

**New Zealand Suicide
Prevention Action Plan
2008–2012**

Report on Progress: Year One

Published in September 2009 by the
Ministry of Health
PO Box 5013, Wellington, New Zealand

ISBN 978-0-478-31958-3 (print)
ISBN 978-0-478-31949-0 (online)
HP 4898

This document is available on the Ministry of Health's website:
<http://www.moh.govt.nz>



MANATŪ HAUORA

Foreword

As Associate Minister of Health I have been delegated responsibility for suicide prevention, and I intend to ensure the good work in this crucial area continues. Every year too many people cannot see any way out other than to take their own life because they are experiencing unbearable psychological pain or are in a seemingly inescapable situation. But suicide is preventable: there are many points at which we can intervene and help to turn things around. Suicide has a devastating effect on family, friends and the community, so anything we can do to prevent suicide also has the potential to prevent pain and grief for countless others.

The *New Zealand Suicide Prevention Action Plan 2008–2012* was released one year ago and is based on the principles, vision and goals outlined in the *New Zealand Suicide Prevention Strategy 2006–2016*. The Action Plan aims to put New Zealand and international evidence into practice by giving us a clear set of priorities for suicide prevention. It contains goals and actions that, together, are likely to prevent suicides. It spells out how each action will be achieved, which agency is responsible for it and when it will happen.

Preventing suicide requires work in a wide range of areas. Our plans to prevent suicide must include targeted initiatives for people who are most at risk of suicide, as well as initiatives to create a society that promotes mental health and wellbeing; one in which people can reach out for help without fear and can access services when they need them. With the global economic crisis hitting hard, this work becomes even more important as worry about job security and financial hardship grows.

This report summarises progress on the goals of the Action Plan after one year of implementation. I know the report will be a valuable resource and will provide the public with clear information about what is being done to prevent suicide in New Zealand. There has been considerable progress and many notable achievements during the past year, and I hope to see the good work continue. Importantly, the report also highlights some areas where a greater focus is needed, and demonstrates the importance of remaining accountable and dedicated to each goal of the Action Plan.

As Minister responsible for suicide prevention, I am committed to seeing the Action Plan through to its completion and to creating a society where people experiencing difficulties feel valued, supported and filled with hope about their future.

Hon Peter Dunne
Associate Minister of Health

Contents

Foreword	iii
Executive Summary	vi
Introduction	1
Statistics and trends	1
Implementing the Action Plan	3
Part One: Key Developments	6
Goal 1: Promote mental health and wellbeing, and prevent mental health problems	6
Goal 2: Improve the care of people who are experiencing mental disorders associated with suicidal behaviour	17
Goal 3: Improve the care of people who make non-fatal suicide attempts	32
Goal 4: Reduce access to the means of suicide	36
Goal 5: Promote the safe reporting and portrayal of suicidal behaviour by the media	39
Goal 6: Support families/whānau, friends and others affected by a suicide or suicide attempt	41
Goal 7: Expand the evidence about rates, causes and effective interventions	44
Part Two: Tables Summarising Progress	50
Symbols	50
Goal 1: Promote mental health and wellbeing, and prevent mental health problems	51
Goal 2: Improve the care of people who are experiencing mental disorders associated with suicidal behaviour	52
Goal 3: Improve the care of people who make non-fatal suicide attempts	57
Goal 4: Reduce access to the means of suicide	59
Goal 5: Promote the safe reporting and portrayal of suicidal behaviour by the media	62
Goal 6: Support families/whānau, friends and others affected by a suicide or suicide attempt	66
Goal 7: Expand the evidence about rates, causes and effective interventions	69
References	73
List of Figures	
Figure 1: Suicide age-standardised death rates, 1986–2006	1
Figure 2: Māori and non-Māori suicide age-standardised death rates, by sex, 1996–2006	2
Figure 3: Leadership structure for implementation of the New Zealand Suicide Prevention Strategy and Action Plan	4

Executive Summary

Suicide and suicidal behaviour are major social and health issues in New Zealand. Every year approximately 500 people die by suicide, and each suicide has a profound impact on friends, family, whānau, and often whole communities. There are many factors that influence suicide, and therefore it requires comprehensive and wide-ranging action, from promoting resiliency to crisis management and support.

The wide-ranging suicide prevention work that is planned and under way in New Zealand is guided by two key documents: *The New Zealand Suicide Prevention Strategy 2006–2016* (the Strategy; Associate Minister of Health 2006) and *The New Zealand Suicide Prevention Action Plan 2008–2012* (the Action Plan; Associate Minister of Health 2008). These documents provide a framework and clear direction for the extensive work being done in New Zealand towards suicide prevention.

The Strategy contains seven goals that outline the key areas for action to prevent suicide. The Action Plan provides details on how the seven goals will be achieved and who will be responsible for them. Each action is also given a time frame for completion: either Phase 1 (years one to three) or Phase 2 (years three to five). The seven goals are to:

1. promote mental health and wellbeing, and prevent mental health problems
2. improve the care of people who are experiencing mental disorders associated with suicidal behaviour
3. improve the care of people who make non-fatal suicide attempts
4. reduce access to the means of suicide
5. promote the safe reporting and portrayal of suicidal behaviour by the media
6. support families/whānau, friends and others affected by a suicide or suicide attempt
7. expand the evidence about rates, causes and effective interventions.

Purpose

The purpose of this report is to provide a snapshot of the key developments in the first year of implementing the Action Plan, which was published in March 2008. Reporting on progress in suicide prevention encourages continuing effort and focus on the Action Plan and ensures that government agencies remain accountable for the achievement of the Action Plan's goals. The report also ensures that progress is monitored by providing in-depth, comprehensive and accurate information to the public about suicide prevention activities.

The report does not attempt to provide an analysis of the relative effectiveness of each or all the interventions in reducing the rate of suicide. Progress on reducing the rate of suicide and self-harm is reported in the annual publications of *Suicide Facts* (Ministry of Health 2008e).

It should be noted that this report does not cover all of the suicide prevention activities occurring in New Zealand; many initiatives funded and provided by, for example, District Health Boards (DHBs) and community and private organisations also make an essential contribution to the sector.

In order to ensure continuing accountability for government agencies, further progress reports will be produced every two years: in 2011 (reporting on Phase 1, years one to three) and in 2013 (reporting on Phase 2, years three to five).

Structure

The report is structured so that a comprehensive picture of suicide prevention activities can be presented, while allowing progress to be measured against the specific actions and milestones set out in the Action Plan.

The **Introduction** provides an outline of the latest suicide statistics and trends, and information about the structures set up to implement the Action Plan. **Part One** is structured around the seven goals of the Action Plan. For each goal, progress on implementing each key action area is discussed at a broad level. **Part Two** contains a table that summarises the progress made on milestones set for the actions in the Action Plan. Each action is given a rating, and a brief note is made about progress and implementation for Māori using the whānau ora framework.

Progress on the five high-priority areas

As stated in the Action Plan, current evidence suggests that the greatest gains in reducing mortality and morbidity from suicide are likely to come from investment in five priority areas. These areas were highlighted as the focus for immediate implementation. Progress on each of these high-priority areas is described below.

Increase support for primary care providers in the recognition, treatment and management of the mental disorders commonly associated with suicide and suicide attempt (Goal 2, Action 2.6)

Primary mental health initiatives have been established in 80 primary health organisations (PHOs). These initiatives provide a better-quality service delivery model for people with mild to moderate mental health and substance use disorders. Key features include extended general practitioner (GP) and nurse consultations, and access to packages of care including counselling and treatments such as cognitive behavioural therapy. There is also a focus on providing GPs and practice nurses with access to ongoing training and support regarding mental health care.

This initiative is supported by the new guideline *Identification of Common Mental Disorders and Management of Depression in Primary Care* (New Zealand Guidelines Group 2008). The guideline contains best practice information on how to assess suicide risk and manage depression and other common mental health disorders. See pages 21 and 22 for more information.

Develop integrated models of care for those at risk of suicide (Goal 2, Action 2.7)

The Ministry of Health is funding a significant randomised controlled trial to compare practice as usual to the delivery of multiple-level suicide prevention initiatives that are intensive, synchronised and within a defined local region. These interventions will have a key, but not exclusive, focus on primary health services, including enhancing access to primary health services and improving the assessment, treatment and management in primary health care of those experiencing common mental health problems such as depression. See page 23 for more information.

Continue to implement and evaluate the guidelines for those at risk of suicide in acute settings (Goal 3, Action 3.1)

Fourteen DHBs are now participating in Whakawhanaungatanga: The Self Harm and Suicide Prevention Collaborative. The Collaborative was established to facilitate the implementation of the best practice evidence-based guideline *The Assessment and Management of People at Risk of Suicide* (New Zealand Guidelines Group and Ministry of Health 2003). This guideline is designed to improve crisis care in emergency departments, Māori health services and mental health services for people who present with self-harm or suicide attempts. The Collaborative is on track to achieve four key targets that will improve crisis care for people who present with self-harm or suicide attempts. See page 33 for more information.

Develop integrated services to provide longer-term care and support to those who have made suicide attempts (Goal 3, Actions 3.2 and 3.3)

Two significant research projects are under way to assess the effectiveness of packages of care for those who have made a suicide attempt. The After Self Harm: Collaborative Care and Enriched Services Study (ACCESS) is a randomised controlled trial that compares receiving treatment as usual to receiving treatment as usual plus multiple promising interventions delivered by specialist 'self-harm teams'.

The second randomised controlled trial, Te Ira Tangata, uses a culturally informed intervention for Māori. It is based on the same principles as ACCESS but the self-harm teams use a structured cultural assessment, and the multiple interventions are informed by Māori knowledge and processes. See page 34 for more information.

Review programmes for key community, institutional and organisational workers ('gatekeepers') to ensure best practice (See Goal 2, Action 2.3)

Reviews of suicide risk assessment and management programmes are being undertaken by the Ministry of Education, Child Youth and Family, and the Department of Corrections to ensure they are safe, effective and appropriate across cultures.

Summary of progress

After one year of implementing the Action Plan, good progress is being made in many areas. As well as progress on the five high-priority areas described above, the following key developments are indicative of the significant progress made in the first year of implementing the Action Plan:

- the establishment of suicide prevention co-ordinators in five DHBs
- an increase in the reach and effectiveness of the National Depression Initiative and associated support services
- an increase in the use of relapse prevention plans with users of specialist mental health services
- a reduction in suicides among children and young people under the care of Child Youth and Family resulting from the Towards Wellbeing programme
- the establishment of local Child and Youth Mortality Review groups
- a movement towards collaboration between the media, researchers and the Government to promote safe reporting of suicide
- the reconfiguration of the Postvention Support Service
- the review of traumatic incident management resources for schools by the Ministry of Education
- changes to the coronial system, including the establishment of the new coronial database, which improves the quality and timeliness of suicide data
- the large investment in suicide research through the Suicide Prevention Research Fund.

As a result of compiling this progress report, some areas have emerged as being in need of particular focus for the next stages of implementation of the Action Plan. As well as maintaining momentum on current initiatives, further attention needs to be placed on the following (note that this is not an exhaustive list):

- improvement of responsiveness to, and management of, suicide risk by primary care services through the implementation of the guideline *Identification of Common Mental Disorders and Management of Depression in Primary Care* (Action 2.6)
- Māori suicide prevention activities, including investing in and prioritising research, reviewing the effectiveness of services for Māori and developing targeted initiatives (Actions 2.9, 2.10, 2.11, 7.8)
- targeted initiatives for other groups at high risk for suicide, such as young people, males, gay, lesbian and bisexual people, those who have made previous suicide attempts and those who are socially isolated or excluded
- development of guidance for the reporting and portrayal of suicide in the media (Actions 5.2, 5.3, 5.4, 5.5) – this work is beginning, and includes consideration of incentives to the media for safe reporting, the inclusion of evidence and issues in journalism training programmes, and guidance about the fictional portrayal of suicidal behaviour in films, television and drama

- a review of programmes and policies within institutional settings (eg, educational settings, mental health inpatient services, Child Youth and Family services, and correctional facilities) to improve the recognition and management of mental disorders, the management of suicide attempts, and access to means of suicide (Actions 2.14, 3.4, 4.1)
- development, implementation and evaluation of interventions to reduce the risk of suicide for people being discharged from mental health inpatient services (Action 2.8)
- a review of existing information resources, guidelines and protocols on managing the aftermath of suicide or suicide attempt for people who are bereaved, key personnel who have regular contact with people who are bereaved, people who are affected by a suicide attempt, and key institutional settings (Action 6.4).

In summary, although some actions have been identified that need further attention, significant progress has been made in the first year of implementing the Action Plan. As a reflection of this, approximately 70 percent of the 53 actions in the Action Plan are currently under way. Based on these measures of progress, the Ministry of Health is encouraged and confident that the implementation of the Suicide Prevention Action Plan is making, and will continue to make, a major contribution to suicide prevention in New Zealand.

Introduction

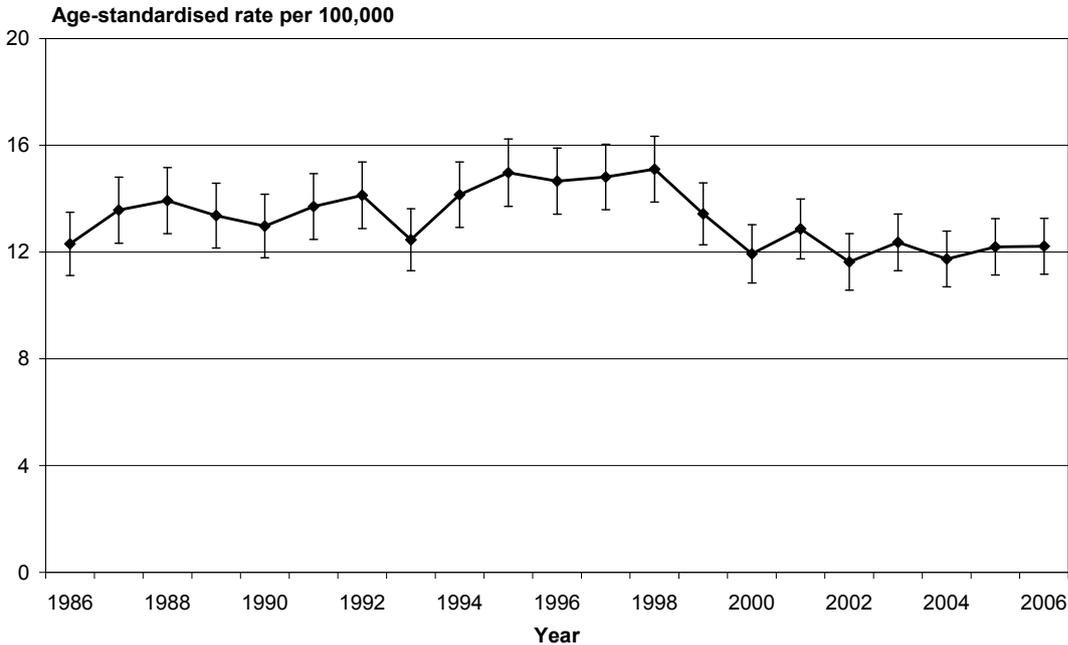
Statistics and trends

Every year approximately 500 New Zealanders die by suicide, and there are more than 2500 admissions to hospital (that last more than 48 hours) for intentional self-harm (Ministry of Health 2008e). Over their lifetime 15.7 percent of New Zealanders will report experiencing suicidal ideation, 5.5 percent will make a suicide plan and 4.5 percent will attempt suicide (Oakley Browne et al 2006).

Although there are many limitations in making international comparisons, it appears that New Zealand's suicide rates rank towards the middle of a group of 13 comparable countries of the Organisation for Economic Co-operation and Development (OECD).¹ However, the suicide rate for young people aged 15–24 years is high in these comparisons (Ministry of Health 2008e).

