as follows:

> *"I would like to see more for families, especially where there have been failed suicide attempts. For me it was as though the word* [suicide] *got lost"*.

Immediate Response/Crisis Services

Victim Support – In New Zealand immediate support following a suicide is provided almost exclusively by Victim Support volunteer workers.[53] Taranaki has three branches of Victim Support – New Plymouth, Central Taranaki and South Taranaki. This support is short-term and Victim Support will refer individuals on to other agencies for longer-term support. One volunteer stated that Victim Support telephone families on the anniversary of a suicide death to see how they are coping and to ask if they need more support. Families generally respond well to this and although not all want to speak to the volunteer they are grateful that the anniversary has been remembered by the service.

Funeral Services – These were identified by a number of respondents as having an important role to play in the immediate days following a suicide death. Some respondents were concerned that funeral services may not be equipped to deal with the complex psychological issues faced by families/whanau following a suicide, particularly as suicide deaths are relatively rare. The funeral service consulted with as part of this needs assessment had dealt with a number of families following a suicide and their experience showed that the issues faced were similar to those following other kinds of sudden death – families had lots of unanswered questions and a broad range of grief reactions. The funeral services provide families with information on the legal and other issues following suicide death, make contact with ACC on their behalf and assist with funeral arrangements. Information provided to families included national "Skylight"

[53] Beautrais AL. 2004. *Suicide Postvention, Support for Families, Whanau and Significant Others after a Suicide – A literature review and synthesis of evidence*. Canterbury Suicide Project: Christchurch

resources for those affected by suicide. Some Funeral Services offer training to Victim Support on the legal issues relating to suicide (a recent training session was run in South Taranaki).

Taranaki DHB Mental Health Services – A sentinel events committee group meets whenever a mental health service client completes suicide. This group has set up Terms of Reference for dealing with families of those bereaved by suicide so that their needs are better met. Families are offered access to support from mental health staff and a clinical psychologist. Professional support and debriefing sessions are also made available to mental health staff that worked with the client.

Longer Term Support Services

Bereaved by Suicide group – This is an informal support group, based in New Plymouth, and open to anyone whose life has been touched by suicide. The group offers regular support meetings, access to information on suicide bereavement and telephone support. The group runs in New Plymouth according to need and the possibility of setting up a group in South Taranaki is now being explored.

Other Support Groups - It was noted that some people may use other kinds of support groups, particularly if they are already part of an existing group (e.g. Concerned Significant Others group, carers support groups, peer support groups for people with mental illness etc.)

Supporting Families – Will provide longer-term follow up support for families affected by suicide. This support has particularly been taken up by families who were previously in contact with Supporting Families through their caring role.

On the Way to Healing (written by Jo Nicholls) – This book was written and published with the support of the Taranaki Suicide Project and contains information on legal, financial and other practical issues relating to suicide, as well as guiding families through the emotional journey that follows the suicide of a loved one. The book has been widely circulated to support organisations in Taranaki and families bereaved by suicide. Like Minds Taranaki are currently seeking funding to translate the book into Te Reo Maori.

Grief Counselling – Available through counsellors and clinical psychologists although a charge is often made. Lower cost counselling could be accessed through GPs (counselling vouchers) or Manaaki Oranga (Taranaki Primary Connections)

Growing through Grief New Plymouth – Uses a peer support programme called "Seasons" to help young people from 5-18 years old cope with loss or change in their lives (death, divorce, imprisonment, etc). Groups of up to 5 children, facilitated by a trained adult, use discussion, storytelling, art and other activities to share their experiences with each other over 10 weeks. The group will support children through bereavement although the programme is not always available as it runs depending on level of need.

4.3.7 Expanding the evidence about rates, causes and effective interventions

Respondents were asked about the availability of information about rates, causes and effective interventions. They were also asked what kind of information they did have access to, and what other kind of information would be useful.

Availability of Information

Responses were mixed – some respondents felt that they had excellent access to information, usually as a result of where they worked or the networking groups they attended, where as others felt they received little or no information.

For those who felt they did have good access, this was often because they were part of an organisation that had information regularly sent to them (e.g. strategy and research documents, mental health information leaflets for passing on to the public):

> *"Yes, we have plenty of information to give out. We get stuff from the Ministry of Health, networking groups, Mental Health Foundation and you hear about things by chance"*

Others had a good awareness of where information was held and proactively sourced their own information. They felt that there was plenty of information available:

> *"The information is out there if you know where to look"*

For those who did not have good access to information it was common for them to have little awareness of what was available and where to access it. For some this was not a problem because they did not need this information for their work. However others felt they needed more information but did not have access to it.

> *"If it is available it's not publicized. People don't know its there".*

> *"We don't get information on how to access services. The practical stuff is missing".*

Types of information available

A number of types of information, and information sources, were identified:

- Ministry of Health (Strategies, research documents, statistics, website information)
- Skylight (excellent resources on mental health and suicide including practical and easily readable information to pass on to the public)
- Mental Health Foundation (mental health information leaflets)
- Living Works (information received during ASIST suicide prevention training course)
- SPINZ (Suicide Prevention Information New Zealand) website (information and research articles on suicide prevention. SPINZ also deliver an annual Suicide Prevention Symposium which is seen as excellent source of free up to date materials

- Like Minds Taranaki (range of information with lots of information about local services). Also produce a local "Directory of Mental Health Services".
- Lifeline and Youthline were also seen as sources of information for those working in the mental health sector

Information that would be useful

- More information about local services to give to mental health consumers and their families
- More information for families about what to do in a crisis and where to get help
- Regular statistics about suicide trends to inform preventative work
- Information about local suicide prevention and mental health awareness training to be advertised more widely

Dissemination of information

Several respondents identified the need for a good system for disseminating information locally. They felt that there was adequate information already available but not everyone had access to it.

> *"It would probably be useful to have a system for disseminating information out to those who don't have access to it through existing networks"*

> *"The current system of dissemination is hit and miss. We all think everyone knows about services but it would be good to have a central place, like WAVES but for mental health, to help coordinate services, support groups and information. This would help small regions like us to share information"*

When asked whose role it should be to disseminate such information, a number of suggestions were made. It was generally agreed that this should not be the role of one person, due to sustainability issues, but rather an organisation or group.

Groups or organisations that were suggested included:

- Ministry of Health (distribution of statistics in particular)
- Taranaki Suicide Project (TSP)
- Health Promotion Unit
- Like Minds Taranaki
- A central mental health information and resource centre
- WebHealth – but from an information centre (like the previous WebHealth Linkage centre, now closed) as opposed to just a website.

4.4 Suicide Prevention in Taranaki – Gaps in Service Provision

4.4.1 Promoting mental health and wellbeing, and preventing mental health problems

Young people were identified as the main population group for whom gaps existed in the mental health promotion area. Older people and those living in rural areas were the other groups for whom gaps were noted.

Young People

Awareness raising in schools – A number of respondents felt that there was a need to talk more about suicide prevention in schools and to raise awareness of where young people could access help (e.g. "IT'S OK TO ASK 4 HELP" or other similar programme). The need for more programmes to develop resilience and coping skills, particularly in secondary schools, was also highlighted

Expand WAVES – The majority of people interviewed said that they would like to see WAVES youth service expanded, both in terms of having larger premises in New Plymouth and expanding into central and rural Taranaki. If the service remains in the current building, it has been suggested (by young people in Stratford) that the health service be accessed by a separate rear entrance as it can be intimidating for new people and those from out of the area to walk past the social area to see the nurse. WAVES was described as a valuable service for young people that should be funded to provide more for Taranaki youth. It was also seen as a safe place by young people where they could hang out and feel accepted. As one young person stated:

> *"I'd like to see more support for places like WAVES because I don't feel weird coming here to help myself"*

Support with identity issues – Several respondents suggested that there was a need to work with young people, particularly young males, to support them with growing up and finding their identity. Problems relating to a lack of 'rites of passage', particularly for young Maori males, was identified by some people. They suggested that there was a need for more Marae based activities, peer mentoring and residential trips for young Maori males to strengthen cultural identity and self esteem.

More 'Youth Friendly' services – While young people felt that there was a need for additional youth services (such as WAVES), they also highlighted a need for existing services to become more youth friendly and for staff in schools to become more understanding of mental health issues among young people.

> *"There needs to be more places for youth to express themselves. Also need a confidential, comfortable and safe place for youth to go, but not set up as a stereotypical place to help youth"*

> *"Teachers need to be more understanding and schools need a suitable venue for people to go to"*

Older People

Retirement planning – The difficulties faced by older people at retirement was highlighted as a key cause of depression, and potentially suicide, among older people. The need for a local retirement planning programme to help prepare older people for retirement was identified. The challenges that retirement brings are summed up by this respondent's comment:

> *"They [work colleagues] all said when I left that they'd keep in touch but no-one does because they are all so busy with their own lives and suddenly these people that you saw every day, who needed you and came to you with their problems and concerns, you just don't see them. I'd lost my total identity and I wish someone could have prepared me for that. It just hit me like a brick. It probably took me about 2 years to adapt to it and find other things to focus my time on. But in that time I became depressed and just felt useless"*

More awareness raising:

Rural areas - The need for more information about mental health issues and services in rural areas was identified. It was felt that creative ways would need to be developed in order to reach farmers and others working in the agricultural sector. Suggestions included more roadshows (like the recent Like Minds Taranaki Stress in Rural Communities road show) and running a mental health awareness campaign on the radio, advertising services such as Lifeline, during periods that farmers are most likely to be listening to the radio (e.g. during milking times).

General awareness raising – Most respondents felt that there was an ongoing need for more awareness raising around mental health issues to reduce stigma and discrimination and to encourage people to use services.

> *"Big employers offer the Employer Assistance Programme but stigma means that people are not accessing it. There's a 'get on with it' attitude at work that puts people off going to counsellors"*

4.4.2 Improving the care of people who are experiencing mental disorders associated with suicidal behaviour

When respondents identified gaps relating the care of people who are experiencing mental disorders they were either linked to particular population groups, or to services. In terms of population groups, young people, families/whanau/carers and those living in rural areas were highlighted as being at most need. With services, gaps were identified in mental health services (particularly 'crisis services') and primary care services. However, gaps where also highlighted within those services who did not provide mental health care as their core business but whose clients often faced mental health issues.

Many of the needs that were identified would require additional funding to be met but respondents often pointed out that this would bring longer-term savings (through early intervention and crisis prevention).

