



Community Action on Suicide Prevention Education & Research

# Suicide Prevention Strategy

September 2011

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## Introduction

New Zealand suicide statistics are grim. They tell us that 11 people die from suicide every week, that 10% of the deaths of New Zealand 10-14 year olds are suicides and that we have rates of youth suicide that are not only the highest in the developed world but double those of the United States and Australia and five times those of the UK.

As bad as these statistics are, we know that they are likely to under-represent the true prevalence of suicide, particularly in Maori and Pacific populations.

No one who has experienced the suicide death of a loved one and who watches as the toll continues to rise, will ever concur with government that good progress is being made in addressing suicide in New Zealand and that current strategies are effective.

Suicide is, in the majority of cases, a preventable form of death. Sadly, New Zealand government has implemented policies which have been shown through robust research to actually increase, rather than decrease suicide rates.

CASPER's strategy sets out an alternative to current suicide prevention policy and practice. It is based on New Zealand and international evidence on effective suicide prevention. It espouses a sociological approach to suicide prevention and the relocation of suicide prevention from mental health settings back to families and communities.

It is produced by families who have lost loved ones to suicide. It honours their lives and ensures their legacy survives their deaths.

## Purpose

In recent years the New Zealand government and government funded organisations have produced a mountain of paper dedicated to the prevention of suicide. Strategies, action plans, reports, programmes and commentaries have been produced at the cost of millions of dollars and none have produced the desired result of reducing New Zealand's status as the world leader in self-inflicted deaths of children and youth.

Albert Einstein said "The significant problems we face cannot be solved at the same level of thinking we were at when we created them." We believe this concept goes to the heart of why New Zealand's approach to suicide prevention has failed so miserably. Put simply, we have done little more than package and repackage programmes underpinned by a flawed understanding of suicide.

It is time to review our thinking and step outside the mind-set which has produced the strategies of the past few decades. It is time to admit that this thinking has led us down a path that research shows actually increases, rather than decreases suicide rates and to view suicide from a truly evidence based perspective – one which is not tainted by the agendas of those who accrue power, status and wealth from the advancement of a mental health approach to suicide prevention. It is time to develop a new model which calls on diverse perspectives from a range of disciplines, groups and individuals rather than being restricted to the same small group of people with the same narrow perspective which has characterised this work for the past twenty years .

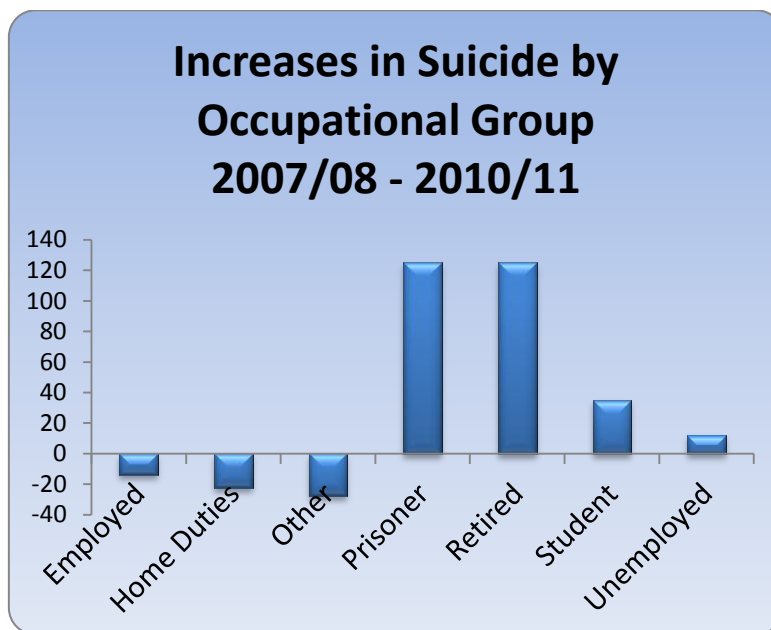
We know that given a particular set of circumstances all New Zealanders are at risk of suicide. We offer this strategy in the hope it will prevent others from experiencing the destruction of their lives and that our loved ones, and we as their families, have experienced.

Suicide prevention has been captured by 'experts' and the health sector. This strategy returns the role of protecting individuals and groups from suicide to families and communities and provides a tool for them to successfully fulfil that role.

## Suicide Rates in NZ

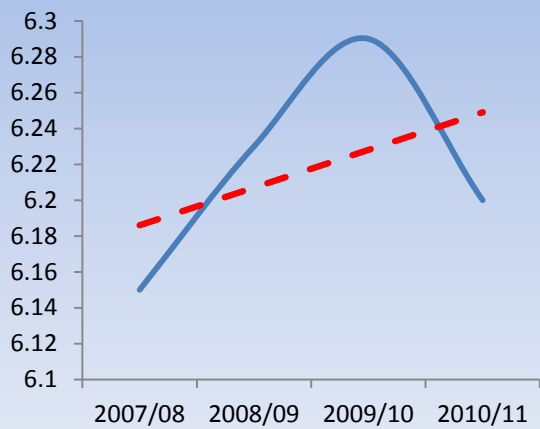
In 2009 the OECD released figures showing New Zealand had the highest rate of youth suicide amongst its member countries. The rates shown were substantially higher than those for countries with which New Zealand traditionally compares itself – twice the rate of the US and Australia and five times the rate of the UK.

Figures for 2011 released by the Chief Coroner show an increase in suicides for those aged 10-14 over the past four years of 300% and increases of 125% for prisoners and retired persons, 35% for students and 12% for the unemployed. Suicide numbers fell significantly for those who are employed (14%) and who perform household duties (22%).

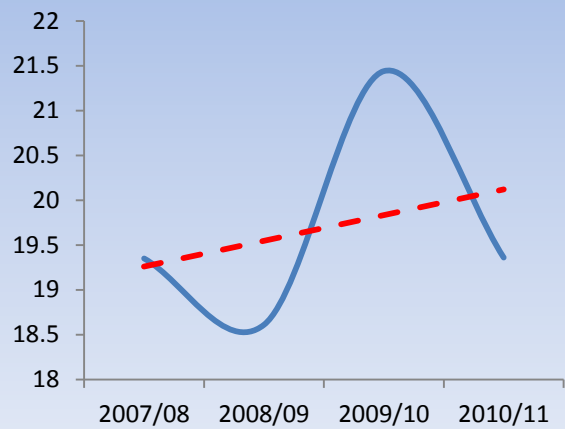


The figures show that girls outnumber boys in suicide deaths in the 10-14 year age group and that overall the female suicide rate increases are steeper than those for males.

### Female Suicide Rate 2007/08 - 2010/11

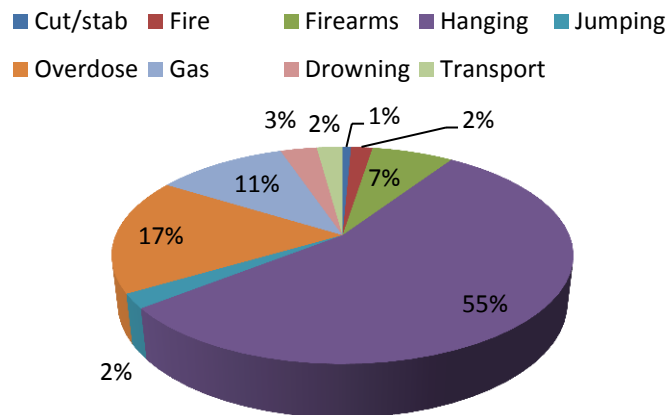


### Male Suicide Rate 2008/09 - 2010/11

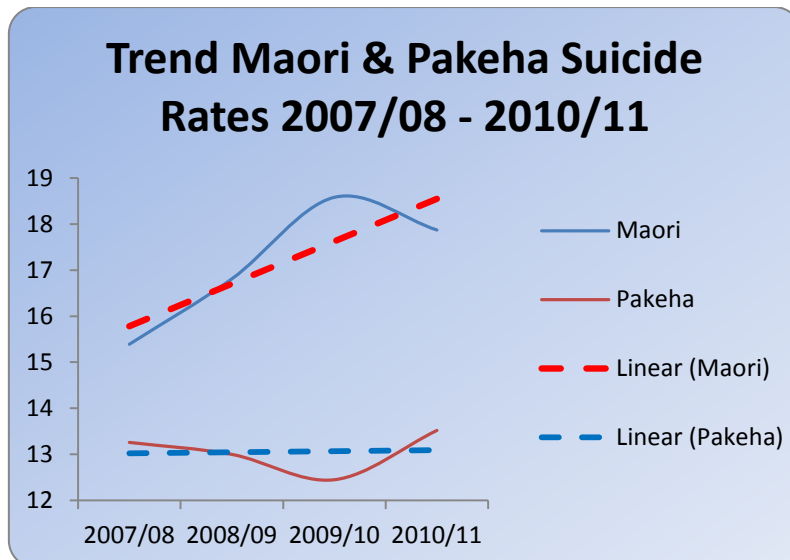


While hanging remains the most common method of suicide in New Zealand accounting for 55% of all suicides, poisoning with prescription drugs is the second most common method of self-inflicted death and has increased by 33% over the past four years.

### Suicide by Method 2010/11



The most common age for suicide in the Maori and Pacific communities is 15-19 years and suicide in these communities is very rare over the age of 60 years. By contrast, Pakeha New Zealanders are more likely to die from suicide in their middle years and suicide amongst older people occurs at very high rates. The Maori suicide rate increased by 16.1% between 2007/08 and 2010/11.



Significant trends and patterns in suicide in New Zealand are masked by the practice of reporting of aggregate data and performing little analysis on sub-populations within New Zealand.

New Zealand’s suicide rates in comparison to those of other countries are often downplayed with claims that they do not represent a true picture due to differences in reporting between countries. Researchers have found however that “factors such as differences in the ascertainment and reporting of deaths by suicide are unlikely to account for all these observed differences.”<sup>1</sup> They have also found that reported rates of Maori suicide are likely to be significantly lower than the actual rate of deaths with New Zealand researchers finding “The under-reporting of indigenous peoples’ suicides appears to be a universal problem.”<sup>2</sup>

Recent changes to the Coroners Act are likely to have reduced our accuracy in reporting suicide. Prior to 2006 it was compulsory to conduct an inquest into all suspected suicides. Change to legislation removed this requirement and New Zealand families are now actively discouraged from going to inquest. Decisions made by Coroners on the papers, without the benefit of proper investigation and testing of evidence, result in lower levels of accuracy in determining whether a death was a suicide. Variation in practice between Coroners in requiring evidence of intent and the fact that the Act refers to self-inflicted deaths rather than suicide, contribute to this lack of consistency.

The release annually of different suicide figures by the Chief Coroner and the Ministry of Health adds further doubt to the accuracy of New Zealand suicide data.

## CASPER Philosophy and Approach

CASPER practice is based on the following primary beliefs:

- Suicide prevention will occur within families and communities rather than mental health clinics or government offices

<sup>1</sup> Collings S and Beautrais A. 2005. *Suicide Prevention in New Zealand: A contemporary perspective*. Wellington: Ministry of Health.

<sup>2</sup> Hirini, P & Collings, S. 2005 *Whakamomori: He whakaaro, he kōrero noa: A collection of contemporary views on Māori and suicide*

- All suicide prevention practice should operate from the ‘first do no harm’ principle

In seeking to understand and prevent suicide, CASPER takes much from the discipline of positive psychology- the study of human strengths and virtues. We conceptualise effective suicide prevention as the identification of optimal states and promotion of strengths and abilities rather than the identification and correction of pathologies or deficits.

We see suicide prevention as broader than a programme or set of activities but something which should be embedded in a way of thinking and behaving in the lives of individuals, families, communities and society. Rather than being confined to emergency rooms, health clinics or government department work programmes suicide prevention should be manifested in the way we interact with others and manage our homes, businesses and organisations in our daily lives.

Hugging a child is suicide prevention. Visiting a neighbour is suicide prevention. Creating a job, cooking a shared meal and starting a community group are all suicide prevention activities. If we each took opportunities to connect with others, to create a sense of belonging and hope, provided everyone with opportunities to participate and showed others we value their contribution, we would create an environment where the urge to live prevailed over the desire to die.

## The Causes of Suicide

Throughout history suicide has been a subject of study within a diverse range of disciplines. While these disciplines have in the past competed for dominance, it is clear that in the past few decades psychiatry has achieved this. So dominant is the discourse of psychiatry in fact, that many both within and outside of the mental health field are unaware that other theories of suicide and approaches to suicide prevention even exist.

Psychiatry promotes what is often referred to as a mental health model of suicide and suicide prevention but is more accurately described as a mental illness model. Its premise is that suicide is caused by mental illness and that the prevention of suicide involves the detection and treatment of mental disorders. Despite acknowledging that suicide is a behaviour, not an illness,<sup>3</sup> the architects of the New Zealand Suicide Prevention strategy have ensured suicide prevention in this country employs a completely medical model.

In recent years it has promoted depression, anxiety, conduct disorder and post-traumatic stress disorder as the key causes of suicide. These ‘disorders’ are what the lay person would call sadness, worry, misbehaviour and fear and correctly identify as normal human moods and behaviours. It promotes detaining people against their will, using force, restraints and seclusion and prescribing drugs known to double the risk of suicide, to prevent suicide in people who are distressed or have been made suicidal by the use of these drugs.

## Mental Illness

In New Zealand, the American Diagnostic and Statistical Manual (DSM) is used to define mental disorder. Known as the ‘bible’ of psychiatry, it lists hundreds of psychiatric disorders and their symptoms in a series of checklists.

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<sup>3</sup> Collings S & Beautrais A. 2005. *Suicide Prevention in New Zealand: A contemporary perspective*. Wellington: Ministry of Health

The presence of the symptoms listed in the DSM cannot be established through blood tests or other biological tests but are ruled present or absent based on the opinion of a mental health worker.