Suicide rates peaked at 15.1 deaths per 100,000 in the late 1990s. Since this peak, there has been a significant downward trend to 12.2 deaths per 100,000 in 2006 (Ministry of Health 2008e), as shown in Figure 1. This represents a 19 percent decline over the last decade.²

Figure 1: Suicide age-standardised death rates, 1986–2006



Source: New Zealand Mortality Collection.

Note: The rate shown is the age-standardised rate per 100,000 population, standardised to the World Health Organization standard world population.

¹ These countries have been selected because they are considered to have reliable data collections, or they are countries most often used for comparison with New Zealand health statistics.

² Data from 2006 represent the most recent suicide statistics available. The latest suicide statistics are published annually on the Ministry of Health website.

Age

Data from 2006 show that over 75 percent of all people who die by suicide are over the age of 24 (Ministry of Health 2008e). The age group with the highest rate of suicide is the 25–29-year-olds (21.1 suicide deaths per 100,000 population). This is also the age group with the highest rate for females (14.2 suicide deaths per 100,000 population), although for males the highest suicide rates are in the younger groups: 15–19 years (30.7 deaths per 100,000) and 20–24 years (31.5 deaths per 100,000). There has been a significant (31.5 percent) decrease in youth (aged 15–24) suicide rates since the peak in 1995.

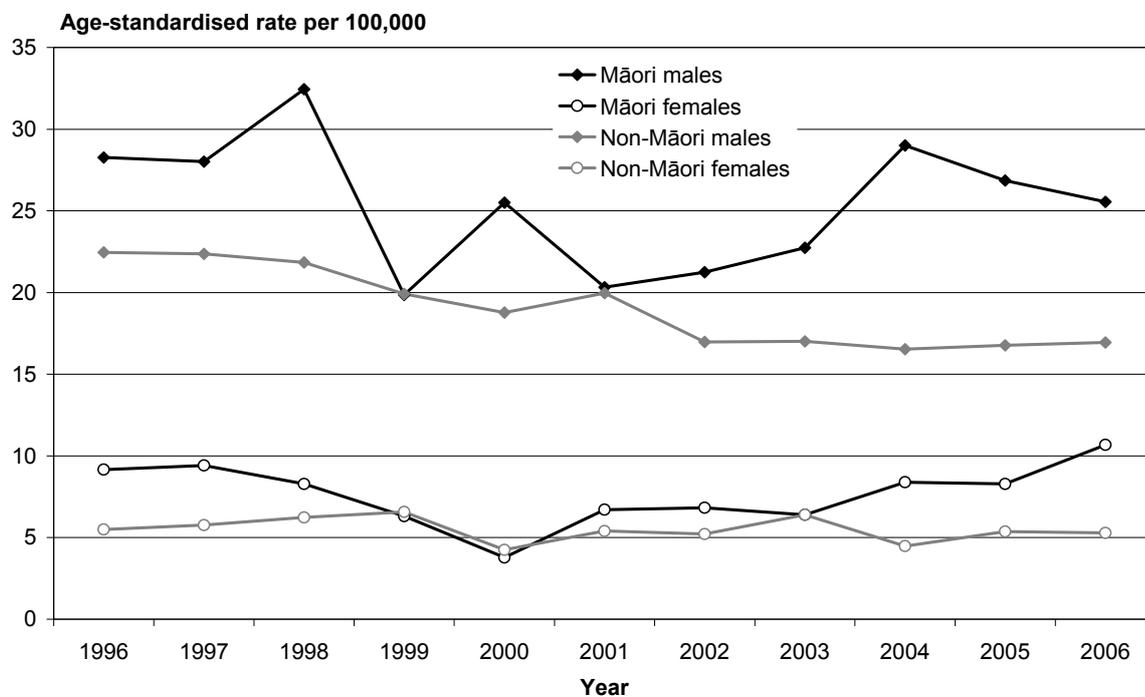
Sex

Males have a higher rate of suicide than females (a ratio of approximately 3:1 in 2006). Conversely, females have a higher rate of hospitalisation for intentional self-harm (a ratio of approximately 2:1 in 2006). Although the female suicide rate has remained relatively stable over recent decades, the male rate increased to a peak in the late 1990s and has subsequently been trending downward (Ministry of Health 2008e).

Ethnicity

Māori continue to have the highest rate of suicide, followed by European/Other, Pacific and Asian peoples. In 2006 the suicide rate for Māori was 17.8 per 100,000, compared with the non-Māori rate of 11.0 per 100,000 (Ministry of Health 2008e). Although the Māori rate has decreased by 14 percent since the peak in the late 1990s, this decline is less than that for non-Māori, whose rate decreased by 21 percent during the same period.

Figure 2: Māori and non-Māori suicide age-standardised death rates, by sex, 1996–2006



Source: New Zealand Mortality Collection

Note: The age-standardised rate (ASR) is the age-standardised rate per 100,000 population, standardised to the World Health Organization population tables.

Methods

Hanging³ is the most common method of suicide in New Zealand, accounting for more than half of all suicide deaths for both females and males (54 percent overall in 2006). Poisoning by gases or vapours (the bulk of which are by vehicle exhaust gas) is the second most common method, used in 17 percent of suicides (Ministry of Health 2008e).

Self-poisoning accounts for a relatively small number of suicide deaths (9 percent of suicides in 2006) (Ministry of Health 2008e). However, it is the second most common method for females (18 percent of female suicides in 2006) and makes a far greater contribution to morbidity, accounting for 81 percent of all hospital admissions for intentional self-harm in 2006 (Ministry of Health 2007b). Firearm-related suicides decreased in New Zealand following the introduction of the Arms Amendment Act 1992 (Ministry of Health 2007b) and in 2006 accounted for 9 percent of all suicides. Submersion (drowning) and jumping from a high place accounted for only 2 percent of suicides for each method in 2006 (Ministry of Health 2008e).

Implementing the Action Plan

The following structures provide leadership and monitor progress on the implementation of the Action Plan:

- Inter-Agency Committee on Suicide Prevention
- Ministerial Committee on Suicide Prevention
- DHB-based suicide prevention co-ordinator pilots.

The Ministry of Health is responsible for leading and facilitating a whole-of-government approach to suicide prevention.

The Inter-Agency Committee on Suicide Prevention (IACSP) provides advice on suicide prevention at a government agency level. Representatives from 13 government agencies (see Figure 3) ensure effective, linked-up suicide prevention services across different sectors. This is done by regularly exchanging information about emerging issues and progress on initiatives, putting in place solutions to any identified gaps or problems with service delivery, and communicating best practice information about suicide prevention.

The IACSP reports to the Ministerial Committee on Suicide Prevention, which is made up of Ministers of the Crown with portfolios that are relevant to suicide prevention. The Ministerial Committee was established to provide leadership and visible high-level commitment to suicide prevention and to monitor and oversee progress on the implementation of the Strategy and Action Plan. The Committee is currently chaired by Associate Minister of Health Hon Peter Dunne, who has delegated responsibility for suicide prevention.

³ Suicide deaths by 'hanging' refer to suicide deaths coded as being by 'hanging, strangulation and suffocation'.

Figure 3: Leadership structure for implementation of the New Zealand Suicide Prevention Strategy and Action Plan



Implementation of the Strategy and Action Plan at the local DHB level is supported by the DHB Suicide Prevention Co-ordinator Pilot (the Pilot). The Pilot is a quality improvement initiative to establish and support a comprehensive programme of suicide prevention interventions at the DHB level. It involves establishing suicide prevention co-ordinators in five DHBs to work with a range of local agencies whose activities have a role in suicide prevention. The aim is to ensure services are integrated, in order to improve the quality and continuity of care for local communities. The initiative allows communities to prioritise different actions and service improvements based on the specific needs of their region.

It is expected that suicide prevention co-ordinators will contribute to a reduction in suicide and suicidal behaviour in participating districts by:

- improving safety, effectiveness and access to local services for people at risk of suicide and their families, whānau and/or significant others
- strengthening relationships and structures to support collaboration across local agencies involved in suicide prevention
- developing and implementing a comprehensive, integrated and evidence-based district suicide prevention plan
- ensuring the specific needs of Māori within local communities are being adequately addressed
- providing a conduit for disseminating national policy and guidance on suicide prevention to local areas and for communicating emerging local issues to government.

Five co-ordinators are now established at Auckland, Counties Manukau, Lakes, Wairarapa, and Nelson Marlborough DHBs. The co-ordinators have established inter-agency suicide prevention steering committees and are undertaking needs analyses to inform the development of their district suicide prevention plans. It is expected that the district plans will be completed by 31 December 2009.

As well as the suicide prevention roles that are part of this Pilot, there are several other suicide prevention co-ordinator positions within individual DHBs throughout New Zealand that aim to improve the responsiveness of services to people who may be at risk of suicide.

The pilot is being externally evaluated and is funded to run until June 2010, when the results of the evaluation will be considered and a decision made on whether to extend the term of the five DHB co-ordinators and/or roll out the co-ordinator role to some or all of the remaining 16 DHBs.

Part One: Key Developments

Goal 1: Promote mental health and wellbeing, and prevent mental health problems

Why is this important? A wide range of factors contribute to vulnerability and resilience to mental health problems and subsequent suicidal behaviours. These factors include individual, social, family, cultural and economic factors.

What are we aiming to do? Goal 1 aims to encourage the development of population-based social, educational, economic and health policies and programmes across different government agencies, which can contribute to suicide prevention.

These policies and programmes need to: have mechanisms for co-operation and collaboration across agencies, ensure appropriateness and effectiveness for Māori, and focus on reducing inequalities by addressing the needs of those who are most at risk.

Key areas for action: The Action Plan identifies that there is evidence for being able to make a contribution to promoting mental health, preventing mental illness and contributing to suicide prevention in the following areas:

- childhood and family
- alcohol and drugs
- life stress and trauma
- socioeconomic inequalities
- social cohesion and support
- cultural identity
- discrimination.

Space does not allow a description of all the policies and programmes that are relevant to this goal, so this section will showcase some examples of developments and achievements during the year.

Childhood and family

Exposure to childhood and family adversity can play an important part in determining a person's vulnerability and resilience to mental health problems and suicidal behaviour. In particular, these include exposure to childhood abuse (including neglect and sexual, physical and emotional abuse), family violence, parental conflict and compromised parenting skills. The development of effective childhood and family policies and programmes is therefore important.

Two key examples of programmes in this area are the Campaign for Action on Family Violence and the various parenting programmes offered throughout the country.

Campaign for Action on Family Violence

New Zealand has a poor record of family violence, and the Police deal with more than 70,000 family violence calls a year. The Campaign for Action on Family Violence is a major initiative of the Taskforce for Action on Violence within Families, which advises the Government on family violence issues. The campaign is led by the Ministry of Social Development and the Families Commission, in association with communities. It is supported by ACC, the Ministry of Health and the New Zealand Police.

The campaign aims to increase awareness and understanding of family violence and promote changes in behaviour to reduce the incidence of family violence. Activities include:

- a Community Action Fund providing financial support for community-led activities, recognising that local communities know what works best for them
- TV advertisements supporting community projects at a national level, leading with a message that 'Family violence is not OK – but it is OK to ask for help'
- an 0800 Family Violence Information Line (0800 456 450) providing self-help information and connecting people to services, where appropriate
- the campaign website (www.areyouok.org.nz) containing information for personal change for people who are violent and people who influence them, as well as information for community engagement and for the media.

Survey results show very positive results, with 95 percent of people surveyed knowing about the campaign and more than two out of three people surveyed (68 percent) saying they have spoken to family or friends about family violence as a result of seeing the It's not OK campaign TV advertisements. More than half of people (57 percent) said they now felt they could help to influence someone to change their violent behaviour. A research and evaluation programme will inform ongoing development of the campaign.

Parenting and family support programmes

Several parenting and family support programmes are available in New Zealand to support people to parent in a positive way that promotes both their mental health and that of their children in the long term. Following are brief descriptions of some examples.

- **Incredible Years:** an evidence-based programme that works with parents and families to address their difficulties in managing child behaviours. A recent study found that the programme was effective, in terms of producing improvements in child behaviour and positive evaluations from parents (Fergusson et al 2009). The programme was also found to be equally effective for Māori and non-Māori families.
- **SKIP (Strategies with Kids, Information for Parents):** a programme that supports parents and caregivers to use effective non-physical discipline. SKIP supports communities to promote positive parenting, works with national organisations to build capacity to support parents, and develops and distributes resources to community groups and parents.
- **Family Start:** intensive home-based support services for families with high needs. It targets the 15 percent of families with the greatest needs and who have or are about

to have young children (pre-birth up to five years old). Family/whānau workers work with the family and provide parenting support and advice, refer the family to other sources of community and government support, and provide information.

Alcohol and drugs

Alcohol and drug dependence and abuse have been shown to be significant risk factors for suicidal behaviours. Accordingly, policies that encourage safe drinking, the avoidance of drug use and harm minimisation have an important role in suicide prevention. The National Drug Policy, led by the Ministry of Health, is the Government's key policy on preventing and reducing the harms that are linked to alcohol and other drugs.

This section provides an update on the Community Action on Youth and Drugs initiative and the Alcohol Advisory Council's efforts to change the binge drinking culture in New Zealand.

Community Action on Youth and Drugs

Seventy-two percent of students have tried alcohol and 61 percent currently drink alcohol according to *Youth '07 – The Second National Health and Wellbeing Survey of New Zealand Secondary School Students* (Adolescent Health Research Group 2008). Of students who reported current drinking, substantial numbers reported associated problems, such as unsafe sex (14 percent), unwanted sex (7 percent) and injuries (22 percent). About 5 percent of students use marijuana. Use of other drugs is uncommon, with 1.2 percent having tried methamphetamine.

Community Action on Youth and Drugs (CAYAD) is a nationwide initiative aimed at addressing youth and drug issues. At a community level it involves community action project workers, communities and researchers working together. The initiative is based on international research on how to work effectively at the local level. It uses a combined community action and kaupapa Māori approach to address youth and drug issues in their community context. Many of the CAYAD initiatives are sited in communities with high Māori populations. The aims of CAYAD are to:

- encourage effective policies and practices to reduce drug-related harm
- increase local capacity to support young people in education, employment and recreation
- reduce the supply of drugs to young people.

There are currently 55 CAYAD co-ordinators working at 29 CAYAD projects located in 25 sites throughout New Zealand. The CAYAD programme has been running for 10 years, and independent evaluations of the impacts of the programme have found positive changes in young people's attitudes and behaviour, increased perception of harm from the use of the drugs, and decreases in drug-related school suspensions and youth crime.

ALAC's Culture Change Campaign

One in five adult drinkers have a potentially hazardous drinking pattern that carries a high risk of future damage to physical or mental health (Ministry of Health 2008a). The Alcohol Advisory Council (ALAC) is implementing a long-term programme to change the binge drinking culture in New Zealand. In April 2008 a new series of advertisements went to air as part of ALAC's culture change campaign to get New Zealanders to see the connection between intoxication and the harms that result. The advertisements show examples of harm resulting from excessive drinking, with three realistic characters eventually making dangerous choices.

Evaluations of the campaign have shown the advertisements have achieved high awareness, and one in two drinkers reported that the advertisements have had some impact. In particular, drinkers reported talking about the advertisements with others and thinking about cutting back on their own drinking behaviour as a result.

Review of the sale and supply of liquor legislation

In August 2008 the previous government introduced the Sale and Supply of Liquor and Liquor Enforcement Bill to address a number of immediate concerns about the regulation of alcohol, and announced that a comprehensive review of the regulatory framework for the sale and supply of liquor would be undertaken by the Law Commission.

The proposals in the Sale and Supply of Liquor and Liquor Enforcement Bill, which is currently before the Justice and Electoral Select Committee, relate to:

- a zero blood alcohol content limit for drivers aged under 20 who do not hold a full licence
- diversion to early intervention alcohol programmes for minors
- the ability to cancel managers' certificates where liquor is sold to a minor more than three times in two years
- offences for the sale and supply of liquor to minors
- the types of premises that are eligible for an off-licence
- constraints on the diversification of liquor stores into selling more general merchandise
- community input into licensing decisions
- a new framework of enforced self-regulation for alcohol advertising.