Needs of Young People

Child & Adolescent Mental Health Services (CAMHS) – Expand CAMHS to provide support to a wider group of young people so that mental health issues are picked up and responded to earlier. CAMHS could provide more support to school teachers and guidance counsellors in how to meet the needs of young people with mental health issues. However, one young person commented that it was important that they were not 'labelled' as a result of using adolescent mental health services:

> *"We shouldn't be supplied with drugs that there is nothing known about. We shouldn't be labelled either"*

Attention Deficit Hyperactivity Disorder (ADHD) – More support for families who have children diagnosed with ADHD but whose needs are not great enough for them to be linked to a mental health/ADHD worker

In-patient services – The ward at Te Puna Waiora was felt to be an unsuitable place for young people who need to be admitted to hospital and many respondents were concerned that young people could become 'revolving door' patients (being repeatedly admitted to hospital). Alternatives such as an adolescent unit or a crisis 'retreat' centre were suggested.

Needs of Families/Whanau and Carers

Supporting Families – Expand Supporting Families so that more staff are available to work with families/whanau. This was seen as particularly important because families often become the main source of support when clients' needs are not met by services. Caring for people who are suicidal is particularly draining and many saw Supporting Families as a key source of support for such carers.

Caring for Carers Training – A number of respondents felt that there was a need to provide Caring for Carers training where carers, or other individuals, could be trained to provide support for other carers as well as to become more effective carers themselves. The concept of carers supporting each other was seen as an important means of sustaining carers ability to continue in their caring role and to support them in setting up local support groups for example. The 'Greef model' was suggested by a number of respondents as an excellent carers' training resource.

Needs of people living in rural areas

Follow-up care for mild-moderate mental illness – More proactive follow up needed for people in rural areas who are diagnosed by a GP or Psychiatrist with mild-moderate mental illness such as anxiety and depression. Follow up is considered necessary to check medication is working and that the person's condition is improving. Lack of follow up has been identified as a problem particularly in South Taranaki where rural isolation

and the self-reliant attitude of farmers mean that they tend not to return to their doctor even if their condition does not improve.

Needs of non-mental health service providers

Mental health/suicide awareness training – A number of service providers reported that although they were not mental health providers they inevitably dealt with clients who experienced mental health problems as a result of other issues in their life (e.g. family violence, physical health problems, poverty, etc.) They felt that their was a need for mental health services to acknowledge the role that they played in supporting people with mental illness and to provide training to help them to provide that support more effectively. Training should include information about different mental illnesses and their symptoms, effects of medication and when and where to get help. Some service providers said it was a struggle sometimes to know whether a client was exhibiting symptoms of a mental illness or whether it was a normal reaction to their other problems. Often they did not have knowledge of pre-existing mental health conditions and this made supporting their clients very difficult. As one family violence service provider stated:

> *"Women who are abused often have mental health issues. We need training to support them but we only receive DV* [Domestic Violence] *training"*

> *"There needs to be more recognition of the mental health issues we deal with and the funding to support this. We need training"*

Some service providers pointed out that due to the long-term relationships they often built up with their clients they would occasionally become the first point of contact if a client was suicidal. This was either due to the trust that existed between the worker and the client, or the fact that the worker had noticed a recent change in the client's mood or behaviour and enquired about it. One service reported that their workers had taken calls during the night from clients who became suicidal. Their workers did not have mental health training and were not counsellors. One of the difficulties faced by services such as this was the cost of training to equip workers to respond effectively in crisis situations. One respondent, speaking about suicide prevention training, stated:

> *"There was a clear need, that we were dealing with kids who self harm and are at risk of suicide, but the cost was out of our reach"*

Links with wider support services – Improve links with other (non-mental health) support services to enable the broader needs of people with mental illness to be met. Wider support services that were identified included those that supported people with physical health issues and illness, disability, gambling, relationship problems and financial issues. A number of people suggested that referrals to these services should form part of the care package for people with mental illness so that their broader social needs are met.

Primary Care

General Practice – A number of respondents felt that there was a need for more education among GPs about what to look out for and where to refer people with mental illness. As one respondent stated:

"You need to educate GPs at primary care level on what to look out for and to refer appropriately"

They also felt that there needed to be more treatment options, not just medication. Although it was acknowledged that some GPs offer exercise (e.g. Green Prescription) and counselling as options, there was a feeling by some that medication was often a treatment of first choice.

However, those GPs interviewed felt that they were very aware of depression and suicide. Some used depression screening tools, and one GP peer group had spent time reviewing a number of different depression screening tools. Some of the GPs commented that their relationship with the crisis team, psychiatrists, counsellors and other mental health services was very good. However, one GP did acknowledge the difficulty of picking up mental health issues in a practice setting:

"It's very hard. We don't always get it right. Easy access to a second opinion is very necessary".

Mental Health Services

<u>*Crisis Service*</u> – Gaps in crisis care in South Taranaki were often raised. Some respondents commented that there was no crisis service available in South Taranaki after 11pm and individuals experiencing a crisis would need to be taken to ED at Taranaki Base Hospital (New Plymouth). Patients seen at Hawera Hospital would also need to be transferred to Taranaki Base if they required admission. One respondent pointed out that this gap in service provision had a knock on effect to other services:

"Mental health crisis support in South Taranaki is non-existent. When you ring, by the time they arrive it can be too late so other services end up picking up the pieces"

Some respondents also highlighted a need for more crisis care options for people who are feeling suicidal (i.e. in addition to in-patient admission).

Where individuals are exhibiting suicidal behaviour it is common for the police to be called. Some of those interviewed had contacted the police because a crisis situation was escalating and they felt the police would respond the fastest. In such a situation the police will call the crisis team in to carry out a mental health assessment. Where an individual's condition is further complicated by substance abuse they are commonly left in the care of the police. This causes particular difficulties for the police because while they can respond to criminal behaviour (e.g. violence) they are not equipped to manage mental health problems. In this situation the responsibility for keeping the person safe from self-harm falls onto the police.

<u>*People with moderate mental illness*</u> – The unmet needs of those who fall outside of the 'top 2%' seen by Taranaki DHB Mental Health Services were frequently raised by respondents. This group was described as having mental illness that was not severe enough to meet the criteria for many DHB services, as well as other services (such as

supported accommodation). However, their mental illness was often severe enough to prevent them making use of other community mental health services.

Lack of service choice – Concerns about lack of service choice usually related to privacy. Some consumers did not want to use services in their local area, due to privacy reasons, but were often unable to travel to other areas to access another service. For one Maori respondent concerns about privacy were compounded by the choice of service being inadvertently limited to Maori providers:

> *"Assumptions are made that Maori will want to use a Maori service. … He was not asked if this is what he wanted. He didn't want to use a Maori service as people would know him and he knew them. He wanted a non-Maori service for his privacy. In the unit they will assign Maori patients a Maori worker, they should ask if they would prefer this"*

4.4.3 Improving the care of people who make non-fatal suicide attempts

Two key issues were raised regarding the care of people who make non-fatal suicide attempts. The first of these related to the care of the person who made the attempt and the lack of follow up after the attempt. The other issue raised was the lack of support for families/whanau affected by the suicide attempt.

This section only focuses on follow-up care for the person who has made the suicide attempt. Issues relating to lack of support for families/whanau are presented in Section 4.3.6 – *Improving the care of families, whanau and carers affected by a suicide or suicide attempt*).

Follow-up care

Emergency Department/hospital discharge – Most concerns around follow up care were related to patients who were admitted to the ED or a hospital ward following a suicide attempt. Those who presented at ED and were known to mental health services would typically be admitted to the ward or discharged and followed up by their key worker. Those who were new to services should have a mental health assessment and follow arranged as needed. However, some respondents expressed concern that in many cases this follow up care did not happen and that the ongoing care fell mainly on to families. This example was given by one worker who supported a family after their daughter's overdose:

> *"…the mother wanted support at discharge but the planning meeting didn't take place and her support needs were not identified. Most of the care ends up falling on to the families and NASC* [Needs Assessment and Service Coordination] *is just not happening"*

Respondents identified another consequence of the lack of follow-up care being repeated admission to ED for self-harm:

> *"The same people keep going into ED again and again. Why?"*

Short-term nature of follow up care – another key issue highlighted in this area was that follow up care was too short-term. Several respondents felt that once individuals showed any kind of improvement they no longer fitted the service criteria and support would be withdrawn, leaving them at risk:

> *"They won't keep you in services if you don't fit the criteria and you then need to wait till you fit the new service criteria before you can get back in. This can be a long process with little or no support in between"*

> *"If you get into a service the support is short term and there's no follow up. If you don't fit in the box you get nothing"*

Many of the organisations interviewed felt that they were dealing with clients who did not "fit in the box" and who remained at risk of self-harm and suicide. They felt that a client's needs would only be picked up if their suicide attempt was serious enough to warrant entry to a mental health service and even then the support was only short term. Some respondents suggested that better linking with the NGO sector as part of the discharge support package would improve the support that people receive in the longer term.

4.4.4 Reducing access to means of suicide

Suggestions around what more could be done to reduce access to means of suicide were very limited, largely because respondents generally felt little could be done to prevent suicides among those who were determined to end their lives. A small number of respondents suggested the following methods:

Centre City (New Plymouth) – Installing netting around the multi-storey car park at centre city as previous suicides through jumping have occurred there.

Restricting access to over the counter medications – Introduction of national legislation to reduce pack sizes and limit over the counter sales of potentially harmful household medications (e.g. paracetamol).

Alcohol sales – Stricter enforcement and penalties for selling alcohol to under 18's, and enforcement initiatives that reduce availability of alcohol (e.g. making it harder to get a liquor licence).

4.4.5 Promoting safe reporting and portrayal of suicidal behaviour

Many respondents identified a need for local media (particularly newspapers) to take a more proactive role in raising awareness of mental health issues and highlighting the availability of local mental health and other support services.

A number of respondents felt that local media should be more open about suicide but cover stories in a positive way, for example focusing on local recovery stories and 'real life' stories of 'celebrities' who have been suicidal but accessed help and can share their experiences.

Some of the young people interviewed agreed that the newspapers could play a greater role in promoting 'positive' stories about young people with mental health problems, and that young people would find this useful:

> *"More stories about what people have gone through and what helped them"*

4.4.6 Supporting families, whanau, friends and others affected by suicide or suicide attempts

Three main themes were identified in the area of support for families, whanau and others affected by suicide attempts. The first of these related to lack support for families/whanau affected by suicide *attempt* (as opposed to completed suicide). The other two issues were around ongoing needs of families/whanau and the unmet support needs of the wider whanau or community following a suicide.