These symptoms are highly subjective and often contradictory as the following list of indicators demonstrates:

- Feels sad most of the day nearly every day for two weeks, decrease or increase in appetite nearly every day, insomnia or hypersomnia (Major Depressive Disorder)
- Often talks excessively, is often "on the go" or often acts as if "driven by a motor", often fidgets with hands or feet or squirms in seat, often has trouble organizing activities (ADHD)
- Often deliberately annoys people, often spiteful or vindictive, often touchy or easily annoyed by others (Oppositional Defiance Disorder)

As the disorders listed in the DSM are unable to be verified through objective testing, they are voted in and out of the manual by popular vote amongst psychiatrists. Former disorders which have been voted out include

- Children running away from home for a day or more without permission
- Feelings of rejection associated with forced retirement and manifested by social withdrawal.
- Fear associated with military combat and manifested by trembling, running and hiding.
- Social maladjustment of individuals thrown into an unfamiliar culture (culture shock) or into a conflict arising from divided loyalties to two cultures.
- grief reaction in infants associated with separation from patient's mother, manifested by crying spells, loss of appetite and severe social withdrawal.
- Giving incorrect but approximate answers to questions associated with being given a death sentence.
- Homosexuality

Disorders being considered for inclusion in the next edition of the DSM due for publication in 2013 include

- Paraphilic coercive disorder (rape)
- Gender Identity Disorder in Children (children dressing up in clothes and playing with toys generally worn by the opposite gender)
- Attenuated psychosis disorder (those who may be at risk of developing a disorder later in life).

The DSM has received much criticism for its lack of evidence base and its propensity to significantly over-diagnose mental disorder, its lack of validity and failure to consider the possibility of environmental causes of human distress by locating problems exclusively within the individual. The British Psychological Society has been particularly critical of the DSM V stating "The Society is concerned that clients and the general public are negatively affected by the continued and continuous medicalisation of their natural and normal responses to their experiences; responses which undoubtedly have distressing consequences which demand helping responses, but which do not reflect illnesses so much as normal individual variation."<sup>4</sup>

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<sup>4</sup> British Psychological Society June 2011 Response to the American Psychiatric Association: DSM 5 Development [http://apps.bps.org.uk/\\_publicationfiles/consultation-responses/DSM-5%202011%20-%20BPS%20response.pdf](http://apps.bps.org.uk/_publicationfiles/consultation-responses/DSM-5%202011%20-%20BPS%20response.pdf)

In New Zealand, Professor Mulder of Otago University raises the concern that “While the general introduction to DSM-IV concedes that all its illness definitions are human constructions (p. xxxi), most mental health workers view depression as a specific mental illness, a natural entity rather than an arbitrary construction.”<sup>5</sup>

Psychiatrist William Glasser explains the unscientific nature of applying the medical model to emotional distress stating

*“...for over a century the entire mental health delivery system has been based on what is called the medical model. This is an illness model that recognizes symptoms, looks for pathology to support those symptoms, but does not diagnose disease unless supportive pathology is found. But when this model is used to diagnose a mental illness such as those described in the DSM-IV, one of the basic tenets of the medical model is completely ignored. In those instances, mental illness is diagnosed from symptoms alone and no supportive pathology is required. This misuse of the medical model has led to the present ever-increasing assortment of diagnoses and treatments, none of which even comes close to meeting the requirements of medical science.”*<sup>6</sup>

The primary reason for the dominance of the mental health model of suicide and suicide prevention are the links that have been drawn between mental disorder and suicide, the notion of depression as a leading cause of suicide and claims that mental health treatment prevents suicide.

In respect of the links between suicide and mental illness, the NZ Ministry of Health consistently claims that 70-90% of those who die from suicide have diagnosable mental disorders. What is not widely understood is that data reliably shows that only around 30% of those who die from suicide had a diagnosis of a mental illness at the time of their death and that higher figures are based on mental health assessments conducted on dead people, using an often criticised technique known as the psychological autopsy. While New Zealand conducts completely inadequate physical autopsies on those who die from suicide, often failing to test for drugs known to induce suicide, it focuses much effort on questioning family and friends of those who die to find any evidence of a mental disorder even where it is clear none exists.

Most who quote the figure of 90% in relation to mental disorders in suicide victims, do not understand that the mental disorders being identified include not only feeling sad for a period of two weeks (depression), but binge drinking (substance abuse disorder), breaking the law (conduct disorder), being a victim (post-traumatic stress disorder), being worried (anxiety disorder) and a host of other normal human moods, behaviours and experiences that are identified after death from the reports of friends and family.

Rather than being the primary and proven cause of suicide, the World Health Organisation (WHO) states that no causal relationship between depression and suicide has been established.<sup>7</sup> In a recent study of 108,664 respondents from 21 countries around the world, the WHO found that a diagnosis

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<sup>5</sup> Mulder, R.. (2008). An epidemic of depression or the medicalization of distress? Perspectives in Biology and Medicine, 51(2), 238-50. Retrieved August 13, 2011, from Research Library. (Document ID: 1481819061)

<sup>6</sup> Glasser, W. 2005 *Defining Mental Health as a Public Health Issue* ,p6

<sup>7</sup> Nock MK, Hwang I, Sampson N, Kessler RC, Angermeyer M, et al. (2009) Cross-National Analysis of the Associations among Mental Disorders and Suicidal Behavior: Findings from the WHO World Mental Health Surveys. PLoS Med 6(8): e1000123. doi:10.1371/journal.pmed.1000123

of major depression was not useful in predicting which people with suicide thoughts would go on to make suicide plans or attempts, and is not associated with unplanned or impulsive suicide.<sup>8</sup>

Professor Mulder of Otago University who has studied the prevalence of depression in suicide attempters dismisses the notion of an 'epidemic' of depression stating that

*the reasons for the increased prevalence of DSM depression in some populations are likely to include classification bias, financial incentives, and social and cultural factors. It seems unlikely the "epidemic" is solely or even largely related to an increase in a mental illness called depression. This conclusion leads to the question of whether individuals with depressive symptoms are best served by a medical solution.*<sup>9</sup>

## Hopelessness

Hopelessness has been defined as a group of negative expectations concerning oneself and one's future life (Beck, Weissman, Lester, & Trexler, 1974; Scotland, 1969). It is distinguished from depression in that it is more a marker of negative orientation to the future, rather than current failures to cope which characterise depression.<sup>10</sup>

Numerous studies have found that hopelessness is a stronger predictor of suicidality than either depression or substance abuse (Beck et al 1975; Wetzel, 1976; Drake & Cotton 1986; Chochinov, 1997; Kazdin et al 1983; Kuo, et al, 2004) and that once hopelessness is taken out of the equation, depression does not predict suicidal intent at all (Wetzel et al 1980; Drake & Cotton 1986; Kazdin et al 1983). Studies of both adults and children have found that the only reason depression is associated with suicidality is because it includes a measure of hopelessness (Kazdin 1983).

A long term study of the role of hopelessness in suicide followed a community sample of more than 3,000 participants rather than a small, hand-picked sample from a clinical trial. It found that persons who expressed hopelessness in 1981 were 11.2 times as likely to have completed suicide over the 13-year follow-up interval and that while hopelessness was strongly associated with death by suicide "depression and substance abuse/dependence were not significantly associated with completed suicide."<sup>11</sup>

Hopelessness in the face of a real inability to change circumstances and events is not a mental disorder, it is a reality for marginalised populations in New Zealand. Evidence not surprisingly shows

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<sup>8</sup> Nock MK, Hwang I, Sampson N, Kessler RC, Angermeyer M, et al. (2009) Cross-National Analysis of the Associations among Mental Disorders and Suicidal Behavior: Findings from the WHO World Mental Health Surveys. PLoS Med 6(8): e1000123. doi:10.1371/journal.pmed.1000123

<sup>9</sup> Mulder, R. (2008). AN EPIDEMIC OF DEPRESSION OR THE MEDICALIZATION OF DISTRESS? Perspectives in Biology and Medicine, 51(2), 238-50. Retrieved August 13, 2011, from Research Library. (Document ID: 1481819061)

<sup>10</sup> Jennifer Langhinrichsen-Rohling PhD, Dorian A. Lamis MA & Patrick S. Malone PhD (2010): Sexual Attraction Status and Adolescent Suicide Proneness: The Roles of Hopelessness, Depression, and Social Support, Journal of Homosexuality, 58:1, 52-82

<sup>11</sup> Kuo, W. H., Gallo, J. J. and Eaton, W. W. 2004. Hopelessness, depression, substance disorder, and suicidality: A 13-year community-based study. *Social Psychiatry and Psychiatric Epidemiology* , 39: 497–501

that hopelessness is not effectively treated by psychiatric drugs<sup>12</sup> and that psychiatric drugs do not prevent suicide (Baldaressini et al, 2007; Sernyak et al, 2001).

## Environmental Factors

Rather than locating the cause of suicide in individual biological or psychological deficits, the sociological model of suicide prevention recognises the role and impact the social environment plays in suicidal thinking and behaviour.

It acknowledges the connectedness of individuals to families, communities and society and the effect that social, political and economic factors have on well-being. It recognises the impact of marginalisation, disconnection, lack of opportunities to participate and influence the future have on groups and the individuals within them and how these factors may lead to suicide.

The sociological approach suggests that given a certain set of adverse circumstances and events any one of us could contemplate or complete suicide. It focuses attention not on assessing individual risk or resilience against checklists of moods and behaviours, but on monitoring and influencing environments to optimise their sustaining of life.

Numerous studies have shown the strong role that adverse life events and circumstances play in completed suicide. Relationship break down, work and school stress, financial pressures, bullying and a host of other factors have been identified as features of the environment in which individuals make the choice to end their lives.

The mental health model conceptualises environmental factors merely as 'triggers' and claims that weakness in an individual's biology or personality is the primary cause of their suicide. It theorises that the reason the majority of individuals who face these adverse life events or circumstances do not end their lives is that unlike those who do, they do not have mental illnesses and personality disorders that exacerbate their risk and lower their resilience. Where evidence of mental disorder in individual cases is not present, and therefore refutes this theory, as is the case in the majority of suicide deaths, an undiagnosed mental illness is magically discovered by means of a psychological autopsy.

The social model sees differential responses to events and circumstances not as pathology but as a marker of human diversity and a reflection of the extent to which the affected individual experiences their ability to tolerate or alter their environment and to achieve a sense of belonging and full participation.

## Cultural Alienation

Suicide as a legacy of colonisation and loss of identity is well established in contemporary research on indigenous suicide internationally (Wexler, 2006; Rochford & Signal, 2009; Lawson-Te Aho & Liu, 2010.) Maori researcher Keri Lawson Te Aho constructs Maori suicide as a soul-wounding which

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<sup>12</sup> AJ Rush, AT Beck, M Kovacs, J Weissenburger and SD Hollon Comparison of the effects of cognitive therapy and pharmacotherapy on hopelessness and self-concept *Am J Psychiatry* 1982; 139:862-866  
Copyright © 1982 by American Psychiatric Association

results from colonisation and creates “a state of mind characterized as kahupo meaning loss of hope, meaning, and purpose, and an enduring sense of despair.”<sup>13</sup> Lawson Te-Aho describes this phenomenon as bearing “the symptoms of chronic dissociation or separation of the physical from the spiritual and vice-versa—the psychological separation of the individual from the collective.”

According to Lawson-Te Aho, a strong and intact set of cultural identities based on time-honoured cultural practices with intact kinship serves to insulate and protect Maori youth from the legacy of colonization and historical trauma.” Research on indigenous suicide has found clear evidence for a strong association between lack of local community control and high suicide rates.<sup>14</sup>

A study conducted this year found that for Maori youth “feeling uncomfortable in Pākehā social surroundings” was a risk factor for suicide attempts finding. The authors consider this may result from Māori young people’s perceptions and experiences of racism and discrimination in Pākehā social surroundings, linking it with a body of research which identify perceptions of racism and discrimination as a risk factor for suicide amongst indigenous communities.<sup>15</sup>

International research shows that suicide rates within ethnic groups appear to be impacted by the size of the ethnic community in which they occur, suggesting that the larger the population of a particular ethnic group, the greater the presence of the cultural supports and networks that protect against suicide.<sup>16</sup> Analysis of the data on suicide rates amongst minority ethnic groups find that factors which contribute to their suicide include marginalisation, disintegration of traditional social support networks and cultural values, socioeconomic deprivation, and alcohol misuse.<sup>17</sup>

## Youth Disengagement

New Zealand has the highest rate of youth suicide in the OECD. Maori and males are disproportionately affected while female and Pasifika youth are populations showing worryingly steep upward trends.

A number of factors contribute to youth in New Zealand experiencing social disconnection and barriers to participation that may increase their suicide risk. These include school exclusion, unemployment and lack of opportunities to participate in communities and political processes.

In 2008, 1,364 students were excluded from schools in New Zealand.<sup>18</sup> Data shows that the average age at exclusion from school is 13.5 years, but that children as young as six years old are excluded.<sup>19</sup>

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<sup>13</sup> Lawson-Te Aho, K. & Liu, J. 2010 Indigenous Suicide and Colonization: The Legacy of Violence and the Necessity of Self-Determination *International Journal of Conflict & Violence*, Vol. 4 (1) 2010, pp. 124 – 133

<sup>14</sup> Kirmayer, Laurence J, Brass, Gregory M, & Tait, Caroline L. (2000). The mental health of aboriginal peoples: transformations of identity and community. *Canadian Journal of Psychiatry*, 45(7), 607-16. Retrieved August 16, 2011, from Research Library. (Document ID: 705618261).