The Review of the Regulatory Framework for the Sale and Supply of Liquor is being led by the President of the Law Commission, Sir Geoffrey Palmer. The review will evaluate current laws and policies, and will formulate a revised policy framework and set of principles to regulate the sale, supply and consumption of liquor in New Zealand. It will consider harms and social outcomes related to alcohol, and the balance between rights and responsibilities under the legislation.

Some of the issues to be considered in the review include the age at which liquor can be purchased, the responsibility of parents for supervising young people who are drinking, the role of competition and advertising in the sale of liquor, ways to ameliorate the health effects of alcohol use, the effects of the proliferation of liquor outlets and their trading hours, and enforcement issues.

A public discussion paper will be released by 31 July 2009 outlining the international context, significant issues for the review, and the underlying principles of the regulation of alcohol. A final report, including the proposed new policy framework and draft legislation, will be produced by the Law Commission by the end of June 2010.

Life stress and trauma

Exposure to various life stresses – such as problems with relationships, employment, finances, the law, health and housing – increases the risk of mental illness and suicidal behaviours. Natural disasters, traumatic events and emergencies may also contribute to mental health problems. Policies and programmes aimed at promoting resilience and reducing exposure to stresses can therefore contribute to suicide prevention.

This section provides examples of school-based programmes that aim to promote mental health, and describes the Psychosocial Recovery Plan, which aims to reduce the adverse effects of disasters.

School-based programmes

The programmes described below work with students in schools to create a positive school climate, promote the mental health of students and support students facing challenging circumstances.

- **Travellers** is a group programme for young people in their first year of secondary school aimed at building resilience and enhancing connections. The programme helps groups of 10 to 12 young people who have been experiencing stressful life events to navigate their movement through change, loss and transition in safe and adaptive ways. The sessions take place in class time and are facilitated by trained school staff. The programme is funded by the Ministry of Health and is now in its seventh year. Most participating schools are in Auckland and Northland, and a national roll-out has commenced. Twenty-four new schools will be participating in the programme in 2009, with 77 schools participating in total.
- **Student Well-being Mental Health Education Initiative** assists schools to develop policies, procedures and sustainable programmes that support students and their families. The programme involves professional development for teachers around mental health education, including teaching students about enhancing personal identity; building relationships; managing stress, loss and change; examining the choices and consequences in relation to drug use and misuse; and addressing stereotyping, discrimination, abuse and harassment. A two-year programme is currently in place in 73 schools around New Zealand, funded by the Ministry of Education.

- **Safe School** teams are a new initiative being developed in schools and early childhood education services throughout New Zealand through traumatic incident planning and support workshops (see page 43 for more information about traumatic incident management in schools). The initiative's goals are to reduce violence and bullying and increase effective learning by establishing safe and emotionally healthy environments. Difficulties with a wide range of issues in schools are examined and addressed. Safe schools then prioritise areas for action and develop and implement a range of school policies, procedures and practices to address areas of difficulty.
- **Mentally Healthy Schools** (MHS) is linked to Health Promoting Schools (HPS) and uses a whole-school approach to promote mental health. HPS is a World Health Organization initiative that includes curriculum teaching and learning, school organisation and ethos, and community links and partnerships. The HPS framework is used in some New Zealand primary, intermediate and secondary schools. The Ministry of Health is currently seeking a clearer understanding of the coverage, uptake, implementation and effectiveness of MHS in order to identify gaps and plan future investment. This will enable the Ministry of Health to plan how it can best work with the Ministry of Education to support schools to promote mental health and prevent mental illness.

Psychosocial Recovery Plan

Most people are affected in some way by the experience of an emergency event, either directly, or indirectly. Emergency events can be natural (eg, an earthquake or influenza outbreak), accidental (the Wahine disaster) or purposeful (the attack on the World Trade Center). The majority of people and communities who experience an emergency event will recover with good support and time. However, a minority will experience longer-term psychological problems.

In 2007 the Emergency Management Team of the Ministry of Health published *Planning for Individual and Community Recovery in an Emergency Event: Principles for psychosocial support* (Ministry of Health 2007a). As part of the National Health Emergency Plan, this document oriented organisations towards evidence-based good practice principles for providing psychosocial support to promote individual and community wellbeing and recovery during and after emergency events or disasters affecting New Zealand.

In March 2009 the Emergency Management Team facilitated seven workshops across New Zealand for those working in the emergency management sector in leadership, quality assurance or training roles concerning the provision of psychosocial support during or after emergency events. These workshops were supported by the production of a resource DVD that can be used to help educate those involved in emergency support about likely individual and community responses to disaster events, and how to help promote wellbeing. This kit can be used both during emergency preparedness activities and during response and recovery phases of an emergency.

In the school setting, the Ministry of Education traumatic incident service provides emergency support to promote school recovery. A manual and resource CD are to be published and released in 2009. See page 43 for more information about this service.

Socioeconomic inequalities

Individuals from socially and economically disadvantaged backgrounds are at increased risk of suicidal behaviour. The *Social Report 2008* revealed that the extent of socioeconomic inequality in New Zealand is improving, with income inequality between the top 20 percent of earners and the lowest 20 percent (the gap between rich and poor) dropping for the first time since 1988 (Ministry of Social Development 2008). The report found that there were fewer people living on low incomes, and that Māori and Pacific peoples have made significant advances in unemployment rates, access to early childhood and tertiary education, and life expectancy. However, significant socioeconomic inequalities remain, and policies and programmes directed at reducing inequalities continue to play an important role in suicide prevention.

This section describes Work and Income's health and disability advisors initiative, Youth Transition Services and the Work and Income ReStart package, which supports families struggling as a result of redundancy.

Health and disability advisors at Work and Income

Over 2008/09 the Ministry of Social Development, in collaboration with the Ministry of Health, DHBs and PHOs, implemented an initiative that assists people who are receiving income support and who may have a mild to moderate mental health problem such as depression. A network of regional health and disability advisors provide support, mentoring and advice to Work and Income case managers on health and disability issues. They may also recommend health and disability services along with employment services. These services may be funded by the Ministry of Social Development or Health (through DHBs or PHOs). Where a person has significant mental health problems, their recommended package of care can include access to mental health services such as talking therapies.

The type and availability of health or disability services differs between regions, hence the importance of advisors that are available to provide information about local services. The advisors also have an educative role. An example is Work and Income's Central and Taranaki regional case managers all receiving Like Minds, Like Mine training about the stigma and discrimination affecting people with experience of mental illness (see page 16 for more information about Like Minds, Like Mine).

Youth Transition Services

Youth Transition Services (YTS) have the goal of ensuring that all 15- to 19-year-olds are in employment, education, training or other activities that lead to their long-term economic independence and wellbeing. From 2004 co-ordinated post-school support services were established to assist at-risk youth to make the transition from school into work, further education, training or other purposeful activities.

As at March 2009 there were 19 YTS operating in 39 territorial authorities. This means that YTS are available in geographical areas covering approximately 62 percent of all school leavers (although not all of these school leavers will make contact with a YTS).

Redundancy support package

In response to anxiety about job security, which has been created by the global economic situation, the Government has established a new package to provide short-term support to families in the event of redundancy. The ReStart package includes payments to support families with dependant children, payments to cover accommodation costs (rent and mortgage repayments), and assistance finding a new job.

Social cohesion and support

Social connectedness or cohesion refers to positive relationships among communities, and people joining together to achieve shared goals. Research suggests that the extent of social connectedness in a society influences suicide rates. Communities with strong social support, connectedness and participation may provide a context that promotes mental health and prevents mental illness.

The *Social Report 2008* found that social connectedness in New Zealand continues to improve (Ministry of Social Development 2008). This was measured by looking at contact with family and friends, trust in others, experiences of loneliness, contact between young people and their parents, and telephone and Internet access in the home, which helps to maintain social connectedness.

Young people in New Zealand are also showing strong social cohesion. The Youth '07 report found that most students report good health and emotional wellbeing and are fully participating in their families, schools and communities (Adolescent Health Research Group 2008).

Government policies to support social cohesion are wide ranging. This section describes two examples of initiatives that aim to increase social connectedness and participation in New Zealand communities: the Kia Piki te Ora Community Development project and the Community Development Scheme.

Kia Piki te Ora Community Development

The Kia Piki te Ora Community Development project was established by the Ministry of Health in 2001 as part of the New Zealand Youth Suicide Prevention Strategy. The Kia Piki te Ora sites promote the health and wellbeing of Māori and contribute to the reduction of suicides and suicidal behaviour affecting Māori. The programme aims to improve the co-ordination of existing services, identify areas where additional service development is needed, and facilitate local action to address these issues. It includes:

- community action to improve the co-ordination and delivery of services that influence the positive mental health of Māori
- training and information resource development to improve community and workforce knowledge and skills.

There are Kia Piki te Ora sites in the following regions: Auckland, Bay of Plenty, Christchurch, Hawke's Bay, Nelson Marlborough, Northland and Wanganui.

Community Development Scheme

The Department of Internal Affairs provides funding to support communities to work together in new ways to determine their own development priorities, generate their own innovative solutions to local issues, and become more self-reliant and resilient.

Effective from 1 July 2008, four funding schemes – the Community Development Scheme, He Ara Whakapakari Papakainga, the Crime Prevention Scheme and the Community-based Youth Development Fund – were merged into an expanded Community Development Scheme (CDS) to provide more flexible funding. The new scheme funds communities over three years to cover project expenses and employ community development project workers who work on community-driven projects.

The merged scheme recognises that complex social issues do not exist in isolation from each other and that integrated strategies for change are necessary. The broader focus of the new scheme retains the community-driven, community development approach while offering greater flexibility for funding government and community priority areas. Communities are empowered to identify their own priorities and have more freedom to determine where they want to focus their resources when responding to local needs.

Māori, youth at risk, Pacific peoples or other ethnic groups in urban, provincial or rural areas are priority populations under the expanded CDS, within the priority regions identified by the Department. Communities in these priority regions that face social challenges or geographical isolation, low household incomes and low Internet access can apply for funding for a community-supported proposal. The community development approach of supporting community-identified proposals ensures that specific groups such as Māori and youth-at-risk initiatives (previously funded under separate schemes) will continue to be considered within the merged scheme.

An example of a community project funded by the scheme is the Otago Health Incorporated community-based youth development project. The project aims to incorporate guidance and direction from strong networks and community groups who are already engaged with youth in Otago to ensure that Māori and Pacific youth are valued, nurtured and strengthened.

Cultural identity

Cultural identity is important for people's sense of self and how they relate to others. Research indicates that a strong cultural identity can contribute to one's overall wellbeing, but alienation from one's culture may be a risk factor for poor mental health and suicide. In many countries, indigenous minority populations have higher suicide rates than the majority population, and this disparity applies to Māori in New Zealand. Increased access to Māori language, family networks, community structures and traditional arts are some ways in which cultural identity can be strengthened for Māori.

The *Social Report 2008* monitors the domain of cultural identity (Ministry of Social Development 2008). The results for the indicators of cultural identity used in the Report are mixed. More local content is being broadcast on television and more during prime-time television hours. The total number of Māori who can speak Māori increased between 2001 and 2006 (to 24 percent in 2006). A Youth '07 report (based on

information provided by 2059 students who reported Māori ethnicity) found that almost all Māori youth are proud to be Māori, and 34 percent speak and 39 percent understand te reo Māori 'fairly well' or better (Clark et al 2008).

The following section describes two examples of initiatives that aim to strengthen the cultural identity of particular ethnic groups: Māori Language Week and websites developed by the Ministry of Pacific Island Affairs.

Māori Language Week

In 2008 Māori Language Week was celebrated at an unprecedented level, and covered by many television channels, radio stations and print media throughout the country. The Māori Language Week Awards were held to celebrate and recognise innovative efforts to promote te reo Māori.

Māori Language Week 2008 marked the launch of two digital resources for te reo Māori speakers. The first was He Pātaka Kupu, the largest online monolingual Māori dictionary, launched by Te Taura Whiri i te Reo Māori (the Māori Language Commission). The website exceeded expectations with the number of searches in the first 24 hours of launching. The second resource was Google Māori, the Māori interface of Google.

Launch of the Pacific Starmap website and Pacific Island language websites

Recognising the importance of language to retaining cultural identity, the Ministry of Pacific Island Affairs has developed three interactive Mind Your Language websites that allow people to learn or relearn Cook Island Maori, Tokelauan and Niuean. These three languages are in most danger of disappearing among the Pacific Island languages in New Zealand. The websites also allow website visitors to hear traditional songs, learn about the islands and experience traditional art and performance. A large number of hits on these websites suggest they are fast becoming a useful resource.

Another important aspect of a person's cultural identity is their knowledge of art and performance. The Pacific Starmap website (www.pacificstarmap.com) was launched in August 2008 by the Ministry of Pacific Island Affairs. It aims to help new and emerging Pacific artists to develop their careers by giving them access to information about training opportunities, business development skills and opportunities, funding sources and role models. This initiative will increase the exposure young Pacific peoples have to these aspects of cultural identity.

Discrimination

Discrimination is experienced in various forms by people with experience of mental illness, gay, lesbian, bisexual, transgender and intersex people, refugees and immigrants, people with disabilities, and minority ethnic groups. Discrimination is associated with a poorer sense of wellbeing and lower self-esteem, as well as with mental health problems. Social policies aimed at reducing discrimination can therefore promote mental health and contribute to suicide prevention.

Like Minds, Like Mine

People with experience of mental illness report discrimination in many aspects of their lives, ranging from employment and housing issues, to discrimination from friends, family, mental health services and the community. The Like Minds, Like Mine programme (Like Minds) aims to counter the stigma and discrimination associated with mental illness. Reducing stigma and discrimination means that people are more likely to recover full social, family and economic participation. They are also less likely to require ongoing specialist mental health services.

Like Minds is funded and led by the Ministry of Health and delivered by national and regional providers. In addition to television and radio advertisements, Like Minds provides community activities and events, training, a telephone helpline, a website, newsletters, resources, hui, research, news media engagement, monitoring of and responding to media coverage, and policy development.

Research shows that the Like Minds programme has brought about significant change, especially in people's perceptions of mental illness. Like Minds and the National Depression Initiative received a Gold EFFIE at the prestigious CAANZ (Communications Agencies Association of New Zealand) EFFIE awards in October 2008, which recognise effectiveness in advertising.

In August 2008 Like Minds published its latest tracking survey, which showed continued success in changing the way New Zealanders understand mental illness (Wyllie et al 2008). One-third of people in the survey noted positive changes in their behaviour towards people experiencing mental illness over the last five years, and 71 percent of people reported that they knew how they could be supportive of someone experiencing mental illness, an increase of 10 percent since the last survey in 2007. The survey also showed that Māori attitudes have made the most significant improvements over the life of the programme.

OUT THERE! Queer Youth Development Project

People with non-heterosexual sexual orientation and non-conforming gender identity are more likely to experience discrimination, social stress and suicidal thoughts than their heterosexual counterparts. OUT THERE! is a national Queer⁴ Youth Development Project that aims to enhance the wellbeing of non-heterosexual youth in New Zealand by developing safe and supportive environments and combating homophobic prejudice and discrimination. To do this, OUT THERE! runs workshops for people who work with youth, produces and distributes resources, and funds research. OUT THERE! also plays an important role in supporting youth groups throughout New Zealand, including school-based diversity groups.

OUT THERE! was funded by the Department of Internal Affairs' Community Based Youth Development Fund until June 2009. Future funding options beyond June are being considered.

⁴ OUT THERE! uses the word 'Queer' to represent sexuality and gender diversity. It is used to encompass people who are lesbian, gay, bisexual, transgender, intersex, fa'afafine, takataapui, or questioning.