Support for families and whanau affected by a suicide *attempt*

Those family/whanau members that were interviewed felt that there was little or no support for families who were affected by a suicide *attempt*. Families commented that they often did not know what support was available, or did not recognize at the time that they needed help. For some families their need for support arose at a later date. When asked what could be done to support families one respondent replied:

"Raising awareness of what is available, also who is a victim. I didn't know I was a victim and it was only until later that I really needed the help, but I didn't know that I needed it if you know what I mean. If you don't know you are a victim, and you don't know what help is out there you just don't get help"

One respondent felt that, because they were Maori, there was an assumption that their needs would be met by their whanau:

> *"An assumption is made that a kaumatua would just come and give you a cuddle and this big whanau would be there to support you. What about those families that are disjointed, and where people can't cope and are just seeking to blame each other?"*

Another respondent highlighted the long-term impact of attempted suicide on the health of the family:

> *"There was no support for us while our son was attempting. There was support for my son but I was not happy with it and we felt let down. There is a long term impact on your health of dealing with attempted suicides and families need more support with it"*

Ongoing support for families and whanau affected by suicide

Lack of longer-term support was identified as the greatest need faced by families following suicide. Many of the support services available to families were immediate crisis services (e.g. Victim Support) and, apart from the Bereaved by Suicide support group,

there was nothing available specifically for families affected by suicide. It was noted that some people would not feel comfortable sharing their experiences within a group and that some kind of one-to-one support would be better. Cost, and a lack of awareness of available services, were identified as the key barriers to accessing counselling schemes. Making free/low cost grief counselling more readily available, and better advertising of PHO counselling voucher schemes, were seen as possible ways of improving the support available to families. It was also acknowledged that for some families this need for support may arise again at a later date and that family/whanau members may need to be referred for grief counselling months or even years after a suicide death.

Support for whanau, friends and wider community

The lack of support, both short and long term, for wider family/whanau members, friends and others affected following a suicide was raised by many people. There was a general feeling that support services focused purely on the immediate family, particularly partners/spouses and parents.

> *"One of our clients committed suicide and his father was known by mental health services so all of their focus went on to him and his needs. The stepmother was distraught but because she wasn't his real mother there was nothing there for her. She was just ignored"*

> *"Sometimes the focus is all on the family but the person's friends and work colleagues may have been even closer but no-one even speaks to them. How do we reach these people?"*

Some noted a lack of specialist support for children also. One respondent commented:

> *"They don't know how to deal with children. They've got no idea, so they do nothing"*

Respondents felt that there was a need for more awareness raising about the impact of suicide on a wide range of people encouraging them to come forward to get help. One respondent suggested the introduction of "community wrap around" support teams whose role was to support communities affected by suicide and strengthen their ability to look after each other as well as the family affected by the suicide.

A need was also identified for more support groups across Taranaki that could offer emotional support as well as information about the grieving process, legal matters, financial assistance and other relevant issues.

4.4.7 Expanding the evidence about rates, causes and effective interventions

The main need identified in this area was around communication and dissemination of information. A number of respondents felt that adequate information was available but that it was often a case of knowing where to look in order to find it. Those service providers who were part of existing local networking groups or who were linked into national organisations generally felt well informed. However, two main groups with a need for more information were identified.

Non-mental health service providers - Those who were not so well informed tended to be those service providers who did not provide mental health services as their core business but who felt they needed more mental health information due to the fact that so many of their clients experienced mental health problems. A small number of mental health providers also felt that they needed more information about suicide prevention in particular, such as local suicide statistics and information about effective suicide prevention initiatives. The need for a central source of information in Taranaki was identified.

Service users, families and carers – Improved systems for getting information out to service users and families was highlighted as an urgent need. Service providers felt that there was a lot of information available; including information about mental illness and local services, but it was easy to assume that everyone knew about these. Mental health professionals and primary care professionals were seen as having an important role to play in disseminating up-to-date information. Local resource centres, like the old Webhealth Linkage centre (now closed) were seen as another means of getting information out. Several people suggested that the Like Minds Taranaki Mental Health Directory should be made more available in public places.

Chapter 5: Suicide Prevention Training & Coordination

5.1 Overview

During the needs assessment stakeholders were asked additional questions about suicide prevention training in Taranaki and coordination of suicide prevention activities at the local level.

Although training and coordination are not listed as one of the seven goals of the national Strategy, they are important strategies in their own right. Training will be necessary to equip health professionals, community gatekeepers, support workers, carers and others with the skills needed to deliver suicide prevention activities locally. Coordination will also play an important role in ensuring that local funding, planning and delivery of suicide prevention activities are carried out efficiently, equitably and in a way avoids duplication. It will also optimise the communication between different service providers to ensure that the multiple needs of those who experience suicidal behaviour can be met.

By exploring the current situation with regards to training and coordination, New Plymouth injury Safe Trust was also keen to find out whether there were any opportunities for the Trust to become more involved in supporting suicide prevention initiatives at the local level.

5.2 Training

Stakeholders were asked the following questions:

- Is there adequate training available for those who work with, or care for, people at risk of self-harm and suicide?
- What training is available? Is it helpful?
- What additional training is needed?

Is adequate training available?

The vast majority of those questioned felt that there was not adequate suicide prevention training available. Although some had been on the ASIST (Applied Suicide Intervention Skills Training) they felt that ongoing training was needed both for themselves and others working in the field. Respondents often complained that training was sporadic and it was hit or miss whether you heard about it. The lack of an ongoing 'training schedule' was noted by some people. However, the biggest barrier to accessing training was the cost, particularly for smaller NGOs and voluntary based organisations. This cost was often compounded by training being held outside of Taranaki:

> *"There's training out there, but it's too expensive"*

"There was the BluePrint training in Hamilton. It's excellent training but it costs too much, especially when you allow for travel and accommodation as well"

A number of people commented that the ASIST training should be available to all (i.e. the general community) but that the cost, even though heavily subsidized at $75 for 2 days, would be a barrier to some 'community people' and volunteers:

"The ASIST training is not open to everyone, there's a cost involved, and if you're not part of an organisation or whatever that is picking up the bill then some people will not be able to afford to go. It needs to be free for community people"

Others felt that some organisations would even struggle with the cost of the programme:

"ASIST needs to be offered more but $75 excludes some organisations, especially if you are like us and want to send all of your staff. All NGO's struggle financially and training can be really expensive"

Those who did feel that they had access to adequate training tended to be those employed by the larger organisations (e.g. Taranaki DHB, New Plymouth Prison, etc.) that had access to a range of in-house training. This training tended to focus more on mental health issues as opposed to suicide prevention in particular (although the prison trains all new staff in suicide awareness, first aid and suicide prevention as part of a national training initiative). The importance of training being backed up by adequate resources and ongoing supervision was noted by one organisation:

"There's lots of training available, but what's needed is follow up - making sure resources are in place, embedding skills and using the things you have learnt. Resources are sometimes put into training but not into the continuation of that learning"

What training is available?

The main suicide prevention training that was identified was as follows:

ASIST (Applied Suicide Intervention Skills Training) – this programme consists of a two-day workshop run by Living Works that trains participants to recognise and respond to those at imminent risk of suicide. The target audience for the programme is community workers who may come into contact with people at risk of suicide through their day-to-day work. The course covers issues such as recognising signs of suicide, identifying suicide risk and supporting suicidal individuals to seek professional help. An evaluation of ASIST in New Zealand showed that the programme enhanced the skills of participants to provide proactive help in situations of imminent suicide risk.[54] The ASIST training programme was organised in Taranaki by the Bishops Action Foundation but ended in April 2008 when funding run out. Any future ASIST training programme in Taranaki would be dependent on obtaining adequate funding.

[54] Hyde P, Innes-Kent S, Mason N. 2006. Report of the evaluation of The Living Works ASIST Programme: Unpublished report produced for LifeLine Auckland

BluePrint – Those who had attended BluePrint training felt that the suicide prevention and mental health training offered was excellent, however the cost of the training, and the additional costs associated with travelling out of area to attend the training were seen as a barrier to some organisations.

Victim Support (general training for volunteers) – The training given to Victim Support volunteers includes a section on suicide prevention.

Victim Support (additional training) – Victim Support recently organised some suicide prevention training in South Taranaki for their volunteers. A local Funeral Service has provided training to Victim Support volunteers in the past.

NZGG Emergency Department Training – Training was provided to ED staff as part of the Taranaki DHB's Whakawhanaungatanga Self-Harm Collaborative project. The training was based on NZGG best practice guidelines for assessment and treatment of people who present at ED and other services following self-harm or suicide attempt.

Department of Corrections Suicide Awareness Training –Suicide awareness training is provided to all new staff, including those at New Plymouth Prison. This training includes suicide awareness, identification or risk factors, first aid and how to deal with those who have attempted suicide. Annual suicide awareness refresher training is provided to staff as part of the Department of Correction's national training programme. This training is one of a number of suicide prevention initiatives run within the Department of Corrections. Suicide rates in custody have fallen in recent years and New Zealand rates are lower than those in Australia, Canada, England/Wales and Scotland.[55]

SPINZ (Suicide Prevention Information New Zealand) Suicide Prevention training – SPINZ offer a one-day training course that provides and overview of suicide prevention using research evidence to highlight suicide risk factors, population groups at highest risk and current evidence of effective interventions. A recent one-day SPINZ training session for those working with young people was organised by the Health Promotion Unit. SPINZ deliver the training for free while the host organisations covers the cost of venue hire and catering as well as advertising the course locally.

What additional training is needed?

When asked what additional suicide prevention training was needed, respondents identified a need for affordable suicide prevention training and for an ongoing suicide prevention training programme (including refresher training). They felt that this training needed to be well advertised and targeted to all people, not just those working in mental health settings. Many respondents wanted the ASIST training to continue to run in Taranaki but suggested that the course be offered free to those people whose organisations could not fund the course, or who were community members on low incomes.

Some respondents identified a need for targeted training, designed for specific settings and population groups (e.g. training for teachers and others working in schools, rural groups, etc.). Due to the high cost of many current training packages it was suggested that a local training package be written and delivered. This would allow training to be

[55] Department of Corrections: Annual Report 2007

designed for specific groups in Taranaki. Training could also be delivered by local people (e.g. training delivered by farmers to farmers). A number of respondents felt that an approach such as this would allow Taranaki to offer affordable training that was targeted to the needs of local people. It would also allow training to be delivered in various settings (e.g. schools, rural communities) which would make it more accessible.