<sup>15</sup> Clarke, T., Robinson, E., Crengle, S., Fleming, T., Ameratunga, S., Denny, S., Bearinger, L., Sieving, R., Saewyc, E. 2011 Risk and Protective Factors for Suicide Attempt Among Indigenous Māori Youth in New Zealand: The Role of Family Connection *Journal of Aboriginal Health*

<sup>16</sup> Hawton, K., & van Heeringen, K. (2009). Suicide. *The Lancet*, 373(9672), 1372-81. Retrieved August 20, 2011, from Research Library. (Document ID: 1683154041)

<sup>17</sup> Ibid

<sup>18</sup> Ministry of Education. Exclusions and expulsions from school. Unpublished Tables, Commentary. Ministry of Education in Freeman, N. 2011 *When One Door Closes: Evidence based solutions to improve outcomes and open new doors for children who are expelled or excluded from school in New Zealand*. Regional Public Health, Wellington.

In her research on New Zealand school exclusions, Freeman (2011) reports that 20% of excluded children do not continue with any schooling and that Maori were 63% more likely to be excluded and Pacific students 32% more likely than non-Māori/non-Pacific students and that 61% of excluded students are from the poorest areas in NZ.<sup>20</sup> It has recently been reported that the rate of stand-downs among five-year-olds has risen from 0.9 in 1000 pupils in 2006 to 1.2 in 1000 pupils in 2010. The rate of suspensions among six-year-olds has remained at 0.3 in 1000 pupils.<sup>21</sup>

Freeman reports that the majority of exclusions are for 'disobedience' rather than violence and that there is no evidence the rate of exclusion is declining. She states that "Exclusion from school can be the first step towards isolation from society" and presents evidence that exclusion causes family disruption, feelings of rejection, marginalisation and exclusion from society and a chance of becoming homeless which is 90 times that of students who achieve a school qualification.<sup>22</sup>

The Human Rights Commission has claimed youth unemployment is a threat to social cohesion. Recently released figures from the Department of Labour show there are 62,300 young people in New Zealand who are not in training or in work. New Zealand researchers regularly deny or minimise the links between unemployment and suicide.<sup>23</sup>

An article in the New Zealand medical journal presented data showing those experiencing unemployment had odds of subsequent suicide that were over 2.5 times higher than for those employed and that this finding had been found in two further New Zealand studies.<sup>24</sup>

A large evidence base around the world links unemployment and suicide with the increased suicide rates among the unemployed being generally attributed to the feelings of worthlessness and being unwanted that comes with unemployment<sup>25</sup> although, somewhat predictably, in New Zealand government has been encouraged to ignore this data in reports that those unemployed who die from suicide do so because of mental illness rather than their employment status.<sup>26</sup>

Research has found however that even in people with no record of serious mental illness unemployment produces an increased risk of suicide of around 70%.<sup>27</sup>

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<sup>19</sup> Ministry of Education. (2009b). Exclusions and expulsions from school. Unpublished Tables, Commentary. Ministry of Education.

<sup>20</sup> Freeman, N. 2011 When One Door Closes: Evidence based solutions to improve outcomes and open new doors for children who are expelled or excluded from school in New Zealand. Regional Public Health, Wellington.

<sup>21</sup> New Zealand Herald, 22 August 2011 Naughty New Entrants Kicked Out of School  
<http://www.stuff.co.nz/national/education/5482314/Naughty-new-entrants-kicked-out-of-school>

<sup>22</sup> Freeman, N. 2011 When One Door Closes: Evidence based solutions to improve outcomes and open new doors for children who are expelled or excluded from school in New Zealand. Regional Public Health, Wellington.

<sup>23</sup> Fergusson, S & Collings, S. 2005 Social Explanations for Suicide in New Zealand, New Zealand Ministry of Health.

<sup>24</sup> Beautrais, A. 2003 Suicide in New Zealand II: a review of risk factors and prevention. Journal of the New Zealand Medical Association 06-June-2003, Vol 116 No 1175.

<sup>25</sup> Sen, A. (1997). Inequality, unemployment and contemporary Europe. International Labour Review, 136(2), 155-172. Retrieved August 24, 2011, from ABI/INFORM Global. (Document ID: 16409720).

<sup>26</sup> Youth Suicide, 31 October 2000 Background Note An information briefing service for Ministers of Parliament 2000/16 <http://www.parliament.nz/NR/rdonlyres/B6BC8204-9A36-4022-879F-A6B4710FB8CC/450/0016Suicide1.pdf>

<sup>27</sup> Agerbo A. Effect of psychiatric illness and labour market status on suicide: a healthy worker effect? J Epidemiol Community Health 2005;59:598-602

OECD research has shown that social support during periods of unemployment is associated with lower suicide rates in wealthy nations such as New Zealand.<sup>28</sup> The authors explain that “if everybody is poor, losing a job for a while is not as much of a stigma as losing a job where everybody else is very successful.” They comment that this reflects the ‘happiness literature’, where happiness is affected more by satisfaction with income in comparison with the income of others, than by absolute income.

The OECD report shows female labour participation and lower fertility rates are correlated with increases in both male and female suicide rates. They suggest that this is because they decrease family and social ties which protect against suicide.<sup>29</sup>

The Ministry of Justice report that over half of the people who should be enrolled to vote but are not, are under the age of 25. Voter turnout rates for young voters and Māori in particular are significantly below the national average.<sup>30</sup> There has been much criticism of young people’s failure to vote which is generally ascribed to apathy. The Ministry’s report showed that most of those who did not vote nevertheless believed voting was important. A British study indicated that trust and voter turnout are linked and that young people’s abstaining from voting is a reflection of lack of trust in the system and in politicians.<sup>31</sup>

## A Unifying Theory of Suicide

Suicide is represented by experts as being a highly complex behaviour which is not easily explained or understood. The multitude of factors which have been shown to correlate with suicide including childhood sexual abuse, psychiatric illness, relative poverty, substance abuse and even temperature fluctuations are seen as testament to this complexity.

Einstein said however “If you can’t explain it simply, you don’t understand it well enough.” It is possible that suicide is seen as highly complex primarily because the mechanism that explains it has not yet been uncovered, not because it is more complex than other human behaviours.

Maintaining suicide as a complex issue, able to be understood and addressed only by experts, upholds the power those experts have and the value placed on their skills. Along with legislation and policy restrictions on ‘non-experts’ such as families and communities speaking about their experience of suicide, it cements the status, power and financial position of a small minority of ‘suicidologists’, researchers and psychiatrists as the only people whose perspective on suicide is valid.

Recently however, research on suicide has focused on the development of a unifying theory of suicide.

The Interpersonal Psychological Theory of Suicide (IPTS) of suicide is a promising theory which attempts to provide a framework, not only for understanding suicide but for developing effective

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<sup>28</sup> Noh, Y.. (2009). Does unemployment increase suicide rates? The OECD panel evidence. *Journal of Economic Psychology*, 30(4), 575. Retrieved August 24, 2011, from ABI/INFORM Global. (Document ID: 1808068471).

<sup>29</sup> Ibid

<sup>30</sup> Catt, H. & Northcote, P. 2009 Prompting participation: can a personalised message to the newly enrolled have an impact on turnout? New Zealand Ministry of Justice.

<sup>31</sup> Russell, A. (2004). The truth about youth? Media portrayals of young people and politics in Britain. *Journal of Public Affairs*, 4(4), 347-354. Retrieved August 16, 2011, from ABI/INFORM Global. (Document ID: 769154611)

interventions. IPTS is a theory for which good evidence of validity is accumulating (Van Orden et al, 2008; Connor et al 2007; Van Orden et al 2006; Joiner, 2002). It was developed as an over-arching theory of suicide by Professor Thomas Joiner. Professor Joiner lost his father to suicide in 1990 and brings both his research skills and his personal experience of suicide to his work.

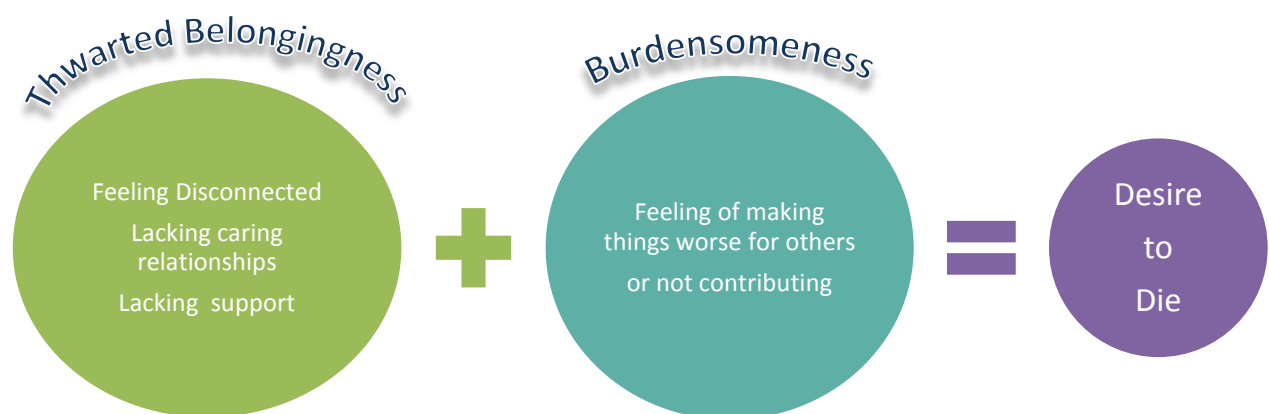
Interpersonal Psychological Theory suggests that suicide requires both the desire to die and the fearlessness to kill oneself and can be understood as the result of the convergence of three factors

1. thwarted belongingness
2. perceived burdensomeness,
3. an acquired capability for suicide

The first two factors represent a sense of disconnection and of failing to make a valued contribution which prompts the desire to die, while the last represents the ability to overcome the fear of pain and death required to take one's life. Individuals are at risk of suicide when they want to die and are capable of killing themselves. The relative rarity of death by suicide is explained by the notion that only a very small group of individuals will experience all three necessary conditions concurrently.<sup>32</sup>

#### *The desire to die*

Joiner's theory is that the desire to die arises from two factors – thwarted belongingness and perceived burdensomeness. He theorises that an individual's unmet need for belonging and connectedness often expressed a feeling of disconnection from others, an absence of mutually caring relationships and a sense of neither being a support for others or being supported, in combination with a sense of being a burden on others by making things worse for them or not contributing the desire for death emerges.



<sup>32</sup> Ribeiro, J., & Joiner, T.. (2009). The interpersonal-psychological theory of suicidal behavior: current status and future directions. *Journal of Clinical Psychology*, 65(12), 1291. Retrieved August 14, 2011, from Research Library. (Document ID: 1894063601)

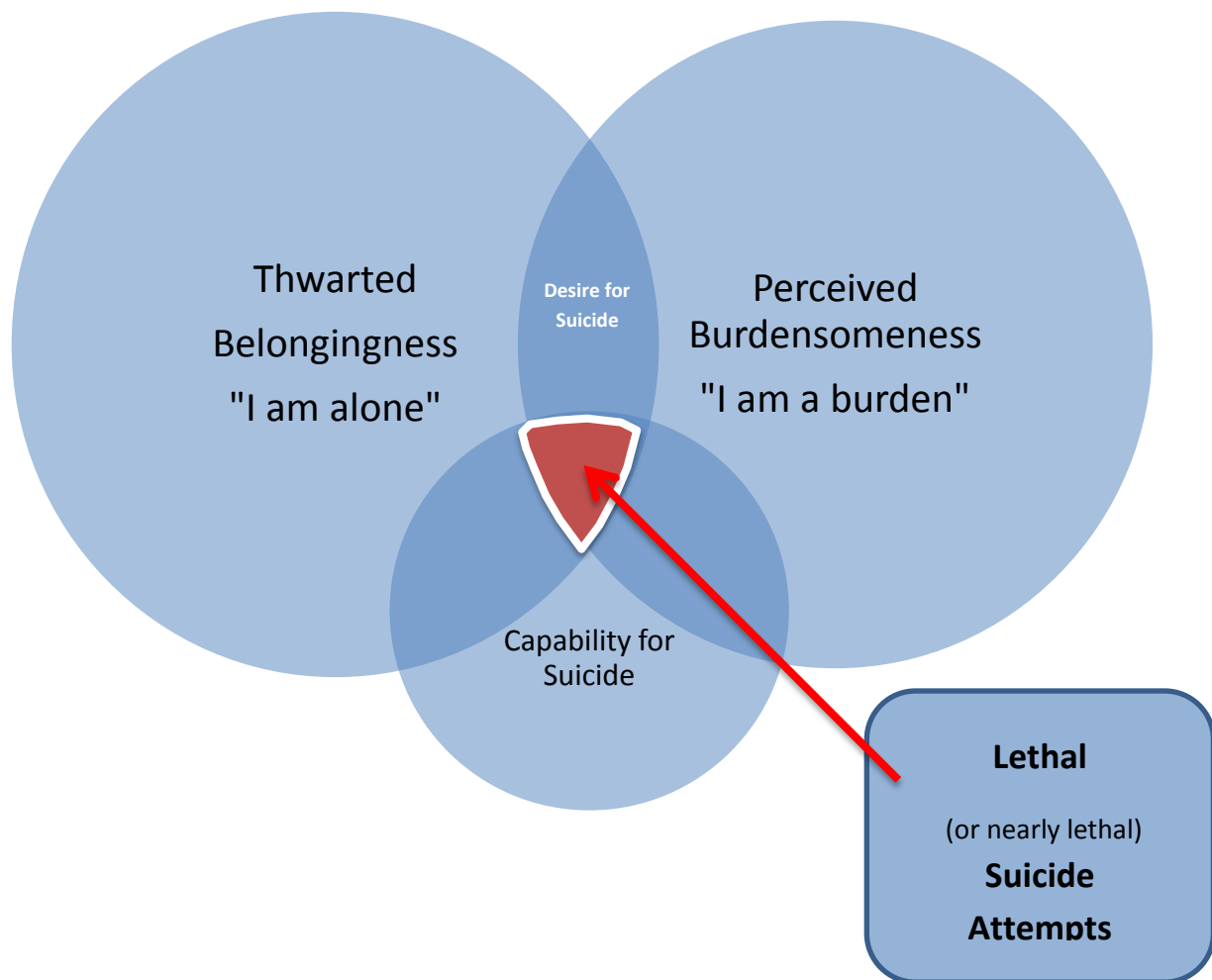
Thwarted belonging arises from lack of social connectedness when individuals experience of marginalisation, cultural alienation, rejection, abandonment and isolation while the sense of being a burden may arise from interpersonal conflict, unemployment, physical illness or disability. This theory provides the framework to explain the role of the range of factors which have been demonstrated to have associations with suicide – abuse, the end of a relationship, financial pressures, work and school stress, hopelessness etc as factors that contribute to thwarted belonging and a sense that one's death has more value than one's life.