United Nations Convention on the Rights of Persons with Disabilities

Discrimination is also experienced by people with disabilities. On 30 March 2007 New Zealand signed the Convention on the Rights of Persons with Disabilities, the first United Nations human rights treaty of the 21st century. The Convention was ratified on 26 September 2008 and makes it explicit that states must ensure the full realisation of all human rights and fundamental freedoms for all disabled people, on an equal basis with others, and without discrimination of any kind on the basis of disability.

The Convention aims to provide a new impetus and practical focus to removing barriers experienced by disabled people in New Zealand that prevent their full participation in society. For example, it will help to ensure that mainstream services are inclusive of disabled people and are delivered in non-discriminatory ways.

Goal 2: Improve the care of people who are experiencing mental disorders associated with suicidal behaviour

Why is this important? New Zealand and international research have found that mental disorders are the strongest risk factors for suicidal behaviour.

What are we aiming to do? The purpose of this goal is to develop strategies, policies and services that improve the recognition, treatment and management of people who are experiencing mental disorders that contribute to the development of suicidal behaviour.

Key areas for action: Focus on the following four key areas could potentially reduce suicidal behaviour:

- population-based initiatives that encourage greater recognition of and responsiveness to mental disorders
- community-based initiatives that enhance the skills of people in the community, institutions and other organisations to identify and improve access to health care by facilitating help-seeking for people experiencing mental health problems
- improvements in the organisation and delivery of quality mental health services, including Māori models of health
- mental health programmes within institutional settings.

Progress on initiatives under each of these areas is described below.

Population-based initiatives

The National Depression Initiative

Depression makes the largest single contribution to suicidal behaviour. Although one in six New Zealanders will experience a serious episode of depression in their lifetime, few seek help early enough, and consequently the negative impacts of depression on their lives are more severe than they need to be. Reasons for not seeking treatment include lack of recognition by the individual of possible mental health problems, and a belief that they should be strong enough to manage without professional care.

The National Depression Initiative (NDI) was established in 2006 and aims to reduce the impact of depression on the lives of New Zealanders. Its two key objectives are to strengthen individual, family and social factors that protect against depression, and to improve community and professional responsiveness to depression. The initiative is led by the Ministry of Health as a key part of the New Zealand Suicide Prevention Strategy.

Following are some of the recent achievements of the NDI.

- TV advertisements featuring former All Black John Kirwan talking about depression have been exceptionally well received, with good recall of key messages. A survey in July 2008 showed a 93 percent recall with 97 percent recall for Māori and 91 percent for young people.
- Monitoring and evaluation of the programme (which includes TV and iwi radio advertising, two information websites, new online support services for young people and a helpline) is demonstrating success in aiding early recognition and appropriate treatment, increasing help-seeking behaviour (especially among young people) and assisting in recovery.
- The Depression helpline (0800 111 757) for those wanting support and information about depression continues to receive an average of over 50 calls a day, and is effectively assisting people to find the professional help they need.
- The NDI campaign information website (www.depression.org.nz) has been redeveloped and made more interactive, with a focus on providing self-management support for users. A new self-management e-tool, based on structured problem solving, is being developed with support from John Kirwan.
- The interactive website for youth, The Lowdown (www.thelowdown.co.nz), was launched in December 2007 and aims to help young people to understand depression and provide access to new online, webcam- and text-based services. A recent evaluation shows that young people's response to The Lowdown has been extremely positive and service use has been higher than expected. For example, in the six months to 31 December 2008, 58,517 texts and 1817 emails were received and sent. The number of unique users of the text services has doubled in the last six months. The site was recently refreshed, with a number of high-profile young sportspeople talking about their experience of depression and what they found helpful.

The Lowdown and the NDI received a Gold EFFIE at the CAANZ advertising awards in October 2008. This year the campaign won a gold and silver RSVP award from

the New Zealand Marketing Association, and another gold award from CAANZ in recognition of its success in communicating effectively with young people.

- The NDI campaign has supported the development of new primary mental health services delivered through PHOs, and the development of the guideline for primary care providers about depression and other common mental health disorders (New Zealand Guidelines Group 2008; see page 22 for more information).

Like Minds, Like Mine

See page 16 for a description of the Like Minds, Like Mine programme. This is a national programme that aims to promote the inclusion of people with experience of mental illness and to reduce stigma and discrimination.

Community-based initiatives

Mental health literacy

The Ministry of Health is funding the development, implementation and evaluation of a new programme to increase knowledge about mental health and mental illness, and to counter stigma and discrimination associated with mental illness ('mental health literacy'). The programme will target adults who, in their day-to-day work, have contact with people experiencing emotional distress and who are well placed to respond. The programme will involve face-to-face workshops and will be supported by web-based information and other materials.

Increasing people's knowledge about mental health and mental illness using methods that counter stigma and discrimination can result in greater recognition of mental health problems, increased help-seeking, increased knowledge of effective treatments, and increased support and inclusion of people with experience of mental illness. Given the associations between mental illness and suicide, increasing mental health literacy can potentially contribute to preventing suicide by leading to more effective prevention, early intervention, treatment and recovery from mental illness.

ASIST training

ASIST (Applied Suicide Intervention Skills Training) is a two-day skills-based workshop that helps equip people for 'suicide first-aid'. The focus of ASIST workshops is on increasing the ability of 'key responders' to promote the immediate safety of someone who may be at risk of suicide and link them to appropriate professional services. ASIST targets staff from frontline services such as police, health professionals, government and non-government agencies, and Māori and Pacific agencies.

ASIST has been funded by the Ministry of Health to adapt the programme to a New Zealand context. It has recently established cultural and clinical reference groups to aid in the development of workshops tailored for Māori and Pacific peoples. The ASIST handbook is being reviewed in consultation with the reference groups to ensure its relevance to New Zealanders.

Māori suicide prevention resource

A new Māori suicide prevention resource is being developed to improve knowledge about safe, effective and evidence-based suicide prevention activities in Māori communities and increase capacity to respond to mental illness in ways that support a reduction in the rate of suicide. *Te Whakauruora* will be a community action-focused resource, assisting Māori to build capacity to prevent suicide and suicide attempts. It will also provide access to information, an insight into how suicide is viewed by Māori, and the importance of Māori tikanga (cultural) frameworks in suicide prevention initiatives.

Health service initiatives

Mental health and addiction services

The development of mental health and addiction services in New Zealand is guided by *Te Tāhuhu – Improving Mental Health 2005–2015: The second New Zealand Mental Health and Addiction Plan* (Minister of Health 2005). *Te Kōkiri: The Mental Health and Addiction Action Plan 2006–2015* (Minister of Health 2006) was jointly developed by the Ministry of Health and DHBs to directly implement Te Tāhuhu. Te Kōkiri is a large programme of work that includes as one of its actions the Suicide Prevention Action Plan. Te Tāhuhu and Te Kōkiri's 10 leading challenges are to:

1. promote mental health and prevent mental illness
2. build mental health services
3. build responsive services
4. build a mental health and addiction workforce that supports recovery
5. broaden the range, quality and choice of mental health and addiction services for Māori
6. build and strengthen the primary health care sector
7. improve the availability of and access to quality addiction services
8. develop and implement funding mechanisms for mental health and addiction
9. strengthen trust in the mental health and addictions sector
10. strengthen cross-agency working together.

Many of these challenges are closely linked to the goals of the Action Plan. For example, challenge 1 (to promote mental health and prevent mental illness) and Goal 1 of the Action Plan are similar.

There is a comprehensive and wide-ranging work programme under way to realise the goals of Te Kōkiri. As well as other initiatives that are outlined in this report and that fall under the challenges above, the following developments since March 2008 are important.

- Phase 2 of the Ministry of Health Nationwide Service Framework project to review, revise and update the Mental Health and Addictions service specifications began in August 2008. The specifications outline a range of mental health and addiction services and are used by DHBs for contracting for these services. Phase 1 of the project reviewed the specifications for infant, child, adolescent and youth mental

health services, adult mental health services, consumer-led services and eating disorder services. Phase 2 is reviewing the specifications for addiction services, kaupapa Māori (for more information, see page 25), Pacific and family/whānau services. The specifications are expected to be available for use in contracting in 2009/10.

- The Ministry of Health has begun developing guidance to inform DHBs on the provision of services for people aged over 65 who are affected by mental health and addiction problems and people with dementia. The project aims to support DHBs to provide services that are consistent in quality throughout New Zealand. The guidance is expected to be completed by the end of December 2009.
- *Future Directions for Eating Disorders Services in New Zealand* was published by the Ministry of Health in April 2008 to guide DHBs to build and broaden the range and effectiveness of the services and supports they have available for people affected by an eating disorder (Ministry of Health 2008b).
- *Let's Get Real: Real skills for people working in mental health and addiction* was released by the Ministry of Health in September 2008 (Ministry of Health 2008c). This document provides a framework that describes the essential skills, knowledge and attitudes required to deliver effective mental health and addiction treatment services.
- *Te Puāwaiwhero: The Second Māori Mental Health and Addiction National Strategic Framework 2008–2015* was released in July 2008 (Ministry of Health 2008f). Te Puāwaiwhero concentrates on prioritised actions from Te Kōkiri to address Māori mental health population need.

Mental health in primary care

By early 2009, 80 PHOs had established primary mental health initiatives targeted at people with mild to moderate mental health and substance use disorders. Different PHOs have used a variety of service delivery models to better meet the needs of people with mild to moderate mental health and/or addiction problems. Common elements include extended GP consultations, individualised 'packages of care' and new dedicated primary mental health co-ordinators. These are typically nurses with mental health professional backgrounds, although some are social workers or psychologists.

The primary mental health co-ordinators undertake a range of tasks, including assessments, problem-solving therapy and other talking therapies. If they feel problems require more help, a 'package of care' will be developed, including specific treatment options. Most commonly this will involve a psychologist or counsellor being contracted, or employed by the PHO, to provide mental health care – often 'talking therapy'. It may also involve putting the person in touch with other community service providers and acting in an advocacy role.

Evaluation results published in March 2009 indicate that the initiatives have been effective (Dowell et al 2009). Eighty percent of service users showed an improvement, and benefits were maintained at a six-month follow-up.

One of the Ministry of Health's current objectives is to identify the core components of an effective primary mental health initiative and over time achieve greater consistency

across regions, while allowing for local variations where appropriate to a PHO's population and circumstances. The Ministry is also aiming to improve access to primary mental health services for children and youth, as these groups have lower levels of access. See pages 25 and 28 for information about primary mental health initiatives for Māori and Pacific peoples, respectively.

Guidelines for primary mental health care

The Ministry of Health released a new guideline on the *Identification of Common Mental Disorders and Management of Depression in Primary Care* in July 2008 (New Zealand Guidelines Group 2008). The guideline contains best-practice information on how to manage depression and other common mental health disorders, including how to assess when a patient of a primary care service is at increased risk of suicide.

The Ministry of Health is currently working to increase uptake of this guideline within primary care. The work includes making the guidelines available electronically to every practice in New Zealand (as an 'electronic decision support' tool on GPs' practice management systems), distribution of educational materials on the use of the guidelines, and a programme of workforce development to support their use.

School-based youth health services

Currently about three-quarters of all secondary schools in New Zealand have a school nursing service. The scope of the nurses' work ranges from the provision of emergency, clinical, sexual and mental health services, to psychosocial assessments, health promotion initiatives, data collection and research. Nurses refer students presenting with mental health issues to primary health care and/or mental health services, counselling services, social workers and local community services such as youth health services and Family Planning.

From November 2008 the Ministry and a number of DHBs began work to progressively implement targeted school-based health services in low-decile secondary schools, teen parent units and alternative education facilities. School-based health services are primary health care nursing services that will be provided by registered nurses who are skilled in youth health and development. These services are over and above the school health services currently being provided by a number of DHBs, such as those involved in the AIMHI (Achievements in Multicultural High Schools) initiative.

Initial results from a 2008 AIMHI evaluation of the school nurse component indicates that school-based health services are having a positive impact in terms of improving student health and educational outcomes. The evaluation recommended ongoing professional development for service staff, including clinical competence, cultural competence and competence in working with youth.

Relapse prevention plans

Well-managed care for people who experience mental illness increases their chances of being included in the mainstream of society without stigma and discrimination, being employed, and having an improved quality of life. A key performance target for all

DHBs is for at least 90 percent of long-term mental health service users to have up-to-date relapse prevention plans. Having a relapse prevention plan reduces the length and frequency of hospitalisations of people with enduring mental illness and encourages individuals to be the driver of their own recovery.

Relapse prevention plans identify early relapse warning signs for services users. The plan identifies what the service user can do for themselves and what the service will do to support the service user. Ideally, each plan will be developed with the involvement of clinicians, service users and their significant others.

There has been a 16 percent increase in mental health service users with relapse prevention plans since this indicator started to be measured. One-third of DHBs have already achieved their annual targets. At a national level, 75 percent of service users have relapse prevention plans.

Multi-level intervention suicide prevention trial

The Ministry of Health is funding a significant randomised controlled trial to enhance access to primary health services for people experiencing common mental health problems, and to improve the assessment, treatment and management in primary health care of those who are experiencing depression. The aim of this trial is the reduction of suicidal behaviours.

The trial will involve setting up pilot demonstration sites, where a range of interventions will be used to improve the experience of primary care for people with common mental health problems such as depression. The interventions will aim to:

- increase community referrals to primary mental health care services
- improve support to primary health care professionals to assess, treat and manage people with depression and other common mental disorders
- improve support for the whānau/families and friends of those experiencing depression and/or suicidal behaviour
- add local value to existing population-based approaches (such as Like Minds, Like Mine and the National Depression Initiative).

The trial is based on a German study (the Nuremburg Alliance against Depression study), which provided promising evidence that delivering multiple interventions within communities reduces the rate of suicidal behaviour (Hegerl et al 2006). Key elements of this approach appear to be that these interventions are intensive, synchronised and delivered within a defined local region. The effectiveness of the New Zealand trial will be evaluated, taking into account the views and experiences of primary care practitioners, non-government organisation staff and users of primary care.

Māori mental health and models of care

Māori mental health needs profile

The *Māori Mental Health Needs Profile: A review of the evidence* (Baxter 2008) documents the mental health needs of Māori people in different age groups and across

regions, and describes what is known about pathways to care for mental health needs among Māori. Knowing what these needs are is key to ensuring that future planning for Māori mental health and investment in mental health promotion, prevention, primary health care and specialist services is headed in the right direction.

The report provides a tool to help DHBs meet the requirements of the New Zealand Public Health and Disability Act 2000. The Act requires DHBs to have a population health focus and reduce health inequalities by improving the health outcomes of Māori. The report draws on data from *Te Rau Hinengaro: The New Zealand Mental Health Survey* (Oakley Browne et al 2006).

The report found that there are high numbers of Māori who are clients of mental health services and that Māori continue to be hospitalised for mental disorders at much higher rates than non-Māori (Baxter 2008). Anxiety disorders were the most common disorders among Māori, with almost four in ten Māori experiencing an anxiety disorder at some time in their lives. One in three Māori experience a mood disorder such as depression at some time in their lives, and one in three will be affected by an alcohol or drug disorder. Māori were also found to be more than twice as likely to have a serious mental disorder lasting 12 months compared with other groups.

The conclusions of the report are that there is a continued need to address socioeconomic disadvantage that contributes to Māori mental health need, and to improve the quality of and access to mental health services for Māori.

Māori Mental Health and Addiction National Strategic Framework

Te Puāwaiwhero: The Second Māori Mental Health and Addiction National Strategic Framework 2008-2015 (Te Puāwaiwhero; Ministry of Health 2008f) was released in July 2008. This strategy provides direction and leadership to the sector, and is a response to the requirements of the New Zealand Public Health and Disability Act 2000 in terms of striving to achieve equity in Māori mental health population need.

Te Puāwaiwhero draws on the 10 leading challenges of Te Tāhuhu, prioritises actions from Te Kōkiri (see page 20) and firmly establishes whānau ora as the key principal for recovery and wellbeing at the population level. Te Puāwaiwhero confirms the shift in emphasis from solely those affected by serious mental illness, to address the health and wellbeing of Māori as a population. This includes an emphasis on getting things right for Māori earlier through responsive mental health promotion and effective and timely primary mental health care.