General mental health awareness training was seen as a particular need for those who worked in organisations who did not deliver mental health care but who often dealt with clients who were experiencing emotional distress or mental health problems (e.g. Women's Refuge). A need for more mental health awareness training was also highlighted for organisations such as WINZ that often dealt with mental health consumers who may be exhibiting different degrees of distress.

Caring for Carers training was suggested by a number of respondents who felt that this would enable support for carers to expand. The support needs of families and carers came up repeatedly during the needs assessment and the delivery of a Caring for Carers training package was seen by some as a starting point to empower and enable carers to support each other in their caring role.

5.3 Coordination

Stakeholders were asked the following questions:

- Are you aware of any local networks or partnerships that have been set up to address suicide prevention, or who you feel could have a positive impact in this area?
- How well does the network/partnership currently function?
- What would help to strengthen it?
- Is there a need for more partnerships? If so, what would these look like?

What local networks or partnerships have been set up to address suicide prevention?

Many of the stakeholders questioned were not aware of any local partnerships that had been set up to address suicide prevention. However, a number of people identified the Taranaki Suicide Project (TSP) as playing an important role in this area. A small number of stakeholders also suggested that the Mental Health Networkers Meeting could play a potential role in coordinating suicide prevention initiatives.

Taranaki Suicide Project – The group serves the North Taranaki area and, until recently, met every couple of months to share information, coordinate activities, advocate on policy issues and work together on suicide prevention initiatives. The group is made up of a number of organisations including Like Minds Taranaki, HELP Trust, Ministry of Social Development, Problem Gambling Foundation and Supporting Families among others.

Mental Health Networkers Meeting – This group meeting is open to anyone working in the mental health field, or with an interest in mental issues. The group provides an opportunity to share information and to improve coordination in local activities.

How well does the partnership function

A number of stakeholders expressed concern that the Taranaki Suicide Project was not functioning as well since the funding for the HELP Trust's paid coordinator had ended (when funding for the 'IT'S OK TO ASK 4 HELP' programme ended).

Some stakeholders commented that a meeting had not been held for a while and they were not sure if the group was continuing. The group was seen as facing a number of challenges at the moment, including a lack of coordination and administrative support to organise meetings. Those who were regular group members were keen to see the Taranaki Suicide Project continue and felt there was a need for ongoing coordination in local suicide prevention work.

The Mental Heath Networkers meeting was seen as running successfully because it was so well attended by a wide range of individuals and was well organised (by Like Minds Taranaki).

What would strengthen the partnership?

Members of the Taranaki Suicide Project identified two main areas where the group could be strengthened:

Direction – Some members commented that the project needed to re-establish a new sense of direction following the withdrawal of funding from the HELP Trust. Some suggested that the group needed to identify some new projects to work on to bring the group together and provide a focus for their work.

Administration/Coordination – The need for more support with administration and coordination of the group's activities was identified. It was noted that all of the members on the group were busy people for whom suicide prevention was often not their main role. A small amount of administrative support, to organise meetings and to take minutes, was seen by some as an important means of getting the group re-established and functioning well.

Is there a need for more partnerships?

The need for a partnership across Taranaki to improve coordination of suicide prevention planning and delivery was seen by most people as a good idea. However, most stakeholders felt that a single Taranaki wide group would not work. Most people suggested a group in the North and one in the South in order to ensure representatives from the smaller NGO's and other community organisations could take part, and to reflect the different needs across Taranaki. Some stakeholders from South Taranaki expressed concern that a single group would inevitably be held in New Plymouth and reflect New Plymouth interests.

The Taranaki Suicide Project was seen by many as a good starting point for a coordinating group in the North. There currently appears to be no similar group in existence in Central or South Taranaki.

Chapter 6: Service Mapping against National Suicide Prevention Action Plan 2008

The following mapping exercise has been carried out to highlight current activities taking place in Taranaki that are linked to the New Zealand Suicide Prevention Action Plan 2008-12 and to identify potential opportunities for future action. The mapping process uses the rationale and specific approaches identified in the national Action Plan and attempts to translate these into opportunities for local action.

Many of the listed actions in the following tables are being carried out at the national level, led by the Ministry of Health and other government agencies. However, these national actions have been included in the mapping to provide insight into how they will impact locally and how their implementation could be facilitated. They also give a feel for how local programmes and initiatives are being supported by higher level strategic approaches that aim to coordinate policies and actions across government agencies.

As with the national Action Plan itself, the opportunities for action that have been identified in the mapping process are not intended to be prescriptive. They exist to inform and support local agencies and strategic partnerships who would like to become more involved in planning, funding and delivery of coordinated approaches to suicide prevention across Taranaki.

Goal 1: Promote mental health and wellbeing, and prevent mental health problems		
Key action area: **Promote mental health and wellbeing, and prevent mental health problems**		
Key outcomes: **Reduced risk and increased resilience in the following policy areas: Childhood and family; life stress and trauma; social cohesion and support; discrimination; alcohol and drugs; socio-economic inequalities; cultural identity**		
National Actions	**Current Initiatives**	**Future Opportunities**
1.1 Strengthen mechanisms for interagency collaboration and cooperation to ensure that issues relating to suicide are recognised and incorporated into both policies and programmes, and their evaluation	-Taranaki Suicide Project (multi-agency suicide prevention coordination group for North Taranaki) -Collaboration between government agencies at national level to address policy areas linked to suicide prevention	-Improved collaboration between local suicide prevention coordination groups (e.g. Taranaki Suicide Project) and other relevant interagency groups including Mental Health Local Advisory Group, Family Violence interagency groups and New Plymouth injury Safe Trust -Identify processes that enable suicide prevention to be considered within Taranaki DHB Planning & Funding mental health contracting processes and District Council strategic planning processes (e.g. Long Term Council Community Plan – LTCCP) -Development of a South Taranaki suicide prevention coordination group -Facilitate the development of a coordinated regional plan to address suicide prevention in Taranaki
1.2 Develop structures to ensure that all policies and programmes are appropriate and effective for Maori	-Implementation of the He Korowai Oranga: Maori Health Strategy (2002) at local level, led by Taranaki DHB (Maori Health Team)	-Maori representation on Taranaki Suicide Project group and other local suicide prevention coordination groups -Work with and support Maori communities and service providers to develop kaupapa Maori initiatives that promote mental health through programmes that strengthen whanau, hapu and iwi and enhance positive cultural identity
1.3 Include a focus on reducing inequalities in policies and programmes that may contribute to suicide prevention	-Use of health equity assessment tools to measure effect of new programmes in Taranaki -Local mental health promotion programmes running in Taranaki in the following areas with a focus on young people and family, life stress and trauma, social cohesion, discrimination, alcohol and drugs, socio-economic inequality and cultural identity	-Taranaki Suicide Project to advocate on behalf of those most affected by inequalities highlighting links between inequality, poor mental health and suicide -Increased collaboration between local government departments to develop local policies and programmes to reduce inequalities -Continuation and expansion of existing successful mental health promotion programmes and development of new programmes for specific target groups at risk of suicide (e.g. youth, Maori, those in rural areas)

Goal 2: Improve the care of people who are experiencing mental disorders associated with suicidal behaviour		
Key action area: Population-based strategies		
Key outcomes: **Reduced stigma and discrimination and improved understanding about mental health problems** **Improved community responsiveness to people with mental health problems** **Improved access to and effectiveness of services for those experiencing mental health problems**		
National Actions	**Current Initiatives**	**Future Opportunities**
2.1 Implement population-based strategies, including mental health and depression awareness, mental illness destigmatisation and telephone counselling	-Like Minds, Like Mine programme delivered by Like Minds Taranaki and Toi Ora -Lifeline telephone counselling service -Mental Health Awareness week activities -Like Minds Taranaki Stress in Rural Communities roadshow	-Explore opportunities for development of a mental health and depression awareness campaign targeting the rural and agricultural sector -Continue Stress in Rural Communities roadshow programme -Link local campaigns with national depression awareness and destigmatisation campaign to enhance impact
2.2 Evaluate the effectiveness of these population-based programmes in leading to improved mental health outcomes and associated reductions in suicidal behaviours. This action includes evaluating effectiveness for Maori specifically.	-Evaluation of local population-based programmes by service providers -Review of telephone counselling services (e.g. Lifeline) to be carried out by Ministry of Health	-Disseminate findings of national evaluations of telephone counselling services at local level -Run a series of mental health awareness workshops and seminars across the region to share information on effective population based programmes and to explore future opportunities for increased delivery of such programmes -Provide local training in evaluation techniques to support providers to carry out effective evaluation
Key action area: Community-based approaches		
Key outcome: **Improved responsiveness of key community 'gatekeepers', to identify those who are experiencing mental health problems associated with suicidal behaviour and to facilitate help-seeking**		
2.3 Review current guidelines, programmes and initiatives for community, institutional and organisational workers	-Living Works ASIST training programme -SPINZ suicide awareness training -Victim Support training programmes	-Seek funding to continue delivery of ASIST training programme locally -Delivery of SPINZ one-day suicide awareness training as required -Explore opportunities for development of training packages for targeted groups (e.g. school staff) to increase understanding of suicide prevention so they can make a safe and effective contribution