#### *Acquired Capability*

IPTS acknowledges that the desire to die and suicidal thoughts are present in many who do not take their lives and that the desire to die by suicide is not sufficient for completed suicide to occur. This is because despite notions that suicide is 'an easy way out or 'cowardly', dying by suicide is not in fact an easy thing to do. It involves overcoming both the instincts to self-preservation and avoidance of pain. As such, Joiner theorises that for suicide to occur in the face of desire to die, a third factor must be present – that of acquired capability or fearlessness.

The theory suggests that acquiring the capability to kill yourself requires reduced fear of death and increased tolerance of physical pain. These can be achieved through repeated exposure to physically painful and/or fear-inducing experiences. The level of fear associated with an initial parachute jump for example, reduces as more jumps are undertaken. The IPTS theory suggests that childhood maltreatment, domestic violence, combat exposure, impulsivity, risk taking behaviours, repeated medical procedures and previous suicide attempts amongst an array of other experiences, may increase the risk of lethal suicidal behaviour because they prompt responses which include desensitisation to fear and pain.

It is also theorised that while acquired capability often develops over a period of time and repeated exposures, alcohol and other drugs with their ability to induce mania or psychosis, increase impulsivity and reduce natural inhibitions can facilitate an instance crossing of the threshold to acquired capability.



This theory helps explain many of the questions which arise from the current literature on suicide. The requirement for simultaneous convergence of desire to die and acquisition of capability, explains why the majority of those who experience adverse events or circumstances do not complete suicide. The socialisation of men to be less sensitive to fear and pain<sup>33</sup> and the socialisation of women to value belonging and social connectedness explains the relative rates of completed suicide and suicide attempts between genders.

Acquired capability explains why the majority of individuals who attempt suicide will not eventually die by suicide and why up to half of those who die by suicide do so on their first attempt. It links disparate factors such as hopelessness, loss of romantic relationships, alcohol, financial pressures and interpersonal conflict under the umbrella of factors that contribute to the desire to die – thwarted belongingness and perceived burden and sexual abuse, illegal and prescription drugs, and risk taking behaviours under the umbrella of acquired capability.

IPTS explains why a history of a past suicide attempt is found in the literature to be one of the strongest and most reliable predictors of suicidal behaviour given its ability to increase tolerance to pain and fear. It also explains why a history of self-harm is not necessary for suicide given the capability for fearlessness to be acquired through behaviours other than suicide attempts. It explains

<sup>33</sup> Smith, P., & Cukrowicz, K.. (2010). Capable of Suicide: A Functional Model of the Acquired Capability Component of the Interpersonal-Psychological Theory of Suicide. *Suicide & Life - Threatening Behavior*, 40(3), 266-75. Retrieved August 14, 2011, from Research Library. (Document ID: 2092378861)

the link between impulsivity and suicide given impulsive individuals are more likely to engage in behaviours that are painful and provocative and build acquired capability.

## Current Approach to Suicide

The New Zealand Director General of Mental Health reports that those who have had contact with mental health services in the year prior to their deaths are at 25 times higher risk of suicide than those who have had no contact in the past 12 months.<sup>34</sup> Rather than having serious mental illnesses, he reports that only 18% of those who died by suicide under the recent care of mental health services had a diagnosis of depression, 11% of schizophrenia and 9% bi-polar disorder while by far the largest group comprising 40% had no specific diagnosis.<sup>35</sup>

The Ministry of Health reports that 46.6% of the New Zealand population and more than half of all Maori experience mental illness during their lifetime and that 37% have more than one mental disorder. Non-service users as defined by the Director General are not those without 'mental disorders' but those who have not engaged with services in the 12 months before their deaths.

	Number suicides		Rate per 100,000 people	
	2006	2007	2006	2007
<b>Service Users</b>	163	175	199	303
<b>Non-Service Users</b>	336	262	10	5

Director General Mental Health, Annual Report 2009

The Ministry of Health and its advisers claim that almost all of those who die from suicide have mental disorders. The presence of a mental disorder therefore is, in the view of the Ministry, common to all those who die. The table above however shows clearly the hugely elevated rate of suicide amongst those who have contact with mental health services and those who do not and that this effect is increasing. While the rate of suicide in those who do not engage with services halved, the rate of those who received services increased by two thirds.

Arguments that the population engaged with mental health services are more ill or have more serious illnesses than the general population, and that this accounts for their increased suicide risk, are not supported by any of the available evidence. The recommendations of the Ministry of Health, the Prime Minister's Chief Science Adviser and others that suicide prevention requires

IPTS helps explain how involvement in the mental health system increases suicide risk by undermining belonging, creating a sense of burdensomeness and assisting consumers to acquire the capability for suicide.

### Belonging & Burdensomeness

Diagnostic labelling constructs individuals as separate and different from others and thwarts a sense of belonging. It positions distressed people as ill and frequently leads to welfare dependence and reduced ability to contribute to families, communities and workplaces. Psychoactive medications, the use of restraints and coerced 'care' facilitate the acquisition of tolerance to pain and fear and therefore the ability to end one's life.

<sup>34</sup> Annual Report of the Director General Mental Health, 2010. Ministry of Health, Wellington.

<sup>35</sup> Annual Report of the Director General Mental Health, 2009. Ministry of Health, Wellington.

A study conducted this year found that

*when people are confronted with a general label of mental illness, in the absence of other information, their default response is to accord the targeted individual with lowered human status. In other words, the mere label of chronic mental illness triggers dehumanizing responses.*<sup>36</sup>

New Zealand based research undertaken by the Mental Health Foundation shows that the process of being assigned a diagnosis leads people to negative thoughts about themselves and their life potential and to becoming socially isolated. It showed that perception of the negative impact a diagnosis is likely to have on their life chances and ongoing well-being can prompt suicidality. Research participants identified involvement in the mental health system and the experience of being labelled as mentally ill as prompting suicidality.<sup>37</sup>

Evidence shows that involvement in the mental health system undermines people's ability to participate, fulfil their family, workplace and community responsibilities and creates distance between consumers and their families. Evidence of this is found in a recent research project undertaken by the mental health foundation which found that discrimination and/or negative treatment from mental health professionals disempowers families and leads to exclusion of the family member using mental health services and undermines family functioning.<sup>38</sup>

While the Privacy Act is clear that personal information may be shared where disclosure is necessary to prevent or lessen a serious and imminent the life or health of any individual, medical professionals and mental health workers persist in withholding information from families that their loved one has planned their suicide. New Zealand research shows that 71% of mentoring agencies have no contact with the families of the children they mentor. Such dismissal of the role of families in suicide prevention increases the isolation of service users and their risk of suicide.

The Cabinet appointed Welfare Working Group reports that in December 2009, 41% of people receiving a Sickness Benefit and 29% of people receiving an Invalid's Benefit had psychological or psychiatric conditions listed as their first condition.<sup>39</sup> Those dependent on welfare and labelled ill or disabled often perceive themselves, and are perceived by others, as a burden on their families, communities and society. Low incomes and the discrimination experienced by those labelled mentally ill are barriers to full participation.

### Acquired Capability

IPTS posits that repeated painful experiences and the use of mind altering substances are antecedents to acquiring fearlessness in the face of pain and death. Legislation and practice in New Zealand allows the mental health system to use forced incarceration, restraints, solitary confinement and drugs which induce mania and psychosis to 'treat' those who suffer emotional distress.

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<sup>36</sup> Martinez, A., Piff, P., Mendoza-Denton, R. & Hinshaw, S. 2011 The Power of a Label: Mental Illness Diagnoses, Ascribed Humanity, and Social Rejection Journal of Social and Clinical Psychology, Vol. 30, No. 1, 2011, pp. 1-23. University of California, Berkeley

<sup>37</sup> Peterson D, A. Barnes, C. Duncan. 2008. Fighting Shadows: Self-stigma and Mental Illness: Whawhai Atu te Whakamā Hihira. Auckland: Mental Health Foundation of New Zealand.

<sup>38</sup> Barnett, H. & Barnes, A. (2010) Walk A Mile In Our Shoes. He tuara, ngā tapuwae tuku iho o ngā Mātua Tūpuna. Exploring Discrimination Within and Towards Families and Whānau of People Diagnosed with 'Mental Illness'. Auckland, New Zealand: The Mental Health Foundation of New Zealand

<sup>39</sup> The Welfare Working Group 2011 Reducing Long-Term Benefit Dependency Recommendations. Institute Policy Studies, Victoria University.

The Director General of Mental Health reports that seclusion is used in every mental health unit in New Zealand and that men and Maori are those most likely to be secluded. The Director General does not report on the use of force and restraints against mental health services but it has been reported that police have used tasers against mental health service users at twice the rate they are used against criminals<sup>40</sup> and disproportionately against Maori and Pacific people.<sup>41</sup>

The most commonly prescribed antidepressants in New Zealand, SSRIs, have been proven to at least double the risk of suicidality when prescribed both for psychiatric and non-psychiatric illnesses<sup>42</sup> and completed suicides have occurred in clinical trials of these drugs (Fergusson et al 2005). Recent studies have shown no differences between the risk of completed suicide across different SSRI drugs (Schneeweiss et al 2010).

Medsafe reports that Ritalin prescribed for ADD and ADHD can cause suicide while numerous clinical trials have shown that antidepressants more than double the risk of suicidal thinking and behaviour (Fergusson et al, 2005; Healy, 2004; March, 2007; Teicher et al 1990). The prescribing of antidepressants to children aged 0-4 years in New Zealand increased 143% between 2009 and 2010. Pharmac data shows 1.3 million antidepressants were prescribed to 485,000 New Zealanders in 2010.

A study undertaken by the Ministry of Health in 2007 found that increases in antidepressant prescribing are directly responsible for increases in serious suicide attempts. New Zealand does not collect data on the presence of prescription drugs in the blood of those who die from suicide but research in other countries have shown the presence of these drugs in toxicology tests on up to 60% of victims (Larsson, 2010).

Forced, coercive and painful experiences within the mental health system combined with the use of drugs which reduce inhibitions induce mania and psychosis and increase impulsivity promotes acquired capability to perform the act of suicide.

### Cultural Appropriateness

Maori researchers have noted that while mainstream researchers included loss of culture and acculturative stress among the instrumental factors driving indigenous suicide this is still within a framework of individual deficits. Indigenous researchers worldwide have advocated a more holistic approach where the primary intervention to reduce indigenous suicide is not to target individual-level risk factors, but the restoration of culture at the group level.

An individual-level epidemiological approach addresses the symptoms of colonization, but does not address the root cause of the high rate of indigenous suicide, which according to indigenous researchers is the traumatic loss of culture over generations.<sup>43</sup>

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<sup>40</sup> O'Brien, A., McKenna, B., Thom, K., Diesfeld, K & Simpson, A. 2011 Use of Tasers on people with mental illness: A New Zealand database study International Journal of Law and Psychiatry Volume 34, Issue 1, January-February 2011, Pages 39-43

<sup>41</sup> Maori, Islanders High in Stun Gun Statistics, New Zealand Herald, 25 August 2011

[http://www.nzherald.co.nz/nz/news/article.cfm?c\\_id=1&objectid=10747277](http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=10747277)

<sup>42</sup> FDA Revisions to Product Labelling retrieved from

<http://www.fda.gov/downloads/Drugs/DrugSafety/InformationbyDrugClass/UCM173233.pdf>

<sup>43</sup> Lawson-Te Aho, K. & Liu, J. 2010 Indigenous Suicide and Colonization: The Legacy of Violence and the Necessity of Self-Determination International Journal of Conflict & Violence, Vol. 4 (1) 2010, pp. 124 – 133

In addition to ignoring the key driver of Maori suicide, research undertaken by a senior lecturer at Auckland University, showed that 60.9% of New Zealand born, male psychiatrists – those most likely to be training and mentoring new staff and developing policy and practice, believe Maori are genetically predisposed to madness.<sup>44</sup> The author of this study expresses concern

*That such a simplistic and unsubstantiated application of the biological paradigm is held by a significant proportion of psychiatrists is a matter of grave concern. Is the belief that a particular race is more genetically predisposed to 'madness' than other races any less racist than the belief that a race is genetically/biologically inferior?*

It should be noted that the biological paradigm in psychiatry has gained far greater dominance than it had at the time this research was published.

The views held by senior psychiatrists of Maori inferiority and that culturally appropriate practice necessary or desirable.

The following comments made by study participants give an insight into the experiences of Maori mental health consumers and their families

*There is no need for taha Maori in training programs, as psychiatrists we are taught skills and we apply them in a cookbook manner. My effectiveness as a psychiatrist is not dependent on the colour of my skin, my culture, nor my understanding of bloody Maori culture.*

*This questionnaire is worthless! I mean the Maoris are always going on about the importance of land etc. etc. so why did they bloody well give it away. They went on about the importance of forestry and lakes and then that bloody idiot cut down the tree on One Tree Hill. I feel that they are getting the appropriate services they need, just not using them, medication is the answer – but they just don't take their pills – if cannabis was prescribed, I'd bet they'd bloody take that.*

The research showed that fewer than 5% of psychiatrists believed that an understanding of the importance of whanau and whakapapa' and the concept of whanaungatanga' were important to their work and only 1.6% thought an understanding of taha wairua was important.