Kaupapa Māori services

As mentioned on page 20, Phase 2 of the Ministry of Health Nationwide Service Framework project to review, revise and update the mental health and addictions service specifications began in August 2008. These are the accountability documents that set out the Government's expectations for access to publicly funded mental health and addiction services. They are an essential component of DHB contracting and audit processes. The review and revision aims to support innovation, integration and flexibility, continuity of care and seamless service delivery, to promote recovery, and to ensure all service users can have their needs well met.

The kaupapa Māori service specifications are part of the suite of specifications being reviewed in Phase 2. The consultation process with Māori has involved utilising existing Māori health networks, particularly Māori mental health and addiction networks, throughout the country. A Māori advisory and technical group, comprising key people from the four DHB regions in New Zealand, provides the guidance and oversight for the review and revision of the kaupapa Māori service specifications. The review has been received very positively by Māori in the mental health and addictions sector and has identified gaps within the current nationwide service framework that will be addressed with the new revised specifications. The overall aim of the revised kaupapa Māori specifications is whānau ora: Māori families supported to achieve their maximum health and wellbeing.

Primary mental health care for Māori

Primary mental health initiatives have been established in 80 PHOs and aim to better meet the needs of people with mild to moderate mental health and substance use disorders (see page 21 for more information). Different PHOs have used a variety of service delivery models to better meet the needs of these people.

An evaluation of the initiatives, published in March 2009, found that new primary mental health services aim at being responsive to Māori and use both kaupapa Māori and mainstream approaches (Dowell et al 2009). Having both options available was perceived by Māori as being optimal. Māori with mild to moderate mental health and substance use disorders showed similar levels of improvement to other ethnic groups. It was found that the initiatives were being provided to Māori at a higher rate than their proportion in the enrolled population. However, given the higher prevalence of some common mental health conditions among Māori, the report emphasised the need for a sustained focus on meeting the needs of Māori (Dowell et al 2009).

Te Rau Matatini

Te Rau Matatini, the Māori Mental Health Workforce Development Centre, supports Māori workforce development to enhance whānau ora, mental health and wellbeing. It supports and assists with the development and implementation of national and local workforce policy, research, training, career advancement, bursary programmes, scholarships and regularly updated information and resources for people accessing or working in health. Over the last year Te Rau Matatini has achieved the following milestones.

- It has significantly increased the uptake of Henry Rongomau Bennett Scholarships and Effective Interventions scholarships (for both the alcohol and other drugs and gambling sectors). The Henry Rongomau Bennett Memorial Programme has led to an increase in the number of Māori in specific mental health disciplines and has contributed to almost doubling the number of Māori psychiatrists in practice in New Zealand.
- An online learning programme has been developed to support the staff of emergency departments, mental health services and Māori health units to strengthen their capability to respond to, recognise and treat those with urgent mental health needs in a more timely and effective manner.
- *Whiria Te Oranga: Kaumatua workforce strategy for mental health and addiction services* (Ihimaera 2008) was published.
- *Māori Mental Health Needs Profile: A review of the evidence* (Baxter 2008) was published.
- Whānau ora and Māori mental health and addiction collaborative guidelines have been developed.

Te Rau Matatini hosts Matua Raki, the National Addiction Treatment Workforce Development Centre. The aim of Matua Raki is to develop the alcohol, drug and gambling addiction treatment workforce to support consumers and their families to reduce addiction-related harm.

Whānau ora tools

The Ministry of Health has produced tools to assist policy- and decision-makers to inform their actions relating to improving Māori health and disability outcomes and reducing inequalities. These tools are based on the concept of whānau ora – Māori families supported to achieve maximum health and wellbeing. *He Korowai Oranga: Māori Health Strategy* (Minister of Health and Associate Minister of Health 2002) sets out four pathways to achieve whānau ora:

1. development of whānau, hapū, iwi and Māori communities
2. Māori participation in the health and disability sector
3. effective health and disability services
4. working across sectors.

There are a number of tools available to assist with achieving whānau ora. For example, the Whānau Ora Health Impact Assessment tool provides a methodology for policy-makers to predict the potential health impacts of their policies for Māori (Ministry of Health 2007c). Other tools include an intervention framework, a programme planning tool and a Health Equity Assessment Tool (HEAT).

Research on Māori models of care

The Ministry of Health is funding a significant randomised controlled trial investigating interventions to improve the longer-term care of those who have made a suicide attempt. One of the trials will have a specific focus on improving the care of Māori who have made a suicide attempt. (See page 34 for further information.)

The Health Research Council is currently funding five projects exploring the following indigenous mental health issues:

- factors that promote resilience
- cognitive behaviour therapy with Māori
- whānau participation in mental health service delivery
- development of a framework to assess clinical and cultural competency in mental health practice
- the significance of culture in understanding mental health.

These research projects will contribute to the body of knowledge about what models of care used in mental health services work best for Māori. This knowledge can be used to improve the efficacy of services for Māori and can contribute to suicide prevention.

Pacific mental health and models of care

Samoan suicide prevention resource

Paolo: 'O o'u Paolo out e malu ai' 'It is my people that give me shelter': Embracing our Samoan Communities: Suicide prevention information for people working with Samoans in Niu Sila (Faleafa et al 2007) is a suicide prevention resource that provides information for people working with Samoans in New Zealand, such as GPs, teachers, school guidance counsellors, church ministers and social and mental health workers. The resource was published in 2007, and was developed by Suicide Prevention Information New Zealand (SPINZ) in partnership with the Samoan community. The content is presented in both English and Samoan.

Le Va – Pasifika within Te Pou

Le Va is the Pacific mental health workforce development unit within Te Pou, New Zealand's National Centre of Mental Health Research, Information and Workforce Development. The aim of Le Va is to improve the mental health and wellbeing of Pacific peoples through progressing the delivery of effective health services by a clinically and culturally competent Pacific workforce.

Le Va provides scholarships to develop a more skilled Pacific mental health workforce that is supported and sustainable, and administers an innovation fund to encourage and enable innovation in Pacific mental health and addictions workforce development in New Zealand. Le Va has also established a Pacific reference group named Le Leo o Le Va (literally, 'the voice of Le Va' in Tokelauan and Samoan). Le Leo o Le Va provides advice, cultural leadership and community perspectives to Le Va on issues related to developing and implementing the projects and related work of Le Va.

Primary mental health care for Pacific peoples

Primary mental health initiatives have been established in 80 PHOs and aim to better meet the needs of people with mild to moderate mental health and substance use disorders (see page 21 for more information). Different PHOs have used a variety of service delivery models to better meet the needs of people with mild to moderate mental health and/or addiction problems.

An evaluation of the initiatives published in March 2009 found there was under-utilisation of services by Pacific peoples compared to their proportion in enrolled populations. The report recommended further work to understand the barriers to access for Pacific peoples. Suggested solutions included specifically incorporating health promotion and de-stigmatisation features in an initiative, and recognising that some Pacific peoples and communities may be reluctant to address or acknowledge mental health issues. The report also found that there are significant variations in Pacific peoples' belief systems about mental health and treatment options, and recommended programmes to accommodate or reflect this.

Research on Pacific models of care

In February 2009 a paper was published reporting on the findings of a study on Pacific models of mental health service delivery (Suaalii-Sauni et al 2009). The study was funded by the Ministry of Health through Le Va and undertaken for the Mental Health Research and Development Strategy, a partnership between the Ministry of Health, the Health Research Council and the Mental Health Commission.

Researchers from the University of Auckland, Waitemata DHB and other organisations analysed focus group interviews with Pacific mental health service providers, mental health service users and the family members of service users (Suaalii-Sauni et al 2009). The paper reports on discussions about the mental health service delivery approaches and models of mental health care known to participants, and what participants thought were uniquely Pacific about these models. Participants identified eight different models of mental health care that they perceived as 'holistic', taking into account physical and spiritual health. Participants also talked about the importance of group therapy and the use of Pacific languages and hospitality practices.

Institutional settings approaches

Educational settings

Schools have an important role in preventing suicide among students, but it can be difficult for all schools to know how to undertake safe and effective suicide prevention and to recognise and respond appropriately to students at risk of suicide. To assist schools to do this, the Ministry of Education and the Ministry of Health are working together to review and update existing suicide prevention guidelines for schools.

The review will seek appropriate Māori and Pacific input to ensure all resources are culturally appropriate. The updated guideline, and a document outlining the evidence the guideline is based on, will be made available on the Ministry of Education website. A short summary document will also be produced and distributed to all schools. It will

direct readers to the guidelines online for further information. Information from this review will also be incorporated into the traumatic incident response service guidelines (see page 43 for more information).

The Health and Physical Education National School Curriculum has a focus on wellbeing. Topics covered include social and classroom relationships, body image, career choices, drug use, sexual health, sexuality, and managing grief, loss and change.

Guidance counsellors and social workers based in schools have an important role in educational settings to assist and support the mental health of students. Social Workers in Schools (SWiS) is an initiative led and funded by the Department of Child Youth and Family (CYF). The service is non-statutory and voluntary. SWiS are based in low-decile (mainly deciles 1–3) primary and intermediate schools with high Māori and/or Pacific rolls. The objective is to provide easily accessible early intervention and prevention services to families by basing social workers in a school or a cluster of schools. The services are designed to provide early help to children and families in order to prevent problems becoming more serious and difficult to overcome. Strengths-based social work practice is used to draw on and build the family's resources and strengths. This scheme began in 1999. In 2009 there were 122 social workers funded by the scheme, working in 330 schools.

Although based in schools, SWiS are employed by local social service providers that are CYF-approved. Some decile 1 secondary schools in South Auckland and Porirua employ social workers under a similar scheme. Some primary and secondary schools in different parts of the country also have a social worker based in their school as part of their pastoral care provision. Funding for these social workers comes from a variety of sources.

Secondary schools have student liaison counsellors, more commonly known as guidance counsellors, on their staff. These people are responsible for helping students fulfil their potential educationally and socially at school. They help students reassess situations, look for alternative actions and support the development of new skills and strategies to cope with the situations they are faced with.

Guidance counsellors are appointed in secondary schools as part of the staffing allowance, based on roll numbers, and they are expected to have qualifications in counselling or be in the process of gaining qualifications. Guidance Counsellor Study Awards are available from the Ministry of Education to enable newly appointed counsellors to gain the qualifications required. Many school guidance counsellors are members of the New Zealand Association of Counsellors.

Careers guidance staff are also available in schools to advise students about career paths, to give guidance in terms of subject choice relating to a chosen path, and to teach career-related skills at all levels. (Also, see page 22 for information about school-based youth health services.)

Child Youth and Family Services

Young people in the care of Child Youth and Family (CYF) are at particular risk of suicide. New Zealand research has shown that they are about 10 times more likely to die by suicide than their non-CYF peers.

A major contributor to suicide prevention for young people in the care of CYF is the Towards Wellbeing programme (TWB). TWB is a national suicide risk assessment, monitoring and management programme for young people under the care and protection of CYF. Clinical psychologists provide advice and support to CYF social workers to help them to develop suicide management plans, monitor these plans and identify referral pathways to specialist mental health services, if required.

TWB requires all youth under CYF care to be assessed using the programme screening and assessment tools. If youth are deemed to be at risk, plans are developed and reviewed in consultation with clinicians to the TWB programme. More than 570 young people per year are managed in this way.

The TWB programme has been reviewed three times by international academic reviewers and is rated as being a benchmark of programmes of its type. Initial evaluation results have shown that the programme has contributed to a sharp decrease in deaths and hospital admissions for deliberate self-harm since its implementation. There has been a 30 percent decrease in the relative likelihood of death and a 50 percent decrease in the relative likelihood of hospital admission. The last evaluation, dated June 2007, highlighted some issues with implementation and these are being addressed through the priority actions for 2009.

CYF residences have standard operating procedures that guide practice in residence in relation to suicide risk. One of these addresses the use of the TWB programme and the management of suicide risk. A review of the TWB standard operating procedures is currently under way.

In order to ensure the programme is made more effective for Māori, the TWB programme has a cultural advisor, and now also has a part-Māori clinician who has had extensive experience with Māori organisations and clients. For the next stage of service delivery Māori females in CYF care will be a priority group.

A multi-agency planning structure has been piloted and is now being rolled out in all seven CYF residences. As a result, the relationship between CYF and education and health providers has improved. Residential staff report improved communication and support when managing young people with significant self-harming behaviours or suicidal ideation. Staff are assisted to understand the complexities of these young people, manage the suicide risk plans and feel confident that they are able to provide the clinical advisors with pertinent information, thus ensuring the plans are appropriate and specific to the needs of these children and young people.

Corrections facilities

The mental health and addiction needs and suicide/self-harm risks of prisoners are assessed at first entry and at critical points throughout their sentences. Prison Services, within the Department of Corrections, are undertaking a full review of the policy and operating procedures for the management of prisoners who may be at risk of suicide. The objective of the project is to identify, evaluate and recommend a best practice model for the operating and management requirements of at-risk units of prisons, including the training and management of staff.

The project will complete a review of the current assessment process in terms of initial and ongoing risk factors for suicide. It will reconfirm the definition of 'at-risk' and determine qualifying criteria for entry and exit within at-risk units of prisons. Where there are no at-risk units, there will be a best practice guide for the management of at-risk prisoners. The scope will also determine a plan of action for the recruitment, training and development of staff within at-risk units.

Visits to sites have been completed as part of the review, and primary mental health training for nurses has been developed and added to the core training calendar for nurses in 2009. Internal consultation is under way at the Department of Corrections on proposed changes to current practice and national policy. A pilot study will begin at the end of June 2009.

In July 2008 the Department of Corrections and the Ministry of Health signed a Memorandum of Understanding on the Management of Prisoners Requiring Secondary Mental Health Services and Hospital Level Care. This aims to ensure that prisoners with acute mental health needs have access to the required level of health care and appropriate facilities. It also seeks to minimise any potential risk that may arise while these prisoners are awaiting transfer from a Department of Corrections facility to a DHB hospital facility. The memorandum of understanding has been implemented, and a service-level agreement with forensic psychiatric services to ensure prisoners access to health care is being reviewed.

Police custody

Police operations for the prevention of suicide in police custody were reviewed throughout late 2003 and early 2004, with new general instructions and operating procedures put in place shortly afterwards in 2004. The procedures ensure police assess the suicide risk of people who have been detained, and put in place a management plan to prevent the suicide of those at risk. At-risk people are searched, monitored frequently, placed in a suicide-resistant cell, and given tear-resistant clothing and blankets. All people who attempt suicide are given the appropriate medical attention and are referred to a health professional for assessment or dealt with under the Mental Health (Compulsory Assessment and Treatment) Act 1992.

These measures have been very successful in reducing the number of custodial suicides. There were three custodial suicides in police cells in 2003. This declined to only one such suicide in 2004. There were no further custodial suicides until 2007 and 2008, when there was one fatality per year.

Mental health inpatient services

When there is a suicide or suicide attempt in a mental health inpatient service, there is a reporting system that ensures action is taken to prevent the recurrence of such an event. When a person who is a patient under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Mental Health Act) dies by suicide, the death is reported to the Director of Mental Health at the Ministry of Health (under section 132 of the Mental Health Act).

On receipt of a report, the Director reviews the information and may seek further clarification from the service. The Director can also initiate an investigation under section 95 of the Mental Health Act. The Director follows up with a director of area mental health services on any recommendations resulting from an inquiry or investigation. The Office of the Director of Mental Health publishes an annual report that includes suicide statistics (Ministry of Health 2008d).

DHBs may also initiate an inquiry if there is concern surrounding the death or suicide attempt of any mental health inpatient (not just those under the Mental Health Act), and the Minister or Director-General of Health can initiate an inquiry under section 72 of the New Zealand Public Health and Disability Act 2000. Reporting these events facilitates the analysis of individual events and helps to identify trends and understand residual risk to individuals and/or the inpatient population. The process of reporting and investigation promotes a culture of learning from such events in mental health inpatient services.