National Actions	Current Initiatives	Future Opportunities
2.4 Where necessary, develop, implement and evaluate new programmes, initiatives or best practice guidelines. This action includes evaluating whether programmes, initiatives or guidelines are culturally appropriate and effective for whanau, hapu, Iwi and Maori communities	-New national community-based mental health literacy programme to be launched by Ministry of Health during 2008	-Support implementation of the new community-based mental health literacy programme through Taranaki
Key action area: Health services approaches		
Key outcome: **Improved mental health and addiction services**		
2.5 Continue to develop more and better mental health and addiction services as described in the New Zealand Mental Health & Addiction Plan for 2006-15 (Te Kokiri 2006-15) and its associated action plan	-Implementation of alcohol and drug service improvement initiatives as part of the New Zealand Mental Health and Addiction Plan 2005-15 being led by DHB in partnership with Ministry of Health	-Explore opportunities for increased collaboration with alcohol and drug service providers to develop local suicide prevention initiatives aimed at those with drug and alcohol problems
Key outcome: **Improved responsiveness of primary health care services to those experiencing common mental health and addiction disorders and suicidal behaviours**		
2.6 Develop, implement and evaluate a best-practice guideline for primary health care providers in the assessment, management and treatment of depression, other common mental disorders and suicidal behaviours. This guideline must include best-practice for providers working with Maori Tangata Whaiora	-Revised best-practice guidelines for the assessment, management and treatment of depression and other common mental disorders in primary health care, including suicide issues for different population groups, to be distributed by Ministry of Health in 2008/9	-Support implementation of the guidelines by identifying training needs of primary care and providing training as required -Develop and deliver training and education seminars aimed at primary care professionals to support effective assessment, treatment and management of mental disorders associated with suicidal behaviour
Key outcomes: **Improved access to health services for those experiencing mental health problems associated with suicide** **Improved responsiveness of primary health care services for those who are experiencing mental health problems associated with suicide**		
2.7 Develop, implement and evaluate demonstration projects aimed at providing integrated models of care. These projects will include a focus on increasing access to health services and supporting the better management of depression, common mental disorders and suicidal behaviour	-Taranaki Primary Connections (service coordination and referral to counselling services) -PHO Counselling voucher scheme	-Other effective models of care will be rolled out to local DHBs following national evaluation -Work with primary health care providers to implement new initiatives that promote mental health and assist with early detection of mental health problems associated with suicidal behaviour

Key outcome: **Improved service provision and transition care for those who are discharged from mental health inpatient services**		
National Actions	**Current Initiatives**	**Future Opportunities**
2.8 Develop, implement and evaluate interventions to reduce risks of suicide and suicidal behaviours among those experiencing mental disorders just prior to and following discharge from mental health inpatient services.	-Development implementation and evaluation of promising interventions being led nationally by Ministry of Health.	-Effective interventions will be rolled out to local DHBs following national evaluation -Hold a regional series of intersectoral forum/ seminar to facilitate sharing of information and good practice and to explore development of a coordinated approach to supporting those discharged from mental health inpatient services
Key outcome: **Improved and effective mental health and addiction services for Maori Tangata Whaiora**		
2.9 Develop a process to begin to evaluate the effectiveness of general population health services provide to Maori experiencing mental health and addiction disorders most commonly associated with suicidal behaviours	-Evaluation of general population health services and Maori specific health services for Maori at high risk of suicidal behaviour currently being carried out by Ministry of Health. Best-practice examples to be disseminated nationally.	-Best practice examples from national evaluation will be disseminated nationally -Work with Tui Ora Ltd. and Maori Mental Health Providers to develop local Maori-led research programmes -Hold a regional intersectoral forum/ seminar to allow opportunities to share information and good practice in mental health service for Maori
2.10 Develop a process to begin to evaluate the effectiveness of Maori specific health service provided to Maori Tangata Whaiora experiencing mental health disorders most commonly associated with suicidal behaviours		
2.11 Monitor new and/or emerging Maori models of health and, as necessary, evaluate whether the implementation of these models is effective		
2.12 Disseminate best-practice examples of implementing Maori models of care to Maori health providers		
Key outcome: **Improved and appropriate service delivery for Pacific peoples who are experiencing mental disorders and suicidal behaviours**		
2.13 Develop, implement and evaluate Pacific models of care for those in the Pacific population who are experiencing mental health and addiction disorders commonly associated with suicidal behaviours	-Consultation with stakeholders and development of Pacific models of care being led by Ministry of Health	-Roll out of effective initiatives by Ministry of Health through DHBs
Key action area: Institutional settings approaches		
Key outcome: **Improved responsiveness of care in institutional settings for those who are experiencing mental heath problems associated with suicidal behaviour**		
2.14 Continue to implement programmes, policies and strategies within institutional settings and, where appropriate, review and evaluate them and address any gaps identified. This action includes evaluating their effectiveness for Maori specifically	-New Plymouth Prison training for staff in assessment and management of prisoners at risk of suicide. -Improved assessment tools for identifying mental health problems, addiction issues and suicide risk in prisoners are being developed nationally	-Review and evaluation of institutional guidelines and programmes taking place at national level. Any outcome will be disseminated and implemented locally

Goal 3: Improve the care of people who make non-fatal suicide attempts		
Key action area: Improving the acute management of those who make a suicide attempt		
Key outcomes: **Improved care for those who present to an emergency department with suicidal behaviour** **Improved working relationships among emergency department staff, mental health services and Maori health services** **Improved collaboration among service providers, consumers/Tangata Whaiora and family advisors**		
National Actions	**Current Initiatives**	**Future Opportunities**
3.1 Continue to implement and evaluate the guidelines for the assessment and management of those at risk of suicide in acute settings	-Implementation and evaluation of the Whakawhanaungatanga Self-Harm Collaborative project in Taranaki DHB	-Cultural assessment tool currently being developed for use in the Collaborative project
Key action area: Improving the longer-term management of those who make a suicide attempt		
Key outcome: **Improved longer-term care for those who have made a suicide attempt**		
3.2 Develop, implement and evaluate the effectiveness of services and interventions for the longer-term care for those who have made a suicide attempt	-Dialectical behaviour therapy for women with personality disorder (pilot study in Taranaki) -Review and evaluation of current service provision to be led nationally by Ministry of Health	-National evaluation will lead to development of a plan for implementation of effective models locally
3.3 Develop, implement and evaluate the effectiveness of services and interventions for the longer-term care for Maori who have made a suicide attempt	-Scoping and evaluation of general population and Maori-specific service provision for Maori who have made a suicide attempt to be carried out by nationally by the Ministry of Health	-Development of future local services and interventions for the longer-term care of Maori who have made a suicide attempt to be informed by national evaluation of effective models of care
Key action area: Improving the management of suicide attempt in institutional settings		
Key outcome: **Improved care for those who have made a suicide attempt in key institutional settings**		
3.4 Review and, if necessary, revise and evaluate initiatives (including policies, procedures, screening, and assessment tools, forms and guidelines) for managing the aftermath of a suicide attempt in key institutional settings. This action includes evaluating whether these initiatives are culturally appropriate and effective for Maori specifically	-Taranaki DHB Sentinel Events Committee held following suicide of mental health service clients -Taranaki DHB, Police and New Plymouth Prison have guidelines, policies, protocols and assessment tools for identifying and managing suicidal behaviour and critical incident reporting and review processes	-National review of guidelines and programmes to be carried out. Outcomes to be disseminated and implemented locally in key institutional settings

Goal 4: Reduce access to the means of suicide		
Key action area: Hanging		
Key outcome: **Reduce risk of suicide by hanging in institutions by providing safe physical environments for people at risk of suicide**		
National Actions	**Current Initiatives**	**Future Opportunities**
4.1 Review and revise institutional policies for preventing and responding to suicide attempts by hanging, to ensure they meet international evidence-based best practice guidelines	-Review of institutional policies and procedures, and development of revised recommendations, being led at national level by Ministry of Health	-Implementation of recommendations locally in key institutional settings
Key action area: Vehicle exhaust gas		
Key outcome: **Reduced risk of suicide by poisoning using vehicle exhaust gas**		
4.2 Review the feasibility of incorporating changes into the vehicle fleet to achieve reductions in the rate of suicide attempt by vehicle exhaust gas	-Being led nationally by Ministry of Health through engagement with Ministry of Transport	-Undertake local advocacy and make submissions on proposed legislation changes as required
4.3 Consider the extent to which the regulation of vehicle exhaust might be changed by alignment with clean air and related policies	-Being led nationally by Ministry of Health through engagement with Ministry of Transport and Ministry for the Environment	-Undertake local advocacy and make submissions on proposed legislation changes as required
Key action area: Firearms		
Key outcome: **Reduced risk of suicide by firearms**		
4.4 Continue to promote awareness of personal responsibilities of gun ownership, including secure storage of guns and ammunition	-Publicity campaign promoting secure firearm storage to be led by New Zealand police	-Work in partnership with police in Taranaki to support publicity campaign at local level -Work in partnership with rural and agricultural sector to identify effective campaign approach to reach the rural and farming community
4.5 Strengthening monitoring checks of firearms security of licence holders during the 10-year licensing period and at change of address	-Mandatory security inspection at key points in the firearms licensing process to be implemented by New Zealand Police	-Implementation through local firearms licensing process

National Actions	Current Initiatives	Future Opportunities
4.6 Encourage health professionals to enquire routinely about guns homes, and to advocate for their removal from the home where patients are depressed or suicidal	-Taranaki DHB Mental Health Services have information sharing agreement with Police in Taranaki and arrange removal of firearms where patient is assessed as being at risk of suicide	-Development of policies and protocol to support other health providers in enquiring about gun ownership and taking steps to remove guns from the homes of depressed or suicidal clients
Key action area: Self-poisoning		
Key outcome: **Reduced risk of suicide by poisoning using medicines**		
4.7 Review the feasibility of tightening the regulations to reduce the risks posed by paracetamol	-Ministry of Health leading a potential application to the Medicines Classification Committee to tighten the regulation of paracetamol	-Support legislation changes through local advocacy and submissions as required -Any changes in regulations would be implemented locally as part of national initiative -Support any changes in regulation with positive advertising campaign at local level and dissemination of good quality, evidence-based information
4.8 Ensure that best practice guidance on the treatment of mental illness includes advice on prescribing less toxic medicines to individuals at risk of suicide	-Close-control prescribing used in Taranaki for patients at risk of suicide -Ministry of Health to ensure guidance included in all new and updated best practice guidelines	-Dissemination of updated best practice guidelines across mental health sector including NGOs and support organisations -Development of local information leaflets outlining best practice guidelines for distribution to patients, families/whanau and carers
4.9 Continue existing information campaigns and institute new ones to encourage the return of unused medicines	-Previous medication waste campaigns have been held in Taranaki -Questions and requests for information about medication waste included in a recent Taranaki DHB Medicines into the Future consultation	-Ministry of Health to develop and implement unused medicine disposal campaigns in partnership with DHBs -Work in partnership with community pharmacists and mental health sector to support unused medicine disposal campaigns at local level through multiple medication drop off points through Taranaki
Key action area: Jumping		
Key outcome: **Reduced risk of suicide by jumping**		
4.10 Undertake data surveillance to identify jumping sites that are emerging as favoured locations for suicide by jumping	-Data from Coroners database to be collected and analysed by Ministry of Justice and Ministry of Health to identify and respond to emerging trends	-Support any national requests for information

National Actions	Current Initiatives	Future Opportunities
4.11 Scope the need for guidance on managing favoured jump sites	-Ministry of Health to lead a scope of the need for information resources to manage jump sites	-Support any national requests for information -Disseminate information resources at local level as required
Key action area: Overarching actions		
Key outcome: **Increased surveillance of methods of suicide**		
4.12 Consider the feasibility of establishing a suicide mortality review committee with one of its roles being to report regularly on the relationship of method access to suicide and suicide attempt	-Mortality Review Committee (for sudden death in under 25's) in Taranaki -Feasibility of a suicide mortality review committee to be investigated by Ministry of Health and established if necessary	-Broad range of stakeholders to be involved in any newly developed suicide mortality review committee including Maori and rural sector representation if established at local level
4.13 Promote guidance to advise family, whanau and others who are caring for people at risk of suicide to remove potential mean of suicide, such as obvious ligature points, firearms and toxic substances (including unnecessary medications) from the home	-Supporting Families provide practical support and communication with families -DHB Family/Whanau Advisor provides strategic input to DHB policies -Ministry of Health and DHBs to ensure new and updated resources contain key messages about removing means of suicide from the home	-Take a collaborative approach across the mental health sector to support DHB with dissemination of new resources containing key messages of removing means of suicide from the home -Link this dissemination of resources with any other relevant campaigns (e.g. Police safe storage of firearms campaign, any changes in paracetamol legislation, etc.)