#### Relocating Suicide Prevention

If the desire and ability to die by suicide arise from social, familial and economic factors, if their reduction involves social connectedness, a sense of belonging, contributing and being valued why would we locate suicide prevention within a system that precipitates social isolation, marginalisation, and inability to contribute? And why would we do so when, in the name of treatment, this system provides drugs which are clinically proven to induce mania and psychosis which instantly confer the capability for self harm and suicide?

Why, would we not locate suicide prevention within families and communities? Why would we not educate families and communities on the importance of social connectedness and opportunity to participate to suicide prevention, assist them to implement strategies to promote a sense of belonging and being a valued contributor and to do so in culturally appropriate ways?

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<sup>44</sup> Johnstone, K., Read, R. 2000 Psychiatrists' recommendations for improving bicultural training and Maori mental health services: a New Zealand survey Australian and New Zealand Journal of Psychiatry 2000; 34:135–145

The mental health approach to suicide prevention has dominated the past two decades. It has reigned during the period of the most rapid rises in suicide New Zealand has ever seen. The introduction of mass psychiatric screening of four year olds in the B4 school check has translated into increases in antidepressant prescribing to this age group of 143% in a 12 month period.<sup>45</sup> Mental Health service delivery provides the perfect recipe for suicide as conceptualised by IPTS.

### Risks to New Zealand in Continuing to Utilise a Mental Health Approach to Suicide Prevention

Continued use of a mental health approach to suicide prevention in New Zealand exposes us to a number of risks. The first is the obvious risk that our citizens will continue to die at rates twice that of comparison countries. In addition to the risks to human life, there are significant legal, economic and political risks to continuing on our current path.

The increase in mental health programme and spending in New Zealand has not improved the health of New Zealand citizens. The Ministry of Health continually reports increases in the prevalence of mental disorders amongst the general population and creates dependence on state assistance. Suicide rates in Maori and women are increasing and the age of children dying by suicide is lowering.

Pathologising normal human distress as illness and encouraging individuals and groups to self-identify as mentally ill through campaigns such as the National Depression Initiative has been identified as encouraging helplessness and reliance on the services of health professionals.<sup>46</sup>

In 2011, Government expenditure on specialist mental health services will be around \$1.4billion. Concurrent with increasing investment in the sector, prevalence of mental distress is increasing. The New Zealand Mental Health Survey indicated that about one in five adults in New Zealand experienced a mental illness in the past 12 months and that rates of mental illness have increased to the point that almost 50% of the population and over 50% of some population groups are deemed by government to be mentally ill.<sup>47</sup> The continued investment of millions of dollars into mental health services appears to increase the level of illness and disability in New Zealand.

The 2011 budget announced an increase of \$40million for mental health services and \$80million for access to medicines over the next four years.

A recent study by the WHO across 76 countries found that general population suicide rates increased in direct relation to increases in the percentage of the total health budget spent on mental health.<sup>48</sup> It also found that

- General population suicide rates in both genders were higher in countries with mental health legislation.
- general population suicides rates in both genders increased with increases in the number of psychiatric beds, psychiatrists and psychiatric nurses.

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<sup>45</sup> Data on antidepressant prescribing by 5 year age group for the year 2009-2010 by Pharmac.

<sup>46</sup> Mulder, R.. (2008). An epidemic of depression or the medicalization of distress? Perspectives in Biology and Medicine, 51(2), 238-50. Retrieved August 13, 2011, from Research Library. (Document ID: 1481819061

<sup>47</sup> Mental Health Commission 2011.

<sup>48</sup> Ajit Shah, Ritesh Bhandarkar and Gurleen Bhatia 2010 The Relationship Between General Population Suicide Rates and Mental Health Funding, Service Provision and National Policy: a Cross-National Study *Int J Soc Psychiatry* July 2010 56: 448-453, first published on August 3, 2009

- General population suicide rates in both genders were higher in countries where training in mental health for primary care professionals was available.

Suicide is conservatively estimated to cost \$1.6 billion per annum against the New Zealand economy. Continued investment of increased funding in a system which at best fails to deliver any reduction in suicide and at worst increases suicide deaths is irresponsible on both economic and humanitarian grounds.

The evidence that psychiatric treatment is at best ineffective and at worst potentially fatal is to be found in a number of reports from the New Zealand government including the report of the Director General of Mental Health that those under the care of Mental health services are 25 times more likely to die from suicide than the general population, research from the Ministry of Health which established that increases in antidepressant prescribing directly caused increases in hospitalisation for suicide attempts and the fact that despite huge investment in funding for mental health services, estimates of the prevalence of mental disorder in the general population continue to rise.

#### *Political and Reputational Risks*

New Zealand's reputation as a great place to raise a child is compromised by appallingly high youth suicide rates, our failure to take strong action to reduce those rates. Our brand as a 'clean, green, natural' country is threatened by our increasing medicating of our population, including babies and children.

## **A New Approach to Suicide**

The challenge for any strategy which encompasses the entire population is to ensure that it does not create inequities in outcomes, by treating diverse groups within the population as though they are the same. This strategy offers information for families and communities to use to develop a strategy and action plan that reflects their particular needs and preferred approach.

Both the Tikanga and IPTS approaches to suicide prevention emphasise belonging and connectedness. Patterns in current suicide rates show the greatest impact on those who are portrayed and perceived as burdens, rather than assets in our communities - adolescents, the aged, those who are unemployed, victims of crime and whose income and social status does not match those of their peers.

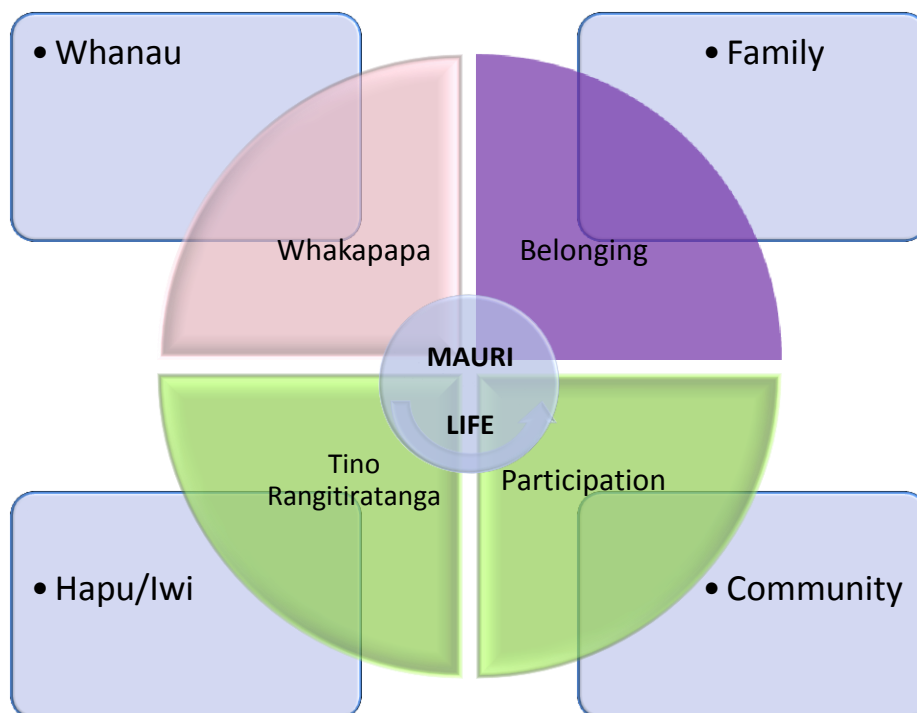
Increasingly, international suicide prevention strategies are recognising the need to move away from suicide prevention strategies based on a narrow psychiatric and individual deficit focus and moving to locate suicide prevention in communities. The aim of these strategies is to support communities to identify local priorities and build local capacity, with specific goals that include building the community's knowledge base, engendering public will to support change and generate resources, and developing a social strategy to accomplish change. Communities are not limited to those based on geography, but include a range of groups based on shared age, ethnicity or interest.

The CASPER model envisages a partnership between government and communities and communities and families rather than suicide prevention being something government agencies engage in when families and communities 'fail.'

The North American CDC Suicide Prevention Strategy, for example, describes its strategic direction for suicide prevention as being “to promote and enhance connectedness within and among individual persons, families, and communities.” It identifies as its particular focus interrupting the development of suicidal behaviour, rather than waiting until this behaviour emerges and providing crisis intervention.<sup>49</sup>

Maori researchers have observed that the concepts of cultural alienation, loss of identity and soul wounding resulting from intergenerational impacts of colonisation do not lend themselves to empirical measurement and are therefore generally dismissed or given insufficient weight by Pakeha researchers.<sup>50</sup> IPTS provides a framework and empirical evidence to support the contribution these factors make to suicide.

A process of parallel development would see Maori and Pakeha forge their own pathways and employ their own tools towards the shared the goal of preventing suicide.



CASPER Suicide Prevention Model

Lawson Te-Aho & Liu (2010) state that

*... unless Maori are able to exercise control over the design of interventions for suicide prevention, the solution will continue to be improperly framed in Western psychological traditions as an individualized, deficit-focused problem inside the individual. This renders the continuity of the trauma of colonization invisible, except in the form of statistics showing massively higher rates of indigenous suicide. Maori cannot look to Western psychological traditions (a colonizing/assimilationist tradition) for this kind of healing. Instead, a reclamation of the authority and resources to develop culture appropriate responses to suicide is*

<sup>49</sup> Rockville, MD : U.S. Dept. of Health and Human Services, Public Health Service, 2001.

<sup>50</sup> Lawson-Te Aho, K. & Liu, J. 2010 Indigenous Suicide and Colonization: The Legacy of Violence and the Necessity of Self-Determination International Journal of Conflict & Violence, Vol. 4 (1) 2010, pp. 124 – 133

*needed. This means the reinstatement of tino rangatiratanga (tribal sovereignty) based on whakapapa (kinship) relations and functioning inside the framework of best cultural practices.*

Pakeha researchers too, are recognising that individualised models cannot achieve effective suicide prevention. They acknowledge that suicide rates are unlikely to decline as long if prevention efforts are confined to those at immediate risk of attempting suicide.<sup>51</sup>

In addition to taking a broader, collective approach to suicide prevention, tailored strategies are necessary. A one size fits all strategy such as our current suicide prevention strategy, creates inequities by ignoring the disparities in the current status of minorities.

Our current strategy relies on aggregate data. This data renders sub-populations invisible. Because men and pakeha dominate the suicide statistics numerically, trends and issues for women, Maori, Pasific, youth, the aged, LGBT and other minority populations are masked. American research and models underpin much of our strategy and interventions and despite being often culturally inappropriate are imposed in the name of 'evidence based practice.'

This strategy proposes collecting and making available good quality information to communities and empowering them to design interventions that work for their members. It proposes devolving power and resources to the groups to which individuals belong rather than locating suicide prevention in hospitals and clinics and government offices. It suggests the key role for government in suicide prevention is the provision of resources and the removal of current barriers to families and communities taking care of their own. It suggests government and the medical profession support families to care for their own rather than intervening directly in families in a way which has been shown to cause harm and increase suicidal risk.

Lawson Te-Aho claims that *"The restoration of indigenous people's rights is understood as an issue of the colonizing power relinquishing control over resources, language, and the cultural development of indigenous peoples. In Maori terms, suicide is associated with a state of mind characterized as kahupo (Kruger et al. 2004), meaning loss of hope, meaning, and purpose, and an enduring sense of despair."*

Families and communities are currently expressing a sense of hopelessness and helplessness in relation to suicide. It is necessary to restore their role and power in relation to keeping their members safe from the desire and capability for self-inflicted death. Increasingly, communities are reclaiming this role and power but in doing so, face threats and withdrawal of resources from the government.

Joiner points to the power of social cohesion and a shared sense of purpose as being protective against suicide. He notes that the practice of 'pulling together' saw fewer suicides during the 9/11 crisis in the United States. Other research has shown that wars can be associated with a decline in suicide rates, and attributes this to greater cohesion and shared sense of purpose in a society during wartime.<sup>52</sup>

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<sup>51</sup> Clarke, T., Robinson, E., Crengle, S., Fleming, T., Ameratunga, S., Denny, S., Bearinger, L., Sieving, R., Saewyc, E. 2011 Risk and Protective Factors for Suicide Attempt Among Indigenous Māori Youth in New Zealand: The Role of Family Connection Journal of Aboriginal Health

<sup>52</sup> Hawton, K., & van Heeringen, K. (2009). Suicide. The Lancet, 373(9672), 1372-81. Retrieved August 20, 2011, from Research Library. (Document ID: 1683154041)

Suicide is one of the most preventable of all causes of death. The evidence is that prevention requires a sense of belonging and hope and opportunities to participate and contribute. The provision of these things sits naturally within families, whānau, communities and hapu, iwi, schools, churches, community and sports groups, not with government or the medical profession.

## Overview of the Strategy

The CASPER suicide prevention strategy has 4 Focus Areas:

1. Understanding
2. Wellbeing
3. Belonging
4. Contributing

The rationale for the focus on each area is provided along with an overview of the evidence for its links with suicide.

The purpose of the strategy is to provide a framework for families and communities to develop a set of suicide prevention initiatives that reflect their culture, needs, priorities and capabilities. Ideally this process would commence with an audit of strengths and development needs and of particular risks and gaps, protective factors and assets currently held. This would help focus the development of an action plan which addresses each of the listed focus areas.

The strategy provides some possible action items as a guide but these are neither exhaustive nor necessary. The best plan of action for each family and community will arise from the expert knowledge they have of their members, needs and resources.