Goal 3: Improve the care of people who make non-fatal suicide attempts

Why is this important? People who make suicide attempts are at high risk of making further attempts: about one in six make a further non-fatal attempt within a year and about one in four attempt again within four years. Their risk of dying by suicide is between one in 200 and one in 40 within one year of their attempt, and around one in 15 after nine or more years. This risk is hundreds of times higher than for the general population (Owens, Horrocks and House 2002). Those who make suicide attempts also have high rates of mental health problems, interpersonal difficulties and problems with the law.

What are we aiming to do? Providing those who make suicide attempts with effective acute and longer-term care and support may improve their quality of life in addition to reducing their risk of suicidal behaviour. This will include trialling and assessing interventions that may be effective, and improving responses to suicide attempts in key settings.

Key areas for action: Goal 3 focuses on three key areas that could potentially reduce the suicide rate among those who have made a suicide attempt:

- improving the acute management of those who make a suicide attempt

- improving the longer-term management of those who make a suicide attempt
- improving the management of suicide attempts in institutional settings.

Progress on initiatives under each of these areas is described below.

Improving the acute management of those who make a suicide attempt

The Ministry of Health commissioned the New Zealand Guidelines Group (NZGG) to produce the best practice evidence-based guideline *The Assessment and Management of People at Risk of Suicide* (New Zealand Guidelines Group and Ministry of Health 2003). This guideline is designed to improve crisis care in emergency departments, Māori health services and mental health services for people who present with self-harm or suicide attempts. The guideline advises on assessing and managing people presenting at hospitals with suicidal thoughts, or after a suicide attempt, and aims to reduce the risk of people making further suicide attempts after discharge from hospital.

To facilitate the implementation of this guideline, the Ministry of Health has funded the establishment of Whakawhanaungatanga: The Self Harm and Suicide Prevention Collaborative, which is being undertaken by the NZGG. In the last year the Collaborative completed the recruitment of 14 DHBs for the second phase of implementation of the guideline and have held their first series of training workshops for DHB staff working in emergency department, mental health and Māori mental health services.

There are four targets that NZGG work with the DHBs to achieve.

1. **Access:** 90 percent of people attending emergency departments with self-harm or suicidality should be seen (ie, begin the process of assessment) within one hour by a clinician skilled in conducting mental health and risk assessments.
2. **Assessment:** 100 percent of people presenting (to any of the relevant services) will have a documented assessment that incorporates an assessment of psychosocial stressors, a cultural assessment, a screen for mental illness and subsequent risk assessment.
3. **Discharge:** whenever a person is discharged from any of the services, they and their whānau or significant others (if appropriate) should be provided with a written copy of their discharge plan. This should also be sent to all others involved in the person's care.
4. **Follow-up:** 90 percent of people presenting to any of the services with suicide or at risk of self-harm will have a follow-up appointment with a continuing care provider within 48 hours of discharge if they remain at risk of self-harm or suicide (and do not have a management plan that states otherwise).

The 14 DHBs are Bay of Plenty, Counties Manukau, Lakes, Northland, Waikato, Taranaki, Waitemata, Hutt, Tairāwhiti, Wairarapa, Southland, MidCentral, Hawke's Bay and Capital and Coast.

Improving the longer-term management of those who make a suicide attempt

Several significant research projects are under way to assess the effectiveness of services and interventions for those who have made a suicide attempt.

The Ministry of Health is funding the design, development, delivery and evaluation of two major randomised controlled trials to inform the improvement of longer-term care for those who have made a suicide attempt. The trials aim to improve the mental health and psychosocial outcomes for those who have made a suicide attempt and to reduce subsequent suicidal behaviour. The studies will be undertaken in Northland, Waitemata and Counties Manukau DHB regions.

The After Self Harm: Collaborative Care and Enriched Services Study (ACCESS) is a randomised controlled trial that compares receiving treatment as usual to a package of care with multiple promising evidence-based interventions. This package is delivered by integrated self-harm teams and can include short-term intensive patient support, sending follow-up 'postcards', brief problem-solving therapy, a cultural assessment, easier access to GPs and development of a risk management strategy.

Māori who present to emergency departments after a suicide attempt will have the option of being involved in ACCESS or the second randomised controlled trial, Te Ira Tangata. Te Ira Tangata is based on the same principles as ACCESS but uses interventions that are informed by Māori knowledge and processes. In this trial, Māori who present to a hospital with self-harm will receive a structured cultural assessment plus culturally informed interventions. Key stakeholders will be consulted when devising an intervention for Māori, which will be informed by Māori tikanga. The trial aims to reduce Māori self-harm and suicide, and to demonstrate that explicitly taking into account cultural factors in health care improves outcomes.

ACC has funded a randomised controlled trial to examine the impact of sending postcards to individuals who have made a suicide attempt to remind them that they can contact the health services any time. This initiative is similar to an Australian study, which demonstrated a 48 percent lower rate of readmission for suicide attempts than a comparison group who were not sent postcards. The New Zealand study involved sending four postcards in the six months following an index suicide attempt and examining the extent to which this intervention reduced re-presentations over this same period. Although initial results were encouraging, results reported in October 2008 showed that the intervention was unable to demonstrate a reduction in re-presentations for suicide attempt when accounting for the group differences in presentations to emergency departments in the 12 months prior to the beginning of the trial. Participants did, however, give positive feedback about the trial, suggesting the need for greater support and contact from services after presentations for self-harm.

Another study funded by ACC since 2004 is a large randomised controlled trial to investigate the effectiveness of problem-solving therapy (PST) in reducing psychological distress and repetition of deliberate self-harm. People randomised to receive PST were offered a course of six to eight one-hour face-to-face sessions of PST with a research therapist. The trial has found that PST is an effective intervention following self-harm, resulting in reductions in feelings of hopelessness, suicidal thinking, depression, anxiety and the number of repeated episodes of self-harm in the three months following a suicide attempt or episode of self-harm. Longer-term benefits will continue to be investigated.

The Ministry of Health funded a further component of this study, which involved looking at the feasibility of providing training in PST principles to people who work with clients at risk of self-harm. Training, in the form of a one-day workshop and a three-month period of supervision, was piloted with 88 participants in four DHB areas (Waitemata, Counties Manukau, Northland and Capital and Coast DHBs). After the workshop, participants' ratings of their understanding of PST, and their perceptions of the usefulness of PST, improved. There was an increase in participants who believed that PST could be effective with clients who have a history of self-harm (from 82 to 89 percent) and an increase in participants who felt confident working with suicidal clients (from 67 to 80 percent). Forty-two percent of participants used the full PST process with one or more clients, and a further 17 percent used aspects of PST with clients, in the three months following their workshop. In addition, 22 percent reported using PST within their personal lives.

Improving the management of suicide attempt in institutional settings

Many of the programmes based in institutional settings that aim to reduce risk of suicide by improving the care of people with mental disorders are also relevant to situations where a person has made a suicide attempt and is at risk of making a further attempt. These programmes were discussed under Goal 2. For example, the Towards Wellbeing programme for those under the care of CYF (see page 30), and precautions taken for prisoners (page 31) and those in police custody (page 31). In educational settings, the traumatic incident management service (page 43) and suicide prevention guidelines for schools (page 28) are relevant. Also see page 32 for information about the reporting of suicide attempts in mental health inpatient services.

Goal 4: Reduce access to the means of suicide

Why is this important? Evidence shows that restricting access to a specific method of suicide frequently results in reduced rates of mortality and morbidity by that method.

What are we aiming to do? The purpose of this goal is to reduce access to, and the lethality of, the means of suicide, in order to reduce rates of suicide and suicide attempt. 'Means of suicide' are objects, substances or locations that are used by a person attempting suicide.

Key areas for action: There is potential for intervention with each of the five most common methods of suicide:

- hanging
- carbon monoxide poisoning by vehicle exhaust gas
- firearms
- self-poisoning
- jumping.

Progress on initiatives to reduce access to each of these means is described below.

Hanging

To reduce the risk of suicide by hanging, the Action Plan states that a review will be undertaken of institutional policies for preventing and responding to suicide attempts by hanging to ensure they meet international evidence-based best-practice guidelines. Reviews of suicide risk assessment and management have commenced in a number of key settings (eg, the Department of Corrections and Child Youth and Family). These reviews are expected to consider the safety of the physical environment, including measures to prevent suicide by hanging.

Vehicle exhaust gas

Actions to reduce the risk of suicide by poisoning using vehicle exhaust gas focus on reducing the amount of carbon monoxide in vehicle emissions. The Government revised the vehicle emissions rule in 2007 to reduce levels of harmful emissions produced from motor vehicles entering the New Zealand fleet. The Land Transport Rule: Vehicle Exhaust Emissions 2007 requires that a vehicle being certified for entry into service in New Zealand for the first time must have been manufactured in accordance with an approved emission standard. Up until then, imported used vehicles manufactured before 1 January 2004 did not have to comply with a minimum emissions standard: vehicles only had to have been manufactured to a recognised emissions standard applicable to the year of manufacture. The revised vehicle emissions rule is intended to clearly establish minimum standards for used vehicles. It also introduces a

testing regime to ensure that emissions from used vehicle imports have remained within stated limits.

The New Zealand Transport Strategy 2008 (Ministry of Transport 2008) includes an action to develop an action plan that co-ordinates initiatives required to address vehicle fleet objectives, including carbon monoxide emissions from vehicles. Due to the change in Government since the publication of the Transport Strategy, the Ministry of Transport is currently awaiting confirmation of government support for proceeding with the development of a vehicle fleet action plan. It is anticipated that if such a plan goes ahead the development will be led by the Vehicle Forum, which comprises the Ministry of Transport and the New Zealand Transport Agency. The Vehicle Forum is likely to use the National Road Safety Management Group, of which the Ministry of Health is a member, to disseminate information about the action plan to other interested agencies.

There is potential for a vehicle fleet action plan to consider ways to remove older vehicles from the fleet and incorporate safety devices on new vehicles.

Firearms

The Police commenced a publicity campaign in October 2008 promoting awareness of the personal responsibilities of gun ownership, including secure firearm and ammunition storage among licensed gun users. The campaign includes advertisements in outdoor, gun and hunting magazines, newspapers, and postcards that are actively distributed by the Mountain Safety Council.

A legislative measure to further reduce the risk of suicide by firearms is the Arms Amendment Bill (No. 3). The Bill will require all those who apply to hold a firearm to ensure that all arms are stored in safe, secure facilities where nobody apart from the licence holder can access them. The Bill is currently before the Law and Order Select Committee.

Self-poisoning

Actions to reduce the risk of suicide by self-poisoning focus on particular drugs that account for many suicides. For example, tricyclic antidepressants are used in 30 percent of suicide deaths by self-poisoning. The guideline *Identification of Common Mental Disorders and Management of Depression in Primary Care* directs primary care practitioners to prescribe the relatively safer antidepressants, selective serotonin reuptake inhibitors (SSRIs), as a first-line treatment of depression in adults, unless there are specific reasons for choosing another type of antidepressant (New Zealand Guidelines Group 2008).

The Action Plan also includes an action to review the feasibility of tightening regulations to reduce the risks posed by paracetamol. Although paracetamol is rarely involved in deaths, up to 25 percent of all hospital admissions for self-poisoning each year involve opioid analgesics such as paracetamol. Work on this action is expected to commence in 2009/10.

Jumping

As part of the New Zealand Suicide Prevention Research Fund, the Ministry of Health is funding an analysis of suicide methods and sites where suicides take place (ie, jump sites). The purpose of this research is to gain a more detailed knowledge of trends in New Zealand that can be used to develop strategies to reduce access to the means of suicide (including placing barriers at jump sites). Although this research covers a range of means of suicide, it is likely to produce useful information about the location of frequently used jump sites. The research began in September 2008 and it is anticipated it will be completed by December 2009.

Overarching actions

The Action Plan contains two further actions under Goal 4 that are relevant to the actions relating to particular means of suicide. The first is to scope the feasibility of a suicide mortality review committee, which would, among other things, monitor trends in suicide methods. The second overarching action is to educate families/whānau caring for suicidal people about the need to observe them closely and remove potential means of suicide.

Surveillance of methods of suicide

The Ministry of Health has begun considering the feasibility of establishing a mortality review committee to focus on suicide prevention. This action is also relevant to Goal 7 of the Action Plan: to expand the evidence about rates, causes and effective interventions. The Action Plan proposed that such a committee meet regularly to review a range of issues, including monitoring trends in methods used and identifying emerging methods or sites. It proposed that the committee could have the following objectives:

- encourage collaboration and sharing of data and information across key stakeholders or agencies
- improve data quality to get a more comprehensive picture of the circumstances surrounding a death
- inform decision-makers and programme planners about the magnitude, trends and characteristics of deaths so that appropriate prevention efforts can be put into place
- evaluate national and regionally based prevention programmes and strategies.

The Ministry of Health made substantial progress in 2008 in assessing the feasibility of establishing a suicide mortality review committee. The findings of this report are being considered in the coming year, alongside other developments in mortality review committees.

A proportion of suicide deaths continue to be monitored by the Child and Youth Mortality Review Committee (CYMRC). The CYMRC reviews deaths of children and young people aged 28 days to 24 years and aims to identify ways to prevent such deaths in the future. The CYMRC produces an annual report to the Minister of Health outlining data and making recommendations for actions that will reduce child and youth deaths in New Zealand. Suicide is one of the leading causes of mortality for young people.

Funding was made available in July 2008 to encourage DHBs to establish local child and youth mortality review groups to participate in the national CYMRC process. There are currently 13 fully functioning local child and youth mortality review groups established in DHBs. A further six DHBs are establishing local groups, with the remaining DHBs expected to establish local groups (or cross-DHB groups) in 2009. The local groups carry out reviews of deaths at a local level, with the involvement of appropriate members from DHBs and other government organisations (eg, the Police and CYF). They also identify interventions that have the potential to prevent future deaths and initiate changes to systems, procedures and practice.

Guidance for families/whānau

The new guideline *Identification of Common Mental Disorders and Management of Depression in Primary Care* (New Zealand Guidelines Group 2008) directs practitioners to provide advice to families and caregivers of individuals with serious suicidal intent. It is recommended that families be advised of the need for close observation, and to remove potential suicide means, such as obvious ligature points,⁵ firearms and toxic substances (including unnecessary medications) from the household. (See page 22 for more information about the guideline.)

Goal 5: Promote the safe reporting and portrayal of suicidal behaviour by the media

Why is this important? There is a large body of international evidence showing that some types of reporting and portrayal of suicide in the media can increase the risk of further 'copycat' suicides (Pirkis and Blood 2001). This evidence suggests that media depictions may influence suicidal behaviour by leading to imitative or copycat suicide attempts using that method, through the facilitation of contagious behaviour and suicide clusters, and through the encouragement of the public perception that suicide is a reasonable, understandable and common approach to solving life difficulties.

What are we aiming to do? The focus of Goal 5 is to promote good practice among the media in reporting and portraying suicidal behaviour, and therefore to minimise the potential for copycat suicide. It applies to a range of types of media, including print, television, film, radio, drama and the Internet, and to both fictional and non-fictional genres.

Key areas for action: The key areas for action are:

- promoting collaboration among the media, the research community, policy-makers and other key stakeholders

⁵ A ligature point is a structure from which a ligature (eg, a rope) can be suspended to be used as a means of suicide by hanging.

- developing, implementing and evaluating guidelines or protocols for the reporting and portrayal of suicide in the media
- providing education and support for the media and those working with the media
- monitoring international developments to mitigate the potential harmful effects of Internet sites that encourage suicide.

Progress on each of these areas is described below.