Goal 5: Promote safe reporting and portrayal of suicidal behaviour by the media		
Key action area: Collaboration		
Key outcome: **Greater stakeholder collaboration on the issue of suicide in the media**		
National Actions	**Current Initiatives**	**Future Opportunities**
5.1 Promote opportunities for exchange of ideas and information, discussion and collaboration among the media, the research community and policy makers, as well as other key stakeholders as appropriate (e.g. clinicians, consumers/Tangata Whaiora and Maori)	-Good existing relationships with Taranaki media on health and related issues -Existing and future opportunities for collaboration to be identified by Ministry of Health in partnership with national media	-Development of local mental health promotion media and communications strategy in partnership with local media -Work with media and key media commentators (e.g. mayor, councillors, school principals) to assist them to report and portray suicide safely in line with Ministry of Health guidelines -Provide media training, incorporating guidance on safe suicide reporting, to assist those working with the media in relation to mental health and suicide related issues
Key action area: Guideline/protocol development, implementation and evaluation		
Key outcome: **Safer reporting and portrayal of suicidal behaviour in the media**		
5.2 Further develop, implement and evaluate guidelines or protocols for the reporting and portrayal of suicide in the media	-New guidance/protocols to be revised and developed with key stakeholders and comprehensive implementation/dissemination plan to be developed by Ministry of Health in partnership with national media	-Local media to support revised guidance and protocols
Key action area: Education and support		
Key outcome: **Improved knowledge of the implications of reporting and portraying suicide in the media**		
5.3 Provide ongoing support, information and incentives to the media and those working with the media	-Like Minds Taranaki have close working relationship with the media as part of Like Minds, Like Mine programme -National resource/guide to assist people working with the media on issues of suicide to be developed by Ministry of Health in partnership with national media	-Further development of relationships with the media through joint development of a local media and communications strategy relating to mental health promotion and suicide prevention -Reward positive and responsible reporting through local journalism awards

National Actions	Current Initiatives	Future Opportunities
5.4 Encourage the inclusion of evidence and issues about the media reporting of suicide in journalism training programmes	-Like Minds Taranaki present to trainee journalists on mental health issues -Like Minds Taranaki offer scholarships to journalism students who cover mental health issues as part of their course assignment -Development of relationships with journalism training organisations to be led by Ministry of Health in partnership with national media	-Development of further initiatives to influence and support journalism training at WITT such as additional scholarships funded by other organisations or business sector -Mental health promotion/ responsible reporting to be included in category in local media awards for new journalists
Key outcome: Safer fictional portrayal of suicidal behaviour		
5.5 Provide guidance about fictional portrayal of suicidal behaviour in films, television and drama. This action may involve considering specific approaches and target groups and including issues about fictional portrayal in more general resources and information	-Fictional media to be considered in development of new guidelines/protocols and consideration of specific approaches to promoting safe fictional portrayal of suicidal behaviour to be led by Ministry of Health in partnership with media	-Outcomes will have benefits at local level through more responsible fictional portrayal of suicidal behaviour -Taranaki Suicide Project or other suicide prevention coordinating groups to challenge irresponsible fictional portrayal through formal media complaints processes
Key action area: Internet		
Key outcome: **Fewer harmful effects from suicide-related Internet sites**		
5.6 Monitor international developments to mitigate potentially harmful effects of Internet sites that encourage suicide	-Ministry of Health to identify and maintain contact with appropriate international organisations and forums	-Provide local advocacy and make submissions as required

Goal 6: Support families, whanau, friends and others affected by a suicide or suicide attempt		
Key action area: Services for those bereaved by suicide, those affected by suicide, and community organisations needing to respond to emerging or occurring clusters		
Key outcomes: **Improved services and support for those bereaved by suicide and affected by a suicide attempt** **Improved community postvention responses**		
National Actions	**Current Initiatives**	**Future Opportunities**
6.1Continue the development of a comprehensive Postvention Support initiative. The work includes: -Developing an effective suicide bereavement service -Identifying and monitoring the availability of specialised local services for those bereaved by suicide and responding to emerging needs – which will include consideration of services for specific population groups such as Maori and Pacific peoples -Developing a service for identifying and responding to emerging or occurring suicide clusters -Providing coordinated management plans to ensure communities are prepared to respond in the event of a suicide -Developing appropriate support services for those affected when someone close to them makes a suicide attempt. All these services must be developed and evaluated to be culturally appropriate for Maori	-Victim Support postvention support (New Plymouth, Central & South Taranaki) -Bereaved by Suicide support group (New Plymouth) -Growing with Grief (Seasons programme) -Taranaki Suicide Project -Ministry of Health leading on the development of the Postvention Support initiative which consists of four key components currently in the process of being trialled and evaluated	-Work with current postvention support service providers and other stakeholders to explore development and implementation of a comprehensive evidence-based Community Postvention Support Service for Taranaki
Key action area: Services for those bereaved by suicide, those affected by suicide attempt, and community organisations needing to respond to emerging or occurring clusters		
6.2 Implement recommendations from the review of the Traumatic Incidents Response Service. This work includes: -Providing a nationally consistent, evidence-based service – part of this service will be to utilise and revise resources appropriate to age and culture, including a support annual and pre-planning support workshops for schools and early childhood services -Developing a communications strategy to inform the sector of this service -Continuing to roll out the pre-planning training package to schools and early childhood services -Continuing training for traumatic incident staff	-Ministry of Education leading on the revision of the Traumatic Incidents Response manual, provision of regional training to traumatic incident coordinators and completing pre-planning support to schools and early childhood services in all regions	-Support with dissemination of revised Traumatic Incidents Response Manual at local level -Support with organisation and coordination of local training as required

Key action area: Resources for those bereaved by suicide, those affected by suicide attempt, those working with the bereaved and affected, and key institutions		
Key outcomes: **Improved quality and utilisation of evidence-based information resources for people bereaved by suicide; people affected by suicide attempt; people working with those bereaved by suicide; and key institutional settings that manage the aftermath of a suicide or suicide attempt**		
National Actions	**Current Initiatives**	**Future Opportunities**
6.3 Develop, implement and evaluate best-practice guidelines for establishing suicide support groups. These guidelines must be culturally appropriate and effective for Maori	-Bereaved by Suicide support group (New Plymouth, and possible new group in South Taranaki) -Taranaki Suicide Project -Ministry of Health to lead on development and implementation of best-practice guidelines for establishing suicide support groups	-Utilize best-practice guidelines for development of future suicide support groups in Taranaki -Where appropriate, work with existing suicide support group leaders to review existing support groups against best-practice guidelines -To carry out a focused needs assessment to identify whether the needs of Maori are met by existing support group services and to explore the development of new service provision as required
6.4 Review existing information resources, guidelines and protocols on managing the aftermath of suicide or suicide attempt for: -People who are bereaved -Key personnel who have regular contact with people who are bereaved -People who are affected by a suicide attempt -Key institutional settings All these resources, guidelines and protocols must be evaluated for cultural appropriateness and effectiveness for Maori	-On the Way to Healing – support handbook for those bereaved by suicide (Jo Nicholls/Taranaki Suicide Project) -Bereaved by Suicide support group resource library -Victim Support resources for those affected or bereaved by suicide -Funeral Services resources for families -Skylight resources accessed by local groups -Existing resources, guidelines and protocols to be reviewed and improved by Ministry of Health, Ministry of Education, New Zealand Police, Ministry of Social Development, Department of Corrections and ACC	-Dissemination of reviewed resources, guidelines and protocols for managing aftermath of suicide and suicide attempt to all relevant stakeholders -Arrange for training in use of new resources as required -Evaluation of cultural appropriateness of resources at local level -Update local resource "On the Way to Healing" -Translation of "On the Way to Healing" into Te Reo Maori -Broad distribution of "On the Way to Healing" to all relevant stakeholders

Goal 7: Expand the evidence about rates, causes and effective interventions		
Key action area: Improving the quality and timeliness of data		
Key outcomes: **Improved timeliness and quality of suicide data** **Improved surveillance of and responsiveness to trends in suicide data**		
National Actions	**Current Initiatives**	**Future Opportunities**
7.1 Improve the quality of suicide-related data	-Ministry of Health to develop a plan to improve quality and consistency of national and regional suicide-related data	-Support with dissemination of suicide related data at local level, ideally through a regionally centralised process so that data is consistent and dissemination is comprehensive
7.2 Address issues regarding the timeliness of suicide data	-Ministry of Justice to establish new Coronial database and develop plan to improve timeliness of suicide data	-Prompt distribution of information through regionally centralised process
7.3 Scope the feasibility of establishing a suicide mortality review committee	-Mortality Review Committee (for sudden death in under 25's) in Taranaki -Feasibility of a suicide mortality review committee to be investigated by Ministry of Health and established if necessary	-Broad range of stakeholders to be involved in any newly developed suicide mortality review committee including Maori and rural sector representation if established at a local level
Key action area: Expanding the research base		
Key outcome: **More and improved evidence-based knowledge about suicide, suicide prevention and effective interventions**		
7.4 Analyse existing suicide-related databases	-Ministry of Health to monitor search of suicide-related information in existing databases and to identify key gaps in existing databases for high-risk groups, including Maori	-Local relevant evidence (e.g. evaluations of suicide prevention initiatives, local research) to be shared with Ministry of Health for inclusion in their evidence base
7.5 Evaluate new suicide prevention initiatives	-All lead agencies in Action Plan have committed to evaluation of new initiatives	-Ensure all local suicide prevention initiatives are evaluated -Evaluation reports shared with Ministry of Health to support the development of their evidence base
7.6 Continue to fund suicide research through the Health Research Council (HRC)	-HRC, ACC and Ministry of Health to align suicide research priorities	-Possible opportunities for local suicide prevention research funded through HRC, including kaupapa Maori research