## Focus Area 1 - Understanding

### *Rationale*

Knowledge is power. Families and communities must be provided with data which is current and accurate if they are to maximise their suicide prevention capability.

Currently families and communities have little information about suicide and its prevention. Most are unaware of the prevalence of suicide within and across populations.

Information from government and government funded agencies is outdated and inaccurate. It conceptualises suicide as a rare occurrence that is a product of mental illness. These messages serve to create a sense for the majority of the population that suicide is not something that could affect their loved ones and provides a false sense of security for families in relation to their level of suicide risk. By contrast, messages about drink driving reinforce the idea that this form of death could occur in any family and that good preventative education and action is required to keep family members safe.

New Zealand families have a right to know that the numbers of suicide deaths far exceed road traffic deaths, that suicide occurs in children under 10 and people over 80 as well as in teens and those in middle age. They have a right to be fully informed about the risk of suicide so that they are able to take preventative action.

The New Zealand Coroner's Court collects and reports minimal data. This includes age, ethnicity, geographical location and method. It does not collect information on sexual orientation, the role of alcohol or prescription or illegal drugs, sexual abuse, domestic violence, bullying, physical health or a range of other data on the circumstances leading to suicide. For the first time this year, the Chief Coroner released data on occupation and employment status of those who died from suicide. If this data is being collected, it is difficult to understand why the Ministry of Health has not reported it. All possible information on suicide victims should be collected in every case, analysed for patterns and trends and made available to the public.

New Zealand has a highly restrictive regime in relation to open discussion of suicide. In contrast to other jurisdictions such as Australia, New Zealand has increased restrictions on the media reporting of suicide rather than relaxed them. There is good evidence that reporting of suicide is an important community education measure that can prevent suicide. A recent submission to the Chief Coroner summarised the international evidence on open reporting of suicide and led the Court to advise it was persuaded that there are more benefits than harms arising from allowing unfettered reporting of suicide deaths.<sup>53</sup> The submission describes the harm done to families of suicide victims by current restrictions under s71 of the Coroner's Act 2006, which include suicide risk.

The New Zealand Suicide Prevention Strategy has as one of its goals to "Expand the evidence about the rates, causes and effective interventions." Recent changes to the Coroners Act which remove the requirement to conduct an inquest for suspected suicides undermines this goal. Increasingly families are discouraged from going to inquest and Coroners are failing to collect the robust data such a proceeding reveals.

### Possible Actions

- Development and implementation of a comprehensive regime of suicide data collection and reporting.
- Reintroduction of requirement for an inquest for all suspected suicides.
- Public education campaigns on the importance of belonging and community cohesion
- Provision of current, accurate information to family/whānau, community, marae, youth/rangitahi, schools/kura and other groups.

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<sup>53</sup> Submission available at <http://www.casper.org.nz/node/132>

## Focus Area 2- Well-being

### Physical Health

#### *Rationale*

Moods, behaviours and perceptions can all be influenced by physical health and illness. Illness and disability can be significant barriers to participation and can lead to a sense of being a burden when they prevent people from fulfilling their roles in families and communities. Good physical health is strongly linked with good emotional health.

Research has found that physical illness is a strong risk factor for suicide, contributing to over 70% of suicides in those over the age of 60. A longitudinal study found the incidence rate of suicide death in participants with asthma was more than twice that of those without asthma.<sup>54</sup>

The U.S. National Comorbidity Survey found statistically significant increases in suicide risk for those with general medical conditions, with particularly high ratios in AIDS patients whose risk of suicide attempt is more than 100 times that of the general population. Those with cancer and asthma have

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<sup>54</sup> Kuo, C., Chen, V., Lee, W., Chen, W., Ferri, C., Stewart, R., Lai, T., Chen, C., Wang, T., & Ko, Y.. (2010). Asthma and Suicide Mortality in Young People: A 12-Year Follow-Up Study. *The American Journal of Psychiatry*, 167(9), 1092-9. Retrieved August 12, 2011, from Research Library. (Document ID: 2138474251).

been found to have a fourfold risk of attempting suicide compared to the general population.<sup>55</sup> Hernia carries an over ten-fold increase, ulcer over a threefold increase while stomach problems, autoimmune disease, kidney problems, heart attack, hypertension, arthritis, and lung disease have been associated with over a twofold increase in the odds of suicide attempt.<sup>56</sup>

It is suggested that pain, physical disfigurement, disability, cognitive dysfunction and disinhibition associated with physical illness, may add to the risk of suicide.<sup>57</sup> This is consistent with the theory of acquired capability.

## Nutrition

A significant body of evidence links a range of micronutrients with emotional health and optimal cognition (Kennedy et al 2010), positive mood (Benton 2003) and higher functioning (Smith et al 2005). Research shows that a significant proportion of the population are deficient in specific vitamins and minerals as a result of high levels of consumption of fast food (Kennedy et al, 2008) and that certain foods may act as mood stabilisers (Silver et al 2002).

Research has shown that adolescents in families who reported sometimes or often not having enough to eat had thoughts of death, desire to die and suicide attempts, independent of family income.<sup>58</sup>

## Exercise

Exercise has been shown to have a significant impact on mood and functioning (Kanning et al 2010) with evidence that participation in physical activity protects against sadness and suicidal behaviours (Brosnahan et al, 2004). Some research has found however that involvement in a team is the protective factor rather than physical activity itself (Taliaferro, 2008) while others have found that both physical activity and team participation play a part in reducing suicidal thinking and behaviour.

Group exercise and exercise that is part of team sport has been shown to have the greatest health benefits as a result of combining the benefits of exercise on physical and emotional health and the benefits of belongingness and social cohesion.<sup>59</sup>

## Drugs

A large number of studies have shown that a range of drugs are causally linked with suicide. In the United States and elsewhere in the world, antidepressants carry warnings of their potential to

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<sup>55</sup> Copsey Spring, T., Yanni, L., & Levenson, J.. (2007). A Shot in the Dark: Failing to Recognize the Link Between Physical and Mental Illness. *Journal of General Internal Medicine*, 22(5), 677-80. Retrieved August 12, 2011, from Research Library. (Document ID: 2395702691)

<sup>56</sup> Goodwin, R., Marusic, A. & Hoven, C. 2003. Suicide attempts in the United States: The role of physical illness. *Social Science & Medicine*, 56(8), 1783-1788. Retrieved August 13, 2011, from Research Library. (Document ID: 537706051)

<sup>57</sup> Copsey Spring, T., Yanni, L., & Levenson, J.. (2007). A Shot in the Dark: Failing to Recognize the Link Between Physical and Mental Illness. *Journal of General Internal Medicine*, 22(5), 677-80. Retrieved August 12, 2011, from Research Library. (Document ID: 2395702691)

<sup>58</sup> Alaimo, K., Olson, C., & Frongillo, E. 2002. Family food insufficiency, but not low family income, is positively associated with dysthymia and suicide symptoms in adolescents. *The Journal of Nutrition*, 132(4), 719-25. Retrieved August 15, 2011, from Research Library. (Document ID: 113780978)

<sup>59</sup> Brown, D., Galuska, D. Zhang, J., Eaton, D., Fulton, J., Lowry, R. & Maynard, L., 2007 Physical Activity, Sport Participation, and Suicidal Behavior: Conclusions and Recommendations for Future Research

induce suicidality as a result of clinical trials showing they at least double the risk of suicide in those who use them.<sup>60</sup>

A study conducted by the Ministry of Health in 2007 found that increases in antidepressant prescribing in New Zealand are the direct cause of increases in hospitalisation for medically serious suicide attempts.

Alcohol has also shown to be linked to suicide attempts.<sup>61</sup> Studies show that like other drugs, nicotine use is strongly linked with suicidal behaviour.<sup>62 63</sup>

### Possible Actions

- Ensure access to preventative health programmes and medical care for all members of all communities
- Promote team sport as a suicide prevention activity and aim for most young people to be involved some form of physical activity.
- Stop the unnecessary prescribing of suicide-inducing prescription drugs through effective regulation, public and GP education.
- Stop marketing alcohol to youth and raise the price point to reduce availability.
- Promote community gardens, farmers markets, and other cooperative programmes to provide access to affordable nutritious food.
- Encourage community elders to teach young families to provide nutritious meals on restricted budgets.

<sup>60</sup> FDA, Department of Health and Human Services retrieved from <http://www.fda.gov/Drugs/DrugSafety/InformationbyDrugClass/UCM096273>

<sup>61</sup> Swahn, M. & Bossarte, R. 2005 Gender, early alcohol use, and suicide ideation and attempts : Findings from the 2005 youth risk behavior survey. *Journal of Adolescent Health* 2007, vol. 41, no2, pp. 175-181 (1) Division of Violence Prevention, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, Atlanta, Georgia, ETATS-UNIS

<sup>62</sup> Yaworski, D., Robinson, J., Sareen, J., & Bolton, J.. (2011). The Relation Between Nicotine Dependence and Suicide Attempts in the General Population. *Canadian Journal of Psychiatry*, 56(3), 161-170. Retrieved August 12, 2011, from Research Library. (Document ID: 2349531761)

<sup>63</sup> Breslau, N., Schultz, L., Johnson, E., Peterson, E. & Davis, G. 2005. Smoking and the Risk of Suicidal Behavior: A Prospective Study of a Community Sample. *Archives of General Psychiatry*, 62(3), 328-34. Retrieved August 12, 2011, from Research Library. (Document ID: 806805471).

## Focus Area 3 – Safety

### Rationale

Sexual and physical abuse, trauma and victimisation and relative poverty are associated with suicide risk. Keeping our homes and communities safe and reducing income disparity are suicide prevention activities. The current rates of suicide of those under the care of mental health services must be reduced.

The Director General of Mental Health reports that 86% of those who die from suicide have had contact with mental health services in the calendar month of their deaths.<sup>64</sup> Many suicide deaths occur within psychiatric hospitals or within a short time of discharge (Fekete et al., 2004; Luoma et al., 2002).

Studies have shown that in many cases physical illnesses will not be diagnosed and treated when a patient is admitted to a psychiatric unit. This has potentially serious implications for patients' overall health, delaying recovery and lengthening hospital stay (Garden, 2005). They have also found that over 50% of American psychiatrists never perform a physical examination and that 45% of psychiatric inpatients have a significant physical disease (Hughes, 1991). This can manifest itself as mental instability, but in fact is an undiagnosed and untreated physical illness.

New Zealand studies outlined in this document clearly show that harm is arising from the labelling and prescribing which are central features of suicide prevention in New Zealand.

Physical, and in particular, sexual abuse during childhood is strongly associated with suicide.<sup>65</sup> Prevalence rates for Child Sexual Abuse in New Zealand have been found to be 23.5% for urban and 28.2% for rural women with Māori women more frequently reporting experiences of CSA than women from European and other ethnic with rates between 30.5% vs 35.1%. A 2007 study found the median age of onset of the abuse was 9 years, and the median estimated age of the abuser was 30 years with the majority of cases being perpetrated by a family member.<sup>66</sup>

The sexual abuse of men is often underestimated by the general population. A New Zealand study<sup>67</sup> found that one in five sexually abused children is male, and overseas research suggests that 16% of males will experience sexual abuse before the age of 18.<sup>68</sup>

The New Zealand crime and victimisation survey in 2008<sup>69</sup> showed that those most likely to be victimised are:

- the young (aged 15–24)

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<sup>64</sup> Annual Report, Director General Mental Health 2009.

<sup>65</sup> Hawton, K., & van Heeringen, K. (2009). Suicide. *The Lancet*, 373(9672), 1372-81. Retrieved August 20, 2011, from Research Library. (Document ID: 1683154041)

<sup>66</sup> Fanslow, J., Robinson, E., Crengle, S. & Perese, L. 2007 Prevalence of child sexual abuse reported by a cross-sectional sample of New Zealand women. *Child Abuse & Neglect* Volume 31, Issue 9, September 2007, Pages 935-945

<sup>67</sup> Fergusson, Lynskey & Horwood, 1996, cited in J. Read (1997). National and international epidemiology. Paper given at the Doctor's for Sexual Abuse Care Conference 1997 - "Sexual abuse of males: New Zealand's Untold Story" cited on Rape Prevention Education website at <http://www.rapecrisis.org.nz/content.aspx?id=55>

<sup>68</sup> Finkelhor, D., Hotaling, G., Lewis, I., & Smith, C. (1990). Sexual abuse in a national survey of adult men and women: Prevalence, characteristics, and risk factors. *Child Abuse and Neglect*, 14, 19-28 cited on Rape Prevention Education website at <http://www.rapecrisis.org.nz/content.aspx?id=55>

<sup>69</sup> Statistics New Zealand (2010). *Crime Victimisation Patterns in New Zealand: New Zealand General Social Survey 2008 and New Zealand Crime and Safety Survey 2006 compared* Wellington: Statistics New Zealand

- Māori
- renters
- people from the most deprived groups.

One in three New Zealand women is estimated to be victims of Domestic Violence.<sup>70</sup> A World Health Organisation multi-country study found the most consistent risk factors for *suicide* attempts were: intimate partner violence, non-partner physical violence, ever being divorced, separated or widowed, childhood sexual abuse and having a mother who had experienced intimate partner violence.<sup>71</sup>

Access to prescription drugs has been shown to have a strong link with attempted and completed suicide. It is suggested that data showing doctors, nurses, dentists, pharmacists, anaesthetists and veterinary surgeons have the highest rates of suicide amongst occupational groups is a result of their greater access to pharmaceutical drugs rather than higher rates of mental illness.<sup>72</sup>

### Possible Actions

- Reduce prevalence and impact of sexual and physical abuse and domestic violence
- Reduce incidence and impact of crime and victimisation
- Ensure compliance with requirements that thorough physical health checks are completed to rule out physical causes of changes in moods and behaviours and that general medical conditions are detected and treated.
- Discontinue practices within the mental and general health system which are known to increase suicide risk
- Reduce availability of prescription drugs known to be fatal in overdose.