Collaboration

A positive development in this area was the seminar series hosted by Suicide Prevention Information New Zealand (SPINZ) for World Suicide Prevention Day in September 2008. The theme of the seminars was the role of the media in suicide prevention. At each seminar in Auckland, Wellington and Nelson a presentation was delivered by Associate Professor Jane Pirkis of the University of Melbourne. Associate Professor Pirkis is chair of the International Association for Suicide Prevention's Media Taskforce and leader of the Media Monitoring Project, which evaluated the quality, extent and nature of media reporting on suicide in Australia. Associate Professor Pirkis presented evidence for the link between high-profile reports of suicide and increases in suicide. Each seminar also featured presentations from key media stakeholders, local initiatives and the Ministry of Health, followed by a panel discussion.

The seminars provided a positive opportunity for engagement between the media, the Ministry of Health and other key stakeholders that will contribute to ongoing collaboration in the future to reduce the risks associated with reporting and portraying suicide.

Guideline/protocol development, implementation and evaluation

The Ministry of Health has initiated discussions with key media and other stakeholders, with the aim of working with media organisations in 2009 to update *Suicide and the Media: The reporting and portrayal of suicide in the media: A resource* (Ministry of Health 1999). This is a resource for media professionals that promotes the safe reporting and portrayal of suicide by the media. The resource also provides information for people who may be asked by the media to comment on suicide.

Education and support

The best way to provide information and support to the media and those working with the media will be considered and discussed with the media as part of the process of updating the *Suicide and the Media* resource described above. Consideration will also be given to the inclusion of evidence and issues about media reporting of suicide in journalism training programmes, and how best to provide guidance for the fictional portrayal of suicidal behaviour in films, television and drama. There are some existing mechanisms for media to seek information and support, such as through Suicide Prevention Information New Zealand.

The Ministry of Health also provides information to coroners on suicide and media issues when required. In 2008 the Ministry contributed information on suicide and suicide prevention, including issues relating to media reporting and portrayal, to a new resource for coroners.

Internet

The internet is another medium through which suicide-related material may increase the risk of suicide for vulnerable people. Websites exist that encourage, promote, facilitate or discuss the pros and cons of suicide. Some provide detailed information or instructions on suicide methods. The Ministry of Health has met with cybersafety organisation NetSafe following a NetSafe conference in July 2008 where this issue was discussed. The Ministry is currently investigating options for reducing the risk of this material and continues to monitor international developments in this area.

Goal 6: Support families/whānau, friends and others affected by a suicide or suicide attempt

Why is this important? Every suicide can have an enormous impact on other people. In a small country like New Zealand, the suicide of just one person can have a long-lasting and profound effect on their family/whānau, friends and the wider community. Friends and family bereaved by suicide are more at risk of suicide themselves.

What are we aiming to do? The purpose of Goal 6 is to develop policies, strategies, resources and services to support families, whānau, friends and significant others after a suicide or suicide attempt, and minimise the risks of contagious suicidal behaviour and the development of suicide clusters.

Key areas for action: The key areas are:

- services for those bereaved by suicide, those affected by suicide attempt, and community organisations needing to respond to emerging or occurring clusters (including the Postvention Support Service and the Traumatic Incidents Response Service in schools)
- resources for those bereaved by suicide, those affected by suicide attempt, those working with the bereaved and affected, and key institutions.

Progress on each of these areas is described below.

Services for those bereaved by suicide, those affected by suicide attempt, and community organisations needing to respond to emerging or occurring clusters

The Postvention Support Service

The Ministry of Health funds a Postvention Support Service to support activities and programmes that are intended to assist those who have been bereaved or otherwise affected by suicidal behaviour in order to prevent further suicides. The Ministry of Health has contracts with Victim Support and Clinical Advisory Services Aotearoa (CASA) to provide the service. This Postvention Support Service was initially launched in July 2007, but after the first-year evaluation the service was reconfigured and a new model was trialled from July 2008. It now consists of three parts:

- the Initial Response Service
- the Specialist Counselling Service
- the Community Postvention Response Service.

The Initial Response Service and the Specialist Counselling Service are currently available in Canterbury, Nelson Marlborough, Hawke's Bay, Tairāwhiti, Counties Manukau, Waitemata, and Auckland DHB areas. The Community Postvention Response Service is available nationally. This service is developing an increasingly strong focus on addressing the needs of Māori, which includes providing outreach to Māori communities.

Initial Response Service

Victim Support provides postvention suicide bereavement support to families, whānau and significant others bereaved by suicide in seven DHB areas. This service involves trained Victim Support workers providing practical and emotional support through a 24-hour, seven-day-a-week crisis response. It also includes some ongoing support using a case management model such as:

- immediate practical assistance
- self-care advice
- information about loss and grief
- information about police and legal requirements
- referral and linkage with specialist counselling services and other appropriate agencies.

Specialist Counselling Service

CASA is currently rolling out a Specialist Counselling Service that will provide culturally appropriate counselling services free of charge for people affected by suicide. CASA is contracted to cover the costs of at least 55 general population and 24 Māori population counselling cases per year. The specialist counselling service is being delivered in the same seven DHB areas as the Initial Response Service.

Community Postvention Response Service

Where there is a cluster of suicides occurring or where there are strong indications that a cluster may form, CASA's Community Postvention Response Service provides a national consultation and advice service. This may include, for example, providing information, ensuring a co-ordinated approach, providing training, and assisting with longer-term suicide prevention planning.

Traumatic incident management in schools

The Ministry of Education provides a service to assist schools that experience traumatic events, including suicides of students or staff. This service includes assisting schools to develop a traumatic incident response plan and team, and providing assistance and support to schools following a traumatic incident.

The Ministry of Education has reviewed this service and has devised a number of key areas for development, including the following.

- A telephone service enables schools to request support from Ministry of Education staff.
- An evidence-informed Ministry of Education manual to support the service is available to all special education staff online. Training on the new manual for Ministry of Education special education traumatic incident co-ordinators and district managers occurred in October 2008. Traumatic incident co-ordinators and district managers now provide yearly regional information and training to Ministry of Education staff across the country. This includes a service for Māori-language settings to ensure culturally appropriate responses and contexts are supported.
- An evidence-informed manual with resources to support psychosocial recovery in schools and early childhood education services will be published in May 2009. This manual supports educational facilities to plan prior to traumatic incidents and to deliver evidence-based psychosocial support to teachers and students affected after a traumatic incident. It is currently being negotiated across the education and wider sector. Training in the use of this manual will be trialled in 2009 before it is released more widely. Traumatic incident co-ordinators will be trained to provide pre-planning support to schools when the manual is released in November 2009.
- A communications strategy for the education sector about the traumatic incident service will be developed in November 2009 when all the above developments are concluded.

Suicide Postvention Checklist

The Ministry of Youth Development (MYD) has developed a Suicide Postvention Checklist that will be included in the updated version of the Ministry's tool kit for its service providers and regional teams. The checklist is a general guide on what processes need to occur following the suicide of a young person on a programme funded by MYD, such as the Youth Service Corps. The checklist is designed to be an easy-to-follow step-by-step guide identifying what procedural processes the programme's managers and staff need to follow to fulfil their obligations to MYD, the client's family, staff and other programme participants.

Resources for those bereaved by suicide, those affected by suicide attempt, those working with the bereaved and affected, and key institutions

Suicide support groups

There are a number of peer support groups for those bereaved and affected by suicide across New Zealand. For some people bereaved by suicide, talking to other people who have been through a similar experience can be an important component of making sense of what has happened, understanding their own grief journey and living with the loss.

Clinical Advisory Services Aotearoa (CASA) have been contracted by the Ministry of Health to provide guidance to peer-led support groups in the form of supervision, advice and support, as needed and requested. This support may include supervision to group facilitators and provision of existing evidence-based information and resources. This is part of the Postvention Support Service, which has a focus on ensuring this service is culturally appropriate to Māori and will meet their needs. Guidance will be extended to any established support groups in the following seven DHB regions: Canterbury, Nelson Marlborough, Hawke's Bay, Tairāwhiti, Counties Manukau, Waitemata and Auckland.

This work being undertaken by CASA could form a preliminary step towards developing New Zealand-based best practice guidelines for establishing support groups if this seems necessary once the service has been widely implemented.

Goal 7: Expand the evidence about rates, causes and effective interventions

Why is this important? The availability of good-quality information and research is fundamental to understand the extent and nature of suicidal behaviours and to inform how best to prevent them. Likewise, evaluation is vital to determine whether prevention efforts are effective and what is needed to improve them.

What are we aiming to do? Goal 7 focuses on improving the timeliness and consistency of suicide mortality data; expanding current knowledge about the nature, causes and consequences of suicidal behaviours; and conducting research that addresses the unique features of suicidal behaviour in New Zealand and, in particular, for specific population groups. A key focus of this is the rigorous evaluation of programmes and policies in order to determine that prevention interventions are making a positive difference. A further aspect of this goal is ensuring effective, accurate and safe dissemination of statistical information and research evidence to all those involved in suicide prevention.

Key areas for action: Key areas are:

- improving the quality and timeliness of suicide data

- expanding current knowledge about the rates of suicidal behaviour, contributing factors and effective interventions
- improving the dissemination of research and information about suicide prevention.

Progress on each of these areas is described below.

Improving the quality and timeliness of suicide data

Information about the number of suicides in any given year can take some time to become available because of the necessary process of a coroner's investigation to officially classify a death as suicide. However, recent developments have led to the minimisation of unnecessary delays in the coronial process. A number of changes were introduced with the passage of the Coroners Act 2006, and these came into effect on 1 July 2007. The changes include the establishment of a new Office of the Chief Coroner, a new Coronial Services Unit and the appointment of 15 full-time coroners, including one full-time relief coroner. Prior to these changes there were 55 coroners working on a part-time basis around New Zealand.

The establishment of full-time coroners has led to faster reporting of suicides, thereby improving the availability of more up-to-date information about suicide trends. On average it is now taking only 147 days from the moment the coroner assumes jurisdiction over a death reported to a coroner to the time a finding is issued. Timely information can be used to better monitor the impact of the Action Plan.

Another change that took effect from 1 July 2007 was the establishment of a new coronial information system. The new coronial database has a classification system to assist with the collection of consistent data and to identify the circumstances surrounding the death and whether it was self-inflicted or not. The database is designed to help researchers and health professionals to describe, measure and monitor the occurrence of injuries, and to investigate the circumstances of occurrence using an internationally agreed classification based on the World Health Organization's injury and disease classifications.

Further to this, the Chief Coroner is required by law to set up and maintain a register of coroners' summary recommendations, which is available for public inspection on the Coronial Services website. This monitors not only the recommendations made by coroners but also the actions implemented in response to them by external agencies. The Ministry of Health is also scoping the feasibility of establishing a suicide mortality review committee (see page 38).

In a separate initiative, the Police are monitoring call-outs to suicide attempts across the country. Recent statistical data indicates an apparent increase in the number of Police call-outs to suicide attempts. The Police are working in collaboration with the Ministry of Health to determine whether the number of suicide attempts is actually increasing, or if the increase is due to other factors, such as changes to the criteria for classifying calls to Police as instances of attempted suicide, or changing public expectations about the role of the Police and the type of services they are expected to provide. It is anticipated that work on this project will be complete by the end of 2009.

Expanding the research base

The Suicide Prevention Research Fund

The Suicide Prevention Research Fund was set up to address the gaps in national research related to suicide. The fund of \$1.5 million over two years is being managed by Te Pou: National Centre of Mental Health Research, Information and Workforce Development, on behalf of the Ministry of Health. In June 2008 funding from the Suicide Prevention Research Fund was confirmed for the following research.

- A content analysis of media reports of suicide to determine the extent and nature of reporting and its alignment with the Ministry of Health's media resource: the study will cover reports in New Zealand print, broadcasting and online media.
- An analysis of suicide methods and sites at which suicides take place (eg, jump sites) to gain a more detailed knowledge of trends in New Zealand: this information will be used in developing strategies to reduce access to the means of suicide.
- A pilot study into the effectiveness of dialectical behaviour therapy (DBT) for suicidal adolescents: DBT involves individual therapy, group skills training and after-hours telephone consultation with a therapist between sessions. It has been shown to be effective in reducing suicidal behaviour and self-harm in adults and has been modified for use with adolescents. The study has the potential to contribute significantly to an understanding of effective treatments for suicidal adolescents in New Zealand.
- A study into the role of dynamic family factors in the development and management of suicidal risk in young people: information collected during individual and family interviews will be used to examine what characteristics, dynamics and strategies assist those families who cope well with the threat of loss by suicide and demonstrate high resilience, from those who struggle.
- An interview study of the impact of the media on suicidal behaviour and ideation for young people, and the media sources of information from which they gain their first awareness of suicide or self-harm: this includes an investigation of suicide-related Internet sites.
- An investigation of trends in the clusters of suicides and hospital-admitted suicide attempts in New Zealand using geospatial statistical techniques: it is anticipated that the study will provide an evidence base for developing responses to suicide clusters as part of national and regional programmes of suicide prevention.

More recently, funding from the Suicide Prevention Research Fund has been allocated to a report on the prevalence of mental illness and suicidal thoughts and behaviours for students who participated in the Youth'07 study. The study randomly sampled nearly 10,000 secondary school students to find out about their health and wellbeing (Adolescent Health Research Group 2008). This additional report will look more closely at the data collected regarding suicidal behaviour and mental wellbeing and illness. In a separate report currently being completed, the Youth'07 researchers are analysing information on the mental health (including suicidality) of same- and both-sex-attracted young people.

The Suicide Prevention Research Fund is also being used to fund the review and updating of suicide prevention guidelines for schools (see page 28 for more information).

Evaluation of e-therapy interventions

Two research projects funded through the Ministry of Health's Primary Mental Health Initiative and currently under way are trials of e-therapy interventions for people with experience of mental illness. These projects are also relevant to Goal 2 of the Action Plan.

The first is the trial of a computer-administered cognitive behavioural programme (e-therapy) for the treatment of adolescent depression. An earlier version of the programme has previously been piloted, with very promising results. The new e-therapy services will be trialled in primary care and school-based settings. Those PHOs that have demonstrated a particular interest in working with young people are participating in the trial, but if successful the programme will be made more widely available after September 2010 to primary care practitioners, schools and through the Ministry's youth website on depression, *The Lowdown* (see page 18).

The second e-therapy trial under way is the Recovery via Internet from Depression (RID) trial, which is running from 2006 to 2010. The major funders of the trial are ACC and the Health Research Council. The Ministry of Health has recently become the third co-funder. The study is being conducted using the Australian computer-based cognitive behaviour therapy programme *Moodgym* in a number of settings in New Zealand.

The purpose of the trial is to test whether web-based self-help programmes for depression that have been successfully used in Australia and Norway will also help people in New Zealand. The web-based programmes provide information and the opportunity for people to work through a number of exercises on the Internet. These exercises are designed to help people manage their depression and related problems. People who enrol for the trial will be assigned by chance to one of three online programmes and will complete exercises at their own pace over four weeks. They will then be followed up via online questionnaires at six-monthly intervals for two years to measure the impact on their mental health. To support this trial, ACC account managers have been given information about how to help people experiencing depression, including how people can take part in the trial.

The Health Research Council

The Action Plan includes the action to continue to fund suicide research through the Health Research Council of New Zealand (HRC). The HRC is responsible for managing the Government's investment in health research. In July 2008 the HRC released its Strategic Plan for 2008–2013. One of the actions signalled in this Plan was a review and potential revision of the annual contestable funding round.

The HRC has recently consulted on a proposal for a new model of investment, and will finalise this new model in 2009, with a view to implementing it in 2010. The proposed model has several broad priority areas for investment, in addition to the introduction of investment signals that will be revised on a more regular basis. Identifying priorities and investment signals will involve significant and ongoing interaction with the Ministry of Health and the Ministry of Research Science and Technology to ensure alignment with government priorities.