National Actions	Current Initiatives	Future Opportunities
7.7 Fund research using the Ministry of Health's Suicide Prevention Fund to support the implementation of the New Zealand Suicide Prevention Strategy 2006-16	-Suicide Prevention Research Fund established, managed and administered by Ministry of Health	-Possible opportunities for local suicide prevention research funded through Suicide Prevention Fund, including kaupapa Maori research
7.8 Invest in Maori suicide research	-Suicide Prevention Research Fund established, managed and administered by Ministry of Health	-Opportunities for local Maori-led research programmes with Tui Ora Ltd. and Maori Mental Health Providers
Key action area: Disseminating research and information		
Key outcome: **Effective dissemination of evidence-based and safe information that meets the needs of different audiences**		
7.9 Develop, implement and evaluate a suicide prevention research and information dissemination plan. This plan will specifically include meeting the needs of Maori service providers and communities	-New mental health website being developed by Like Minds Taranaki -Current development of New Plymouth injury Safe website for dissemination of injury prevention information -Taranaki Suicide Project -Ministry of Health to carry out stocktake of current dissemination approaches and to develop a suicide prevention research and information dissemination plan	-Development of local suicide prevention research and information dissemination plan in partnership with all relevant stakeholders -Establishment of regional centralised process for dissemination of information -Like Minds Taranaki mental health website and New Plymouth injury Safe website as a potential source of suicide prevention research and information -Plan and deliver a regional conference/seminar to share information and research evidence relating to suicide prevention -Actively promote the annual SPINZ Suicide Prevention Symposium at local level and support practitioners working in the suicide prevention field to attend where possible -Organise the delivery of SPINZ suicide awareness training across Taranaki as required

Chapter 7: Recommendations

New Plymouth injury Safe Trust have developed a number of recommendations based on the findings of the Taranaki Suicide Prevention Needs Assessment.

The first set of recommendations relate to the general findings of the report and suggest a strategy for moving forward and developing a process for prioritising and addressing the issues that have been identified during the needs assessment process.

The second set of recommendations have been developed for the specific consideration of the funder (Ministry of Health, Health & Disability National Services Directorate). These recommendations reflect those identified needs that could be met through public health and population based approaches which are supported by current New Zealand suicide prevention research literature.

7.1 General Recommendations

- Taranaki Suicide Prevention Needs Assessment Report to be published and widely disseminated to all stakeholders with an interest or role to play in suicide prevention in Taranaki

- New Plymouth injury Safe Trust to facilitate the creation of a broad multi-agency group that can develop a plan of action for prioritising and addressing the needs identified in the report and begin the process of developing a regional suicide prevention action plan

- Any regional multi-agency group that is established should be supported by at least two locally based suicide prevention working groups (e.g. North and South Taranaki) to facilitate engagement of groups and individuals across the region, including the rural sector

- To establish a mental health and suicide awareness training programme that meets the needs of community-based mental health workers, non-mental health support service workers and community gatekeepers. The training programme could include the Living Works ASIST programme and one-off training packages and workshops targeting specific groups

- To establish a centralised system for dissemination of suicide prevention information, including statistics, current services and evidence of effective interventions. The centralised system would ensure comprehensive and accurate, evidence-based information is distributed to all stakeholders in a timely manner

7.2 Recommendations for public health approaches to suicide prevention in Taranaki

- Improving public health awareness and mental health literacy including programmes to increase public awareness and understanding of depression and to challenge discrimination and stigma associated with mental illness. Targeted programmes should be developed locally to meet the identified needs of those living in rural areas and working in the agricultural sector in Taranaki

- Expand and support the development of school-based competency promotion and skill enhancing programmes that focus on protective factors such as enhancing self-esteem and coping skills. Existing models that could be developed in other local schools include the Waiora Wellness Centre (New Plymouth Girls High School) and the Taranaki Secondary Schools Peer Support Programme (Health Promotion Unit).

- Development of local services that promote young people's access to primary health care. Such services should be targeted, youth friendly and provided in a physically separate setting (e.g. school, youth centre). Existing models that could be expanded into other settings and areas include the WAVES youth health service and the Waiora Wellness Centre (New Plymouth Girls High School).

- Development of programmes that strengthen cultural identity through increased access to Maori language, family networks, community structures and Maori customs and traditions. Existing programmes that could be expanded include the Waka Ama project the Hauora Rangatahi programme led by the Health Promotion Unit.

- Encouragement of responsible, factual and accurate media coverage of suicide and mental health issues at the local level in line with the Ministry of Health's media guidelines. Approaches to working with local media could include the development of a joint mental health media and communications strategy for Taranaki. This could be supported through the dissemination of local media guidelines and the delivery of media training to those who have contact with the media

- Improving control of alcohol through strategies designed to restrict access to alcohol and promote safe and sensible drinking. Such programmes could include the development of an alcohol reduction strategy in Stratford and South Taranaki (similar to the approach used by the New Plymouth District Council Strategy) and ongoing campaigns and initiatives to raise awareness of the dangers of excessive alcohol consumption and promotion of safe alcohol use

- To promote the mental health of older people through the development of social support programmes (such as befriending and social clubs) and increased opportunities for exercise. This could include building on existing schemes, such as the Friends Plus visiting scheme and Sport Taranaki's Green Prescription scheme, as well as developing service provision to meet the specific needs of particular groups of older people (e.g. Maori, those in rural areas). Continue to utilise New Plymouth Positive Ageing Trust and Stratford Positive Ageing Trust as a means of disseminating mental health promotion information to older people.

- Local advocacy on issues relating to suicide prevention. There are a number of opportunities for local groups to advocate and make submissions on issues relating to suicide prevention. Such issues could include proposed changes in the legislation (e.g. restrictions on paracetamol sales, vehicle emissions changes).

- Support for programmes that focus on enhancing the skills of community, organisational and institutional gatekeepers and improving their ability to identify mental health problems and encourage early mental health intervention. Such programmes could include the coordination and delivery of local training programmes, such as the Living Works ASIST training programme and SPINZ suicide awareness training, for local community gatekeepers

References

Aseltine RHJ, DeMartino R. 2004. An outcome evaluation of the SOS Suicide Prevention Program. Am J Public Health, 94:446-51

Associate Minister of Health. 2006. *The New Zealand Suicide Prevention Strategy 2006-16.* Wellington, New Zealand

Babiker G & Arnold L. 2003. *The Language of Injury: Comprehending Self Mutilation.* British Psychological Society, UK

Beautrais AL, Collings SC, Ehrhardt P, et al. 2005. *Suicide Prevention: A review of evidence of risk and protective factors, and points of effective intervention*. Wellington: Ministry of Health

Beautrais AL, Collings SCD, Ehrhardt P, et al. 2005. *Suicide Prevention in New Zealand: A contemporary perspective.* Wellington: Ministry of Health

Beautrais AL, Fergusson D, Coggan C et al., 2007. Effective strategies for suicide prevention in New Zealand: a review of the evidence. The New Zealand Medical Journal, 120:1251 http://www.nzma.org.nz/journal/120-1251/2459/

Beautrais AL. 2004. *Suicide Postvention, Support for Families, Whanau and Significant Others after a Suicide – A literature review and synthesis of evidence*. Canterbury Suicide Project: Christchurch

Connor KR, Langley J, Tomaszewski K & Conwell Y. 2003. *Injury Hospitalisation and Risks for Subsequent Self-Injury and Suicide: A National Study from New Zealand*, American Journal of Public Health, 93:1128-1131

Coupe NM. 2005. Whakamomori Maori Suicide Prevention. PhD Thesis. Massey University, Palmerston North, New Zealand

Denzin NK. 1988. The Research Act: A Theoretical Introduction to Sociological Methods, 3rd Ed. Englewood Cliffs. NJ: Prentice Hall

Department of Corrections Annual Report. 2007.

Eggert LL, Thompson EA, Herting JR, Nicholas LJ. Reducing suicide potential among high risk youth: Tests of a school-based prevention program. Suicide Life Threat Behav. 1995;25:276-96

Ellis P, Collings S. 1997. *Mental Health in New Zealand From a Public Health Perspective.* Wellington: Ministry of Health

Fergusson D, Horwood LJ, Ridder E et al. 2005. *Sexual orientation and mental health in a birth cohort of young adults.* Psychological Medicine 35:971-981

Fredriksson L. 1999. *Modes of relating in a caring conversation: a research synthesis on presence, touch and listening.* Journal of Advanced Nursing, 30;5:1167-1176

Gould MS, Kalafat J, Harris Munfakh J. 2007. An evaluation of crisis hotline outcomes: Part 2 – suicidal callers. Suicide and Life-Threatening Behaviour 37: 338-52

Gould MZ, Greenberg T, Velting DM, Shaffer D. Youth Suicide risk and preventive interventions: A review of the past 10 years. J Am Acad Child Adolescent Psychiatry. 2003;42:386-405

Hunter Institute for Mental Health. 2001. Response Ability, Resources for Journalism Education. Commonwealth of Australia: National Suicide Prevention Strategy

Hyde P, Innes-Kent S, Mason N. 2006. Report of the evaluation of The Living Works ASIST Programme: Unpublished report produced for LifeLine Auckland

Kalafat J, Gould M, Harris Munfakh J, et al. 2007. An evaluation of crisis hotline outcomes Part 1: Non-suicidal crisis callers. Suicide and Life-Threatening Behaviour 37: 322-337

Kishi Y, Robinson R, Kosier J. 2001. *Suicidal ideation among patients with acute life-threatening physical illness: Patients with stroke, traumatic brain injury, myocardial infarction and spinal cord injury.* Psychosomatics 42(5): 382-390

Langley J, Stephenson S. 2001. *Suicide and Occupation in New Zealand*. Journal of Occupational Health and Safety – Australia and New Zealand, 7: 363-370

Lawson Te Aho K. 1998. *A Review of Evidence: A background document to support Kia Piki te Ora o te Taitamariki: New Zealand Youth Suicide Prevention Strategy.* Wellington: Te Puni Kokiri