<sup>70</sup> "It's not OK": New Zealand's efforts to eliminate violence against women

Leitner Centre for International Law and Justice at the Fordham Law School, New York, 2009

<sup>71</sup>Devries, K., Watts, C., Yoshihama, M., Kiss, L., Schraiber, L., Deyessa, N., Heise, L., Durand, J., Mbwambo, J., Jansen, H., Berhane, Y., Ellsberg, M., & Garcia-Moreno, C.. (2011). Violence against women is strongly associated with suicide attempts: Evidence from the WHO multi-country study on women's health and domestic violence against women. *Social Science & Medicine*, 73(1), 79. Retrieved August 21, 2011, from Research Library. (Document ID: 2402891791).

<sup>72</sup> Hawton, K., & van Heeringen, K.. (2009). Suicide. *The Lancet*, 373(9672), 1372-81. Retrieved August 20, 2011, from Research Library. (Document ID: 1683154041)

## Focus Area 3 – Belonging

### Rationale

A sense of belonging is central to life satisfaction and the desire to live. It not only protects against suicide but confers a range of other benefits for individuals and communities. Ensuring every New Zealander has a sense of belonging to family, community and society is critical to suicide prevention.

Belongingness increases self-esteem, improves well-being and happiness, promotes independent thought and allows young people to resist peer pressure.<sup>73</sup> It ensures individuals are invested in their families, communities and society.

The importance of belonging or social connectedness including factors such as number of friends, higher frequency of social contact, and lower levels of social isolation have been shown to protective against suicidal thoughts (Uchino et al., 1996; Bearman and Moody, 2004; Kaminski et al., 2009) and behaviours (Rubenowitz et al. 2001; Beautrais, 2002; Turvey et al. 2002). Research shows that lack of social interaction increases suicide risk independent of mental disorders and employment status and that lack of social interaction and religious involvements confer suicide risk over and above the effects of active mood disorders and occupational status.<sup>74</sup>

New Zealand research shows an estimated a 27% reduction in elderly suicide if limited social interaction was available for that group<sup>75</sup> while connectedness of adolescents to their schools has

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<sup>73</sup> Levett-Jones, T., & Lathlean, J.. (2009). The Ascent to Competence conceptual framework: an outcome of a study of belongingness. *Journal of Clinical Nursing*, 18(20), 2870. Retrieved August 15, 2011, from ProQuest Nursing & Allied Health Source. (Document ID: 1857763681)

<sup>74</sup> Duberstein, P., Conwell, Y., Conner, K., Eberly, S., Evinger, J., & Caine, e.. (2004). Poor social integration and suicide: Fact or artifact? A case-control study. *Psychological Medicine*, 34(7), 1331-7. Retrieved August 13, 2011, from Research Library. (Document ID: 790803311)

<sup>75</sup> Beautrais, A. L.. A case control study of suicide and attempted suicide in older adults. *Suicide Life Threat Behav* 2002;32:1–9.

been shown to protect against suicidal thoughts and behaviours (Rojas & Stenborg 2010; Bearman & Moody, 2004; Borowsky et al,2001; Resnick et al, 1997).

A study which followed a cohort of male children over thirty years found that rather than being linked with actual numbers of social relationships, social isolation may be associated with the subjective feeling of not being involved in meaningful relationships. The same study cites evidence that social ties in school have been shown to have protective effects on attempted suicide among male adolescents and argues that where young people do not experience a sense of belonging at school, they are at risk of suicidal behaviour.<sup>76</sup>

The National Strategy for Suicide Prevention in the United States is based on the belief that “effective prevention strategies are needed to promote awareness of suicide and encourage a commitment to social change.”<sup>77</sup> It has connectedness among persons, families and communities as one of its primary aims on the basis that “Connectedness is a common thread that weaves together many of the influences of suicidal behavior and has direct relevance for prevention.”

Studies show a role in suicide prevention through promoting connectedness and belonging, for a wide range of community organizations including schools, universities, workplaces, community centers, and churches or other religious or spiritual organizations. These groups have the potential to contribute to, or to undermine, a person’s sense of belonging and importance to a group, a sense of personal value or worth, and access to a larger source of support which can result in greater motivation and ability to cope with adverse life circumstances or events.

Studies have shown reluctance, particularly in young people, to engage with mental health services. A study of help seeking amongst minority youth in America found that youth were less comfortable with formal interventions in school, religious institutions or traditional mental health settings but open to programmes located in school, church or community settings if helpers were

- young adults
- empathic listeners
- non-judgmental
- maintained confidentiality, and
- viewed as "natural helpers".

In respect to the last requirement, a feature of a number of programmes in other countries is the identification and use of ‘natural helpers.’ In most communities natural helpers are recruited as volunteers but one community had members fill out an anonymous survey identifying two friends or peers and two adult or community contacts they turn to for help. Those whose names were mentioned most frequently were approached and asked if they would be prepared to train as natural helpers.<sup>78</sup> Most are based in schools or universities but some in the wider community and perform the roles of peer trainer, personal and program advocate, referrer and counsellor to people who preferred to seek help and assistance from knowledgeable and trusted laypersons in less formal settings.

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<sup>76</sup> Rojas, Y., & Stenberg, S.. (2010). Early life circumstances and male suicide - A 30-year follow-up of a Stockholm cohort born in 1953. *Social Science & Medicine*, 70(3), 420. Retrieved August 20, 2011, from Research Library. (Document ID: 1928241011).

<sup>77</sup> National strategy for suicide prevention : Goals and objectives for action. Rockville, MD : U.S. Dept. of Health and Human Services, Public Health Service, 2001.

<sup>78</sup> Wellness Centre, University of Calgary, Alberta, Canada <http://www.ucalgary.ca/wellnesscentre/>

The only similar programme to have run in New Zealand was the Yellow Ribbon programme which was shut down by government despite having demonstrated effectiveness in an independent evaluation. Citizens in Christchurch who experienced a significant drop in suicide following the earthquake describe a post-disaster community where hairdressers, sports coaches, shopkeepers provided informal counselling and support and became natural helpers and suicide preventers within their community.

There are a number of ways in which social ties and a sense of belonging can be promoted across society and within sub-populations. For Maori, whakapapa is central to this goal and viewed as a core component of any suicide prevention strategy.<sup>79</sup>

Maori researchers in suicide prevention describe Whakapapa in connecting individuals to the web of relationships within hapu and iwi as "... the culturally appropriate way of framing suicide prevention for Maori." They comment that "the survival and healing of the tribal or sub-tribal kin group is contingent upon the survival and healing of each individual connected by blood (acknowledged through whakapapa) to the collective identity of the tribe or sub-tribe" and that "A strong and intact set of cultural identities based on time-honoured cultural practices with intact kinship serves to insulate and protect Maori youth from the legacy of colonization and historical trauma."<sup>80</sup>

In recent years, New Zealand has adopted many programmes from North America. Funding for these programmes is often dependent on 'programme fidelity' or strict adherence to the programme as developed. While Maori programme providers are permitted to make token changes which involve using Maori faces and language in programme delivery and resources, the adaptation of programmes to a tikanga base is prohibited. Funding is not made available for the implementation of Kaupapa Maori programmes developed by Maori for Maori.

While New Zealand does not collect information on the sexual orientation of those who die from suicide, a recent survey of New Zealand youth attracted to the same or both sexes had five times the rate of suicide attempts than those attracted to the opposite sex.<sup>81</sup> A study undertaken this year, demonstrated that negative characteristics of the social environment increase risk for suicide attempts among LGB youth, independent of individual-level risk factors. The study suggests that creating more supportive and tolerant environments in schools and communities may help to reduce sexual orientation-related disparities in suicide attempts.<sup>82</sup>

Joiner suggests that public education campaigns on the importance of social connectedness could be an important suicide prevention strategy.<sup>83</sup>

## Belonging and Deprivation

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<sup>79</sup> Lawson-Te Aho, K. & Liu, J. 2010 Indigenous Suicide and Colonization: The Legacy of Violence and the Necessity of Self-Determination *International Journal of Conflict & Violence*, Vol. 4 (1) 2010, pp. 124 – 133

<sup>80</sup> Lawson-Te Aho, K. & Liu, J. 2010 Indigenous Suicide and Colonization: The Legacy of Violence and the Necessity of Self-Determination *International Journal of Conflict & Violence*, Vol. 4 (1) 2010, pp. 124 – 133

<sup>81</sup> Fortune, S., Watson, P., Robinson, E., Fleming, T., Merry, S., & Denny, S. (2010). *Youth'07: The health and wellbeing of secondary school students in New Zealand: Suicide behaviours and mental health in 2001 and 2007*. Auckland: The University of Auckland.

<sup>82</sup> Hatzenbuehler, M. (2011). The Social Environment and Suicide Attempts in Lesbian, Gay, and Bisexual Youth. *Pediatrics*, 127(5), 896. Retrieved August 21, 2011, from Career and Technical Education. (Document ID: 2358434401).

<sup>83</sup> Van Orden, K., Witte, T., Cukrowicz, K., Braithwaite, S., Selby, E., & Joiner, T. (2010). The Interpersonal Theory of Suicide. *Psychological Review*: 23922, 117(2), 575. Retrieved August 14, 2011, from Research Library. (Document ID: 2061790941).

A sense of belonging and opportunities to connect with others can be undermined by deprivation.

Analysis of data in 2008 showed that 23 percent of New Zealand children aged 0-17 experienced material hardship, which was particularly concentrated in Pacific populations with 51 percent of Pacific children experiencing hardship, 39 percent of Māori populations and 59 percent of families dependent on benefit incomes.<sup>84</sup> A longitudinal study recently commenced in New Zealand found that 40% of our children are being born into a family living in the most deprived areas of New Zealand.<sup>85</sup>

Research on the links between suicide and poverty have found the odds of suicidal ideation around two times higher and the odds of attempting the odds of attempting suicide about four times higher in poor neighbourhoods than in wealthier neighbourhoods. The authors found that these effects remained after controlling for background vulnerabilities and that the associations were not explained by late-adolescence psychosocial risks.<sup>86</sup>

Research suggests that relative poverty – where people stand in relation to others – has a stronger direct impact on suicide than absolute poverty. This is supported by data showing elevated suicide rates in countries with the highest income disparity and low rates in some of the poorest countries in the world. Studies have shown that mortality in developed countries is affected more by relative than absolute living standards with mortality rates be lowest in countries that have smaller income differences and thus have lower levels of relative deprivation.<sup>87</sup> Studies also suggest that income instability may have more direct links on suicide risk than low income.<sup>88</sup>

Studies have shown that those bereaved by suicide experience high rates of rejection and isolation within families and communities. Support for those bereaved by suicide should focus on strengthening ties to the community and providing peer support rather than further stigmatising them with psychiatric diagnoses and a focus on perceived deficits. Education for families and communities on the evidence that families who lose loved ones to suicide are indistinguishable from other families<sup>89</sup> in the community should be promoted to counter myths that these families are characterised by parental abuse, neglect and psychopathology. Recent New Zealand research states

*There is ample research to suggest that in all ways there is nothing different and unique about the families of those who attempt and complete suicide. There is no single identifying or mitigating characteristic about families that have experienced the death of a young family member to suicide and those that have not.*

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<sup>84</sup> 1000 days to get it right for every child The effectiveness of public investment in New Zealand children  
A report prepared by Infometrics Ltd for Every Child Counts

<sup>85</sup> Morton, S.M.B., Atatoa Carr, P.E., Bandara, D.K., Grant, C.C., Ivory, V.C., Kingi, T.R., Liang, R., Perese, L.M., Peterson, E., Pryor, J.E., Reese, E., Robinson, E.M., Schmidt, J.M., and Waldie, K.E. 2010. Growing Up in New Zealand: A longitudinal study of New Zealand children and their families. Report 1: Before we are born. Auckland: Growing Up in New Zealand.

<sup>86</sup> Dupéré, V., Leventhal, T., & Lacourse, . (2009). Neighborhood poverty and suicidal thoughts and attempts in late adolescence. *Psychological Medicine*, 39(8), 1295-306. Retrieved August 20, 2011, from Research Library. (Document ID: 1873481321).

<sup>87</sup> Wilkinson, R. Socioeconomic determinants of health Health inequalities: relative or absolute material standards? *BMJ* 1997;314:591–5

<sup>88</sup> Rojas, Y., & Stenberg, S.. (2010). Early life circumstances and male suicide - A 30-year follow-up of a Stockholm cohort born in 1953. *Social Science & Medicine*, 70(3), 420. Retrieved August 20, 2011, from Research Library. (Document ID: 1928241011).

<sup>89</sup> Fitzgerald, J., Galyer, K., Whiu, G. & Thomas, P. 2010 Understanding Families and Suicide Risk. Te Pou o Te Whakaaro Nui The National Centre of Mental Health Research, Information and Workforce Development.

Promoting this understanding may help reduce the suicide risk of bereaved families by decreasing stigma and social isolation. Providing access to peer networks, including the voice of bereaved families in suicide prevention initiatives and providing practical, active support to these families in the community rather than in health settings may increase their sense of belonging.

There is emerging evidence that social networking is a key tool for building social capital and a sense of belonging. Interestingly, researchers have found evidence that when youth disclose and express more information about themselves the quality of their relationships improves and that these positive interactions lead to improved self-esteem and psychological well-being.<sup>90</sup> A study of young people found that Facebook helped students stay connected to others and that users with low self-esteem and low life satisfaction may benefit from online social networking.<sup>91</sup> Harnessing the capabilities of social networks to build social cohesion and belongingness in a range of groups, and recognising the effects of not having access to this tool, could help the development of family and community approaches to their use.