Ministry of Health. 2002. *Reducing Inequalities in Health*. Wellington: Ministry of Health

Ministry of Health. 2007. *Suicide Facts: 2005-2006 data.* Wellington: Ministry of Health

Ministry of Health. 2008. *New Zealand Suicide Prevention Action Plan 2008-1012: The Summary for Action and The Evidence for Action*. Wellington: Ministry of Health

National Centre for Classification in Health. 2002. *The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification (ICD-10AM)*. Sydney: National Centre for Classification in Health

Oakley Browne M, Wells JE, Scott KM (eds). 2006. *Te Rau Hinengaro: The New Zealand Mental Health Survey.* Wellington: Ministry of Health

O'Dea D and Tucker S. 2005. *The Cost of Suicide to Society*. Wellington: Ministry of Health

Problem Gambling Foundation of New Zealand. Fact Sheet: *Problem Gambling and Suicidal Behaviour*, January 2007. Auckland. www.pgfnz.org.nz

Ramsay RF, Tanney BL, Lang WA et al, 2004. Suicide Intervention Handbook. Living Works/Lifeline

Simmons DJ, Voyle et al. 1997. *Community-based approaches for the primary prevention of Non-Insulin Dependent Diabetes Mellitus.* Diabetic Medicine 14(7): 516-526

Sisack M, Varnik A, Wasserman D. 2005. Internet Comments on Media Reporting of Two Adolescents' Collective Suicide Attempt. Archives of Suicide Research, 9:87-98. International Academy for Suicide Research

The Royal Australian and New Zealand College of Psychiatrists. 2005. *Self-harm: New Zealand Treatment Guide for Consumers and Carers*. RANZCP, Wellington: New Zealand

Vaughan G. 2004. Like Minds, Like Mine. In S Saxena and PJ Garrison (eds). 2004. Mental Health Promotion: Case Studies From Countries. Switzerland: World Health Organization

Appendix 1 - Information Sheet for Interview and Focus Group participants

INFORMATION SHEET

Taranaki Suicide Prevention Needs Assessment

Thank you for agreeing to take part in a stakeholder interview/focus group as part of our Suicide Prevention Needs Assessment. This interview/focus group is being conducted by the Programme Manager of New Plymouth injury Safe Trust, who is also a trained researcher. New Plymouth injury Safe Trust is made up of representatives from ACC, Kidsafe Taranaki Trust, New Plymouth Police, New Plymouth District Council, Taranaki District Health Board, Tui Ora Ltd. and Department of Labour. The Trust exists to raise awareness of injury issues and to improve co-ordination of local injury prevention activities.

The information from this interview/focus group will be used to identify those population groups at greatest risk of self-harm and suicide and to inform future service planning and delivery aimed at supporting those individuals at risk. All information gathered in this interview/focus group will remain strictly confidential and will only be used for the needs assessment.

We are interested in hearing your views and experiences relating to the extent of self-harm and suicide in Taranaki, those populations groups that you feel are at greatest risk, and any initiatives taking place in Taranaki that aim to promote mental health and support those at risk of self-harm and suicide (both delivered by your organisation and by other organisations/groups).

The needs assessment will lead to the publication of a report that will suggest recommendations for service development to address any identified barriers or gaps in service provision. It will also support the development of more effective strategic partnerships to improve co-ordination and collaboration in local suicide prevention activities to support those at greatest risk of self-harm and suicide.

It is expected that the interview/focus group will take about 1 hour. You will receive a $20.00 gift voucher in appreciation of your time and effort. You have the choice of a petrol or grocery voucher. If you live out of town and need to travel to attend the interview you will also receive an additional $10.00 voucher.

We are aware that for some people, particularly those whose lives have been touched by self-harm or suicide, that this interview/focus group may raise difficult issues that you wish to speak to someone about. If this is the case, Sue Hohaia, (ASIST Trainer from LivingWorks) will be available for you to contact after the group by calling 09 523 7576.

The interview/focus group will be held on:

Please contact Channa Perry, Programme Manager, on 06 753 7777 extn 8792 or email npis@tdhb.org.nz if you have any further queries.

Appendix 2 – Consent forms for Interviews and Focus Groups

CONSENT FORM

Taranaki Suicide Prevention Needs Assessment

As a participant in this needs assessment you have certain rights. Please read the following information.

- All information gathered in this interview/focus group will remain strictly confidential and only be used to assist with the NPiS Taranaki Suicide Prevention Needs Assessment
- Your name or any other personal identifying information (e.g. your job title) will not be used in the final report*
- You do not have to answer any questions you don't want to
- You can ask any questions about the evaluation at any time
- With your permission, the interview/focus group may be tape recorded, but you have the right to ask for the audiotape to be turned off at any time during the interview

If you agree to participate in the interview/focus group, please sign this permission slip prior to the start of the interview.

Thank you.

I have read the above and agree to take part in the interview/focus group.

Participant's name…….

Participant's signature……

Please state whether you are happy for your organisation to be listed in the "Acknowledgements" section of the report: YES / NO

Appendix 3 – Stakeholder/Focus Group Questionnaire

QUESTIONNAIRE

1) National research suggests that ***self harm*** is under-reported in official hospital statistics. Do you feel self-harm goes under reported in Taranaki?

   If yes, why do you think this is?

   What do you think is the real extent of self harm in Taranaki?

2) What population groups or individuals do you think are at the greatest risk of ***self harm*** in Taranaki?

3) What population groups or individuals do you think are at the greatest risk of ***suicide*** in Taranaki?

4) Are you aware of any initiatives taking place in Taranaki to promote mental health and wellbeing, and to prevent mental health problems?

   What more could be done?

5) Are you aware of any initiatives taking place in Taranaki to improve the care of people who are experiencing mental disorders associated with suicidal behaviours?

   What more could be done?

6) Are you aware of any initiatives taking place in Taranaki to improve the care of people who make non-fatal suicide attempts?

   What more could be done?

7) Are you aware of any initiatives taking place to reduce access to the means of suicide

   What more could be done?

8) Do you think stories or articles about self-harm and suicide are reported responsibly by the media in Taranaki?

   If **yes**, why do you think this? / If **no**, why not?

Can you give any examples?

Do you think things could be improved in any way?

9) Are you aware of any initiatives taking place in Taranaki to support families/whänau, friends and others affected by a suicide or suicide attempt?

   What more could be done?

10) Do you think there is adequate information available to you to expand the evidence about rates, causes and effective interventions?

    If **yes**, why? If **no**, why not?

    What kind of information (if any) do you currently receive/have access to?

    What other information or data would you find useful?

    Whose role do you think it should be to disseminate such information?

11) Is there adequate training available for those who work with, or care for, people at risk of self harm and suicide?

    What training is available? Is it helpful?

    What more training is needed?

12) The NZ Suicide Prevention Strategy advocates taking a collaborative and coordinated approach to suicide prevention. Are you aware of any local networks or partnerships that have been set up to address suicide prevention, or who you feel could have a positive impact in this area?

    How well does the partnership/network(s) currently function?

    What would help to strengthen it?

    Is there a need for any more partnerships? What would these look like?

Thank you for your time

Appendix 4 – Young people's focus group questionnaire and notes for participants

Young Persons Questionnaire

1) What do you understand by the term "*self-harm*"?

……
……
……

2) Do you think *self-harm* is a problem among young people in Taranaki?

……
……
……

3) If you think *self-harm* IS a problem, how common do you think it is?

……
……
……

4) Are there any particular kinds of young people that are at greater risk of *self-harm* in Taranaki? If so, what kinds of people and why are they at more risk?

……
……
……

5) Do you think there are any particular kinds of young people that are at greater risk of *suicide* in Taranaki? If so, what kinds of people and why are they at more risk?

……
……
……

6) **Do you know of any services available in Taranaki that promote mental health and wellbeing of young people? If yes, please list them below**:

……
……
……

What additional services would you like to see available to improve young people's mental health?

……
……
……

7) Do you know of any services available in Taranaki to improve the care of young people who feel suicidal? If yes, please list them:

……
……
……

What additional services would you like to see available to help people who feel suicidal?

……
……
……

8) Do you know of any help offered to young people who have actually self-harmed or attempted suicide? If yes, please list:

……
……
……

What additional help should be offered to young people who have self harmed or attempted suicide?

……
……
……

9) Do you think the local media (e.g. newspapers, TV news, TV shows, magazines, etc.?) should report more stories about young people's mental health?

If yes, what kinds of stories would you like to see them cover?

……
……
……

10) Do you know of any services available in Taranaki to support young people who have had a friend or family member die by suicide?

……
……
……

What more could be done to help young people bereaved after suicide?

……
……
……

11) Is there enough information available to young people about mental health issues?

If no, what information do you think young people would find helpful?

……
……
……

Young Person's Questionnaire - Notes for Participants

Why are we holding this focus group?

This focus group is being held as part of a study looking at the issue of self-harm and suicide in Taranaki, and what help is available to those people who are at risk of self-harm and suicide. Many different groups are being asked for their views, including those who work in mental health services, schools, the prison service and other local services.

Why do we want to know the views of young people?

We are trying to find out the views of many different age groups, including young people. We want to make sure that the report we write up at the end of the study includes young people's views about what services are most helpful and what additional services they feel should be provided.

What will you do with the information?

We will analyse the findings of the focus groups and interviews and write up a final report that reflects the views of all who have been involved. We will make recommendations for how mental health promotion and suicide prevention services can be developed in future to meet the needs of local people, including young people.
The information you give will only be used for the report and will not be passed on to others. The report will not give any information that could be used to identify the people who took part (i.e. it will not include your name, where you are from, etc.).

What is in it for me?

You will be helping to ensure that the views of young people are included in this study so that the final report includes views and ideas that young people feel are important. We value your time and as an appreciation of this you will be given a $20 gift voucher.

Who will run the group?

The group will be run either by a young person or a youth worker. This person will ask questions and write your responses down on a questionnaire.

Is there anything else I need to know?

Taking part in this focus group is your choice and even if you decide to take part you can change your mind at any time. If you feel uncomfortable talking in the group you may leave at any time. Some people may find discussions about self-harm and suicide distressing, particularly if their lives have been touched by this issue. If you feel that this discussion may be difficult for you, we would advise you not to take part. If you do take part and feel that you need to speak to someone after the group please contact the WAVES youth service on 757 9901 or Youth Line on 0800 37 66 33.