### Possible Actions

- Identify, train and deploy natural helpers in communities.
- Improve school performance in creating belongingness in students.
- Reduce school exclusions
- Train and engage schools, marae, universities, workplaces, community centres, and churches or other religious or spiritual organizations in developing community connectedness strategies and actions.
- Provide resources for kaupapa Maori programmes which include a focus on whakapapa.
- Address economic and social deprivation and inequity.
- Provide practical support and opportunities to participate in community life and suicide prevention, for those bereaved by suicide.

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<sup>90</sup> Ahn, J.. (2011). The effect of social network sites on adolescents' social and academic development: Current theories and controversies. *Journal of the American Society for Information Science and Technology*, 62(8), 1435. Retrieved August 16, 2011, from ABI/INFORM Global. (Document ID: 2421690931).

<sup>91</sup> Summerskill, B.. (2009). Online social networks and wellbeing. *The Lancet*, 374(9689), 514. Retrieved August 21, 2011, from Research Library. (Document ID: 1838453641).

## Focus Area 4 – Contributing

### Rationale

The ability to participate fully in family, community and society and a sense that the contribution made is valued are key to preventing the desire to die. Marginalisation, lack of opportunities to participate and of trust has been shown to increase suicidal thinking and behaviours.

Sociologists have long argued that social recognition –being known, ‘visible’, admired, invited, loved, and valued is protective against suicide and that absence of this recognition propels an individual towards the ‘distress of an existence without justification’ (Bourdieu, 2000; Rojas, 2010).<sup>92</sup>

Lack of social recognition is a component of perceived burdensomeness defined as “a self-view that one is defective and flawed, to the point of being a liability to others.”<sup>93</sup> Studies have found strong evidence to support the role of ‘burdensomeness’ in completed suicide (Cukrowicz, Cheavens, Van Orden, Ragain, & Cook, 2011; Van Orden et al 2006; Van Orden, Lynam, Hollar, & Joiner, 2006; Joiner et al., 2002;) and those who use more lethal methods to complete suicide (Joiner et al., 2002;).

A 2008 study involving 22,227 participants from 11 European countries found the higher the level of social trust in a country, the lower the suicide rate. Social trust is the extent to which people perceive others can be trusted, the extent to which they believe others are helpful and fair or attempt to take advantage of others and promote their own needs.<sup>94</sup>

Societies, communities and families that provide opportunities for their members to contribute, recognise the contributions they make and have high levels of trust and reciprocity, provide environments where individuals flourish and see meaning and value in their lives.

In addition to social factors, economic and political policies can create a sense of burdensomeness and have been shown to influence suicide rates.

Evidence shows economic recessions are associated with increased suicide rates, where they give rise to negative outcomes such as job losses and home foreclosures (American Association of Suicidology, 2009) and that recessions may affect different age groups (Luo et al, 2011) and genders (Snipes et al, 2011; Barth et al, 2011) and require interventions tailored to specific groups rather than universal suicide prevention programmes.

A recent American study found a pattern of lower suicide rates in states with higher per capita income and that “the relationship is dramatic in terms of its substantive impact.”<sup>95</sup> The authors found that “cost” of reducing a state’s suicide rate by a full point is an increase of roughly \$45 in per capita public assistance spending and that if every state in the nation increased per capita public assistance funding by \$45 per year, this would translate into 3,000 fewer suicides and 300,000 fewer suicide attempts each year, representing a 10% reduction in the total number of suicides.

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<sup>92</sup> Rojas, Y., & Stenberg, S.. (2010). Early life circumstances and male suicide - A 30-year follow-up of a Stockholm cohort born in 1953. *Social Science & Medicine*, 70(3), 420. Retrieved August 20, 2011, from Research Library. (Document ID: 1928241011).

<sup>93</sup> Marty, M.. Older adults and the desire for suicide: The role of perceived burdensomeness and thwarted belongingness. Ph.D. dissertation, University of Colorado at Colorado Springs, United States -- Colorado. Retrieved August 21, 2011, from Dissertations & Theses: Full Text.(Publication No. AAT 3457462).

<sup>94</sup> Kelly, B., Davoren, M., Mhaoláin, I., Breen, E., & Casey, P.. (2009). Social capital and suicide in 11 European countries: an ecological analysis. *Social Psychiatry and Psychiatric Epidemiology*, 44(11), 971-7. Retrieved August 21, 2011, from Research Library. (Document ID: 1884242001)

<sup>95</sup> Flavin, P., & Radcliff, B.. (2009). Public Policies and Suicide Rates in the American States. *Social Indicators Research*, 90(2), 195-209. Retrieved August 21, 2011, from ABI/INFORM Global. (Document ID: 1582090431).

The comparable numbers in New Zealand would be an increase of \$54.71 in per capita welfare benefits resulting in the prevention of 54 suicides deaths and 5,400 suicide attempts. Measured against the Ministry of Health's 2004 estimation of the cost of suicide at \$238,531,000 in direct and \$1,381,492,000 in indirect costs, this investment represents significant economic value.

A recent study of the links between suicide and debt found that after controlling for socio-demographic, economic, social and lifestyle factors, those in debt were twice as likely to think about suicide. Difficulty in reducing debt from hire purchase, mail order repayments and credit cards along with rent and mortgage arrears, were strongly associated with suicidal thoughts. This relationship was impacted by the degree of hopelessness felt about the ability to repay.<sup>96</sup>

The mental health model of suicide prevention leads government to question their ability to influence suicide rates on the basis that they have little control over individual behaviour. The state cannot, for instance, legislate that citizens must join more community groups, play teams sports or drink coffee with their neighbours more often. Researchers point out however that they can ensure that welfare benefits are at a level that helps to insulate citizens from the social consequences of poverty and welfare dependence and the insecurity, marriage break ups, residential mobility, lack of opportunities to participate and perceived burdensomeness that are associated with them and with suicidal thinking and behaviour.<sup>97</sup>

International researchers argue that the monitoring of and response to socio-economic factors – a is a key role of government and critical to suicide prevention (Barth et al, 2011). Gunnell (2009) found that improvements in welfare support and other changes since the 1930s may offset the impact of the recession on suicide.

A comparative analysis of trends in young male suicide in New Zealand and Finland (Howden-Chapman et al, 2005), found that while unemployment increased to a greater extent in Finland than in New Zealand in the recession of the 1980s and 90s, Finland had lower increases in suicide as a result of a higher social spending in Finland than New Zealand during that time.<sup>98</sup>

Gunnell (2009) cites this as evidence for the benefit of more welfare support in reducing unemployment related suicide. Increasing welfare support as a suicide prevention measure is supported by an analysis of changes in suicide rates in the United States where reductions in welfare spending were associated with rises in suicide.<sup>99</sup>

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<sup>96</sup> Meltzer, H., Bebbington, P., Brugha, T., Jenkins, R., McManus, S., & Dennis, M.. (2011). Personal debt and suicidal ideation. *Psychological Medicine*, 41(4), 771-778. Retrieved August 13, 2011, from Research Library. (Document ID: 2275329661)

<sup>97</sup> Flavin, P., & Radcliff, B.. (2009). Public Policies and Suicide Rates in the American States. *Social Indicators Research*, 90(2), 195-209. Retrieved August 21, 2011, from ABI/INFORM Global. (Document ID: 1582090431).

<sup>98</sup> Howden-Chapman P, Hales S, Chapman R, Keskimaki I. *The impact of economic recession on youth suicide: a comparison of New Zealand and Finland. Report 4: Social explanations for suicide in New Zealand*. Wellington: New Zealand Ministry of Health, 2005

<sup>99</sup> Flavin, P., & Radcliff, B.. (2009). Public Policies and Suicide Rates in the American States. *Social Indicators Research*, 90(2), 195-209. Retrieved August 21, 2011, from ABI/INFORM Global. (Document ID: 1582090431).

### Possible Actions

- Identify and support individuals who perceive they are a burden on their families and communities.
- Create opportunities for marginalised groups and individuals to participate
- Take opportunities to recognise the contribution of men, youth, the aged, Maori, Pacific, the unemployed, students and other groups with high suicide rates to the community.
- Increase the economic base of those on welfare to increase their ability to participate and lower the sense of burdensomeness
- Ensure media reports on marginalised groups do not portray them as a burden on the community.

### Government Role in Suicide Prevention

We believe that government has three key roles in suicide prevention.

1. Support families and communities to prevent suicide
2. Properly regulate industries whose products and services may cause suicide
3. Ensure economic, political and social policy and practice supports suicide prevention

Reviews of the circumstances leading to the suicide show a pattern of families and communities encountering significant barriers to preventing suicide. These barriers include government funding models which promote ineffective and culturally inappropriate suicide prevention strategies, lack of availability of appropriate support to families managing suicide risk, failure to regulate potentially harmful products and services and social policy which drives suicidal thinking and behaviour.

The practice of New Zealand governments in recent years of ignoring the social drivers of suicide has been challenged by a number of commentators including psychiatrist Mason Durie who has stated that “Enough is known about health to justify an integrated approach to cultural, social and

economic development and to recognise the futility of designing highly sophisticated treatment procedures while blatantly ignoring educational failure or inadequate housing.”<sup>100</sup>

It is our strongly held view that direct suicide prevention is best positioned within families and communities. It is these groups who are best placed to identify and address suicide risk. Government needs to focus on removing barriers to their doing so, ensuring their efforts are not undermined by corporate entities or government agencies and addressing social, political and economic drivers of suicide risk.

## Community Role in Suicide Prevention

Just as those at risk of suicide live within families, families live within communities. Most families belong to a range of communities – those provided by geography (neighbourhood communities), those which represent an ethnic community, those based on shared interests and a range of other communities including increasing numbers of virtual communities.

Communities are often based on inclusion but also arise from exclusion. The basis of a range of communities are based on exclusion from other groups – on the basis of ethnicity, beliefs, sexual orientation, religion, age and many other factors including suicide bereavement.

Communities can play a key role in supporting individuals and families who are managing suicide risk. Conversely they may also play a key role in increasing that risk through socially isolating individuals and families, denying their access to resources and participation and undermining a sense of belonging, connectedness and value in some of their members.

## Family Role in Suicide Prevention

The family is the primary place in which individuals are socialised, experience belonging, develop a sense of identity and receive help and support. The role and confidence of families to perform this function has been seriously undermined by current suicide prevention strategies. Families have been devalued and disempowered by discourses and practices which locate them as the source of suicide risk, dismiss their skills and knowledge in protecting their loved ones and disempower them in their efforts to keep their members safe in favour of promoting suicide prevention as the province of ‘experts.’

Families must reclaim their role and power in protecting their members, become better informed consumers of suicide prevention services and challenge thinking which undermines their role in preventing suicide. Well informed and supported families play a pivotal role in protecting individuals from suicide.

In addition to the role of diagnostic labelling to suicidal thinking and behaviour, the ubiquitous use of psychopharmacology as a first line treatment in New Zealand mental health services using drugs clinically proven to at least double the risk of suicide argues against locating suicide prevention within mental health services.

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<sup>100</sup> WHAIORA: MĀORI HEALTH DEVELOPMENT by MASON DURIE OXFORD UNIVERSITY PRESS, 1998 (2ND EDITION)

## Conclusion

Suicide is a highly preventable form of death. A sense of belonging, opportunities to contribute and hope for the future insulate against the desire to die which precedes suicide.

Armed with good knowledge and with a sense of having the power to prevent suicide, families and communities can make the primary contribution to suicide prevention in New Zealand. The failure of the current medical model of suicide prevention means it is imperative that families and communities take back this role and responsibility and be resourced to do so.

Evidence in New Zealand and around the world is that resourcing and implementing a mental health approach to suicide increases suicide risk and rates. When government policy markets alcohol, denies employment, causes relationship break ups, promotes financial hardship and educational failure, identifies the victims of these factors as mentally ill and provides drugs which double the risk of suicide to treat them, it is not surprising that suicide rates escalate.

Rather than creating families and communities who are trained to identify deficits in their members, suicide prevention strategies must support families and communities to identify and build on strengths and encourage inclusion, participation and support for their members. In contrast to an overarching one size fits all strategy, families and communities will develop plans which are tailored to the age, culture, gender and other characteristics of their members and represent more targeted and refined strategies than those any government could produce.

The more than 80% reduction in suicide in the aftermath of the Christchurch earthquake shows what can be achieved when families and communities reclaim their role in suicide prevention. Similar results can be achieved by all communities in New Zealand without waiting for a natural disaster.

New Zealand currently leads the OECD in the suicides of its children and young people. CASPER believes that should this country have the courage to acknowledge the failure of current practice and implement the strategy outlined in this document, we could lead the world in suicide prevention.

## Appendix One

### *Family and Community Audit*

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Families and Communities could commence the implementation of this strategy by conducting an audit of

- their current practice in creating a sense of belonging in their members
- the opportunities they provide for participation and their recognition of the value the contribution of each member makes
- their success in limiting the use of alcohol and drugs
- their success in protecting the physical health of their members
- the reduction of abuse and crime
- the level of knowledge of suicide and its prevention

and the development of strategies to build on strengths and address gaps.

A family may begin to make themselves 'suicide safe' by asking

- Who has the strongest/weakest sense of belonging in this family?
- How do we recognise and show we value the contribution of each member of the family?
- Does anyone in this family consider they are a burden?
- Do members of our family abuse drugs or alcohol?
- Are members of our family taking prescription drugs known to induce suicide?
- How do we talk about suicide in our family?
- Do all members of our family have a healthy diet, participate in exercise and take care of their physical health?

Developing a plan to protect a family against suicide may involve building on the strengths identified and addressing any gaps.

Communities could employ a similar process in identifying the relative strengths and weaknesses in belonging, participation, suicide knowledge and healthy behaviours in groups within the community and building on strengths and addressing gaps.

Assistance with conducting a 'suicide safe' audit and developing and implementing an action plan is offered by CASPER who can be contacted at [www.casper.org.nz](http://www.casper.org.nz)

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