The HRC is currently funding the following research projects that contribute to suicide prevention:

- five projects exploring indigenous mental health issues:
 - factors that promote resilience
 - cognitive behaviour therapy with Māori
 - whānau participation in mental health service delivery
 - development of a framework to assess clinical and cultural competency in mental health practice
 - the significance of culture in understanding mental health
- two projects exploring mental health treatment in primary care settings
- a mobile phone-based depression prevention programme for young people
- a project exploring ways of gaining consumer and family/whānau perspectives to improve mental health services
- a project exploring the biological mechanisms of antidepressants
- continued funding for two well-established and internationally recognised mental health research studies, including the Canterbury Suicide Project.

Improving the dissemination of research and information

Suicide Prevention Information New Zealand (SPINZ)

SPINZ supports best-practice suicide prevention through the provision of evidence-based information. Its role is to provide high-quality information about suicide prevention to assist communities, professionals and key agencies to reduce the incidence of suicide. SPINZ is part of the Mental Health Foundation of New Zealand and is contracted by the Ministry of Health.

SPINZ has been developing new ways to make information about suicide prevention available to a diverse audience. This has meant using new technology to reach more people and providing tailored information to specific audiences. For example, SPINZ recently launched its redeveloped website (www.spinz.co.nz). The content is now organised by audience so that people can immediately find the information relevant to them. In addition, SPINZ released the first issue of its new newsletter in January 2009. The newsletter will be published three times a year and will feature updates on suicide prevention initiatives and news from SPINZ.

Suicide Facts

The Ministry of Health produces annual suicide statistics in *Suicide Facts*, available on the Ministry's website (www.moh.govt.nz/suicideprevention). This annual publication is a key document that monitors trends in suicidal behaviour and informs suicide prevention work. The latest *Suicide Facts* was published in December 2008 and used data from 524 suicide deaths and 2868 intentional self-harm hospitalisations in 2006 (Ministry of Health 2008e). The publication informed the section on 'Statistics and trends' in this report.

Part Two: Tables Summarising Progress

Progress on individual actions in the Action Plan is summarised in the tables below.

Work has not begun on all actions of the Action Plan. The Action Plan sets out time frames for the completion of actions in Phase 1 (years one to three, 2008 to 2010) and Phase 2 (years three to five, 2010 to 2012). Each milestone or measure for each action is given a rating (see the symbols below), and a brief note is made about progress and implementation using whānau ora pathways.

It is crucial that all suicide prevention activities under this Action Plan address the status of Māori as tangata whenua, and the fact that Māori are over-represented in suicide statistics. It is also important to support Māori-centred initiatives, based on the concept of whānau ora: Māori families supported to achieve maximum health and wellbeing. *He Korowai Oranga: Māori Health Strategy* (Minister of Health and Associate Minister of Health 2002) sets out four pathways to achieve whānau ora:

1. development of whānau, hapū, iwi and Māori communities
2. Māori participation in the health and disability sector
3. effective health and disability services
4. working across sectors.

The Action Plan indicated how actions should be implemented to follow these whānau ora pathways and contribute to reducing the rates of suicide for Māori, as well as for the general population. The 'Whānau ora pathways' column of the action tables highlighted the pathways that are most relevant for specific actions. All four pathways to whānau ora, however, should be considered when implementing each action. In the summary below, the 'Whānau ora pathways' column contains information about how implementation of the actions has followed the four pathways listed above to achieve whānau ora.

Symbols

The following symbols are used throughout the tables to indicate progress on each milestone or measure for each action. The symbols are also displayed at the bottom of each table for convenience.

✓	Complete
	Under way
	Work is ongoing
	On hold
±	Mixed results/progress
	Not yet begun / planned for a later time

Goal 1: Promote mental health and wellbeing, and prevent mental health problems

Key action area: Promote mental health and wellbeing, and prevent mental health problems

Actions	Milestones/ measures	Timeframes	Rating	Note	Whānau ora pathways
1.1 Strengthen mechanisms for inter-agency collaboration and co-operation to ensure that issues relating to suicide are recognised and incorporated into both policies and programmes, and their evaluation.	A suicide prevention inter-agency steering group is established.	Phase 1 and ongoing	🔄	The Inter-Agency Committee for Suicide Prevention (made up of 13 government agencies) monitors progress implementing the Action Plan (see page 3).	Te Puni Kōkiri (the Ministry of Māori Development) is represented on the Inter Agency Committee for Suicide Prevention.
1.2 Develop structures to ensure that all policies and programmes are appropriate and effective for Māori.	Māori are represented in key implementation and governance structures for the Action Plan.	Phase 1 and ongoing	🔄	For example, the Ministry of Health has produced a series of whānau ora tools (see page 26).	Tools and structures are developed in consultation with Māori.
1.3 Include a focus on reducing inequalities in policies and programmes that may contribute to suicide prevention.	Reducing inequalities is taken into consideration in key implementation and governance structures for the Action Plan.	Phase 1 and ongoing	🔄	All agencies on the Inter Agency Committee for Suicide Prevention aim to ensure policies and programmes address high need.	Reducing inequalities includes a focus on Māori, who are more likely to have a mental disorder and are more likely to die by suicide.

Key:

✓ Complete

👉 On hold

🔄 Under way

± Mixed results/progress

🕒 Work is ongoing

🕒 Not yet begun / planned for a later time

Goal 2: Improve the care of people who are experiencing mental disorders associated with suicidal behaviour

Key action area: Population-based strategies

Actions	Milestones/ measures	Timeframes	Rating	Note	Whānau ora pathways
2.1 Implement population-based strategies, including mental health and depression awareness, mental illness destigmatisation and telephone counselling.	Continue to implement the <i>Like Minds, Like Mine National Plan 2007–2013</i> .	Phases 1 and 2		Ongoing. See page 16 for further information.	Like Minds, Like Mine is supported by a Māori caucus. The programme has proven to be effective for Māori, who have made the most significant improvements in attitudes toward mental illness over the life of the programme.
	Continue to implement and evaluate the National Depression Initiative	Phases 1 and 2		Ongoing. See page 18 for more information.	
2.2 Evaluate the effectiveness of these programmes in leading to improved mental health outcomes and associated reductions in suicidal behaviours. This action includes evaluating effectiveness for Māori specifically.	Review current provision of telephone helpline services.	Phase 1		This project is planned for 2009/10.	This action includes evaluating effectiveness for Māori specifically.
	Investigate options to facilitate consistent quality assurance processes, including evaluation, for telephone helpline services.	Phase 1			

Key:

✓ Complete

 On hold

 Under way

± Mixed results/progress

 Work is ongoing

 Not yet begun / planned for a later time

Key action area: Community-based approaches

Actions	Milestones/ measures	Timeframes	Rating	Note	Whānau ora pathways
2.3 Review current guidelines, programmes and initiatives for community, institutional and organisational workers.	Continue to implement guidelines, programmes, and initiatives for key workers.	Phases 1 and 2		Guidelines, programmes and initiatives are reviewed on an ongoing basis.	Guidelines are reviewed for cultural appropriateness and effectiveness for Māori. See the section on Kia Piki te Ora and Te Whakauruora on pages 13 and 20 respectively.
	Undertake a review of relevant guidelines, programmes and initiatives, including assessing alignment with the evidence and cultural appropriateness.	Phase 1			
2.4 Where necessary, develop, implement and evaluate new programmes, initiatives or best-practice guidelines. This action includes evaluating whether programmes, initiatives or guidelines are culturally appropriate and effective for whānau, hapū, iwi and Māori communities.	Where necessary, implement changes and/or implement new programmes or initiatives.	Phases 1 and 2		The Mental Health Literacy programme is in development (see page 19) and will be externally evaluated.	This action includes evaluating whether programmes, initiatives or guidelines are culturally appropriate and effective for whānau, hapū, iwi and Māori communities.
	Evaluate the effectiveness of the programmes and initiatives.	Phases 1 and 2			

Key:

✓ Complete
 On hold

 Under way
 Mixed results/progress

 Work is ongoing
 Not yet begun / planned for a later time

Key action area: Health services approaches

Actions	Milestones/ measures	Timeframes	Rating	Note	Whānau ora pathways
2.5 Continue to develop more and better mental health and addiction services, as described in the New Zealand mental health and addiction plan for 2005–2015, <i>Te Tāhuhu</i> (Minister of Health 2005) and its action plan, <i>Te Kōkiri</i> (Minister of Health 2006).	Implement a range of service improvement initiatives as part of <i>Te Kōkiri</i> (2006–2015).	Phases 1 and 2		Work in many actions in <i>Te Kōkiri</i> is progressing (see page 20).	A leading challenge in <i>Te Kōkiri</i> and <i>Te Tāhuhu</i> is to broaden the range, quality and choice of mental health and addiction services for Māori.
2.6 Develop, implement and evaluate a best-practice guideline for primary care providers in the assessment, management and treatment of depression, other common mental disorders and suicidal behaviours. This guideline must include best-practice information for providers working with Māori tangata whaiora.	Develop and implement the guideline. Evaluate the effectiveness of the guideline.	Phase 1 Phases 1 and 2	 	This guideline was published in July 2008 and the Ministry of Health is currently progressing with implementation. See page 22 for more information.	The guideline considers special issues for service delivery for Māori and notes the importance of Māori involvement when implementing these guidelines at a community level.
2.7 Develop, implement and evaluate demonstration projects aimed at providing integrated models of care. These projects will include a focus on increasing access to health services and supporting the better management of depression, common mental disorders and suicidal behaviours.	Develop and implement proposed model(s) of care. Evaluate the effectiveness of model(s). Develop a plan for national roll-out of the model(s) found to be effective.	Phase 1 Phases 1 and 2 Phase 2	  	A major randomised controlled trial is under way. See page 23 for more information.	Māori service providers will be included in the integrated models of care. Particular focus will be given to supporting the management of depression, common mental disorders and suicidal behaviours for Māori.
2.8 Develop, implement and evaluate interventions to reduce risks of suicide and suicidal behaviours among those experiencing mental disorders just prior to and following discharge from mental health inpatient services.	Develop and implement a trial of promising interventions. Evaluate the effectiveness of the interventions. Develop a plan for national roll-out of any interventions that are effective.	Phase 1 Phases 1 and 2 Phase 2	  	Scoping work is scheduled to begin in 2009/10. Also see information about relapse prevention plans on page 22.	Consideration of Māori issues will occur.

Actions	Milestones/ measures	Timeframes	Rating	Note	Whānau ora pathways
2.9 Develop a process to begin to evaluate the effectiveness of general population health services provided to Māori experiencing mental health and addiction disorders most commonly associated with suicidal behaviours.	Evaluate the effectiveness of general population health services delivered to Māori at high risk of suicidal behaviour. Following the results of the evaluation, if necessary, re-orient services to be more effective for Māori.	Phases 1 and 2 Phase 2	± ⌚	No evaluation is under way, but see page 25 for information about the review of DHB service specifications for kaupapa Māori mental health services.	Consideration of Māori issues will occur.
2.10 Develop a process to begin to evaluate the effectiveness of Māori-specific health services provided to Māori tangata whaiora experiencing mental health and addiction disorders most commonly associated with suicidal behaviours.	Evaluate the effectiveness of Māori-specific health services delivered to Māori at high risk of suicidal behaviour. Following the results of the evaluation, if necessary, re-orient services to be more effective for Māori.	Phases 1 and 2 Phase 2	± ⌚	No evaluation is under way, but see page 25 for information about the review of DHB service specifications for kaupapa Māori mental health services.	Consideration of Māori issues will occur.
2.11 Monitor new and/or emerging Māori models of health and, as necessary, evaluate whether the implementation of these models is effective.	Develop a system for monitoring new and emerging Māori models. Evaluate the effectiveness of models that are put into practice. If necessary, implement effective models nationally.	Phase 1 Phases 1 and 2 Phase 2	± ⌚ ⌚	Work has not begun on an evaluation or monitoring system. A range of models are being investigated through various means (see page 26).	Consideration of Māori issues will occur.
2.12 Disseminate best-practice examples of implementing Māori models of care to Māori health providers.	Disseminate best-practice examples.	Phases 1 and 2	⌚	Work has not begun.	Consideration of Māori issues will occur.

Actions	Milestones/ measures	Timeframes	Rating	Note	Whānau ora pathways
2.13 Develop, implement and evaluate Pacific models of care for those in the Pacific population who are experiencing mental health and addiction disorders commonly associated with suicidal behaviours.	Consult with key stakeholders about the provision of Pacific models of care.	Phase 1	±	Work has not yet begun but some research has been funded on perceptions of Pacific models of mental health service delivery (see page 28).	
	Develop and implement a promising model(s) of care.	Phases 1 and 2	⌚		
	Evaluate the effectiveness of the model(s) of care.	Phases 1 and 2	⌚		
	Develop a plan for further roll-out of the model(s) if effective.	Phase 2	⌚		

Key:

✓ Complete

👉 On hold

👉 Under way

± Mixed results/progress

🔄 Work is ongoing

⌚ Not yet begun / planned for a later time

Key action area: Mental health programmes in institutional settings

Actions	Milestones/ measures	Timeframes	Rating	Note	Whānau ora pathways
2.14 Continue to implement programmes, policies and strategies within institutional settings and, where appropriate, review and evaluate them and address any gaps identified. This action includes evaluating their effectiveness for Māori specifically.	Continue to implement guidelines, programmes and initiatives in key institutional settings.	Phases 1 and 2	🔄	Work is ongoing. A specific review has not yet begun, but reviews of suicide risk assessment and management are under way in various settings (eg, the Department of Corrections and Child Youth and Family).	A review of guidelines, programmes and initiatives will include assessing cultural appropriateness and effectiveness for Māori.
	Undertake a review of relevant guidelines, programmes and initiatives, including assessing alignment with the evidence and cultural appropriateness.	Phase 1	⌚		
	Where necessary, implement changes and/or implement new programmes or initiatives.	Phases 1 and 2	⌚		
	Evaluate the effectiveness of the programmes and initiatives.	Phases 1 and 2	⌚		

Goal 3: Improve the care of people who make non-fatal suicide attempts

Key action area: Improving the acute management of those who make a suicide attempt

Actions	Milestones/ measures	Timeframes	Rating	Note	Whānau ora pathways
3.1 Continue to implement and evaluate the guidelines for the assessment and management of those at risk of suicide in acute settings.	Continue to implement and evaluate this initiative in 10 DHBs.	Phases 1 and 2		Whaka-whanaungatanga: The Self Harm and Suicide Prevention Collaborative, which will be evaluated independently, has completed the recruitment of 14 DHBs for the second phase of implementation (see page 33).	This project aims to increase collaboration between emergency departments, mental health services and Māori health services, and has a specific focus on the needs of the Māori population.
	Extend this initiative to achieve national roll-out.	Phases 1 and 2			
	Continue ongoing evaluation of the initiative, including evaluation of effectiveness for Māori.	Phases 1 and 2			

Key:

✓ Complete

 On hold

 Under way

± Mixed results/progress

 Work is ongoing

 Not yet begun / planned for a later time

Key action area: Improving the longer-term management of those who make a suicide attempt

Actions	Milestones/ measures	Timeframes	Rating	Note	Whānau ora pathways
3.2 Develop, implement and evaluate the effectiveness of services and interventions for the longer-term care for those who have made a suicide attempt.	Review current provision of follow-up and support for those who have made a suicide attempt.	Phase 1		See page 34 for information about the ACCESS trial, the Postcard Study and the Problem Solving Therapy trial.	See the information below (Action 3.3) about the Te Ira Tangata trial.
	Identify and implement opportunities for improving the longer-term care for those who have made a suicide attempt.	Phase 1			
	Evaluate the effectiveness of these services and interventions.	Phases 1 and 2	±		
	Based on the evaluation findings, develop a plan for implementing effective models nationally.	Phase 2	±		

Actions	Milestones/ measures	Timeframes	Rating	Note	Whānau ora pathways
3.3 Develop, implement and evaluate the effectiveness of services and interventions for the longer-term care for Māori who have made a suicide attempt.	Scope current provision of services and interventions in both general population and Māori-specific services for Māori who have made a suicide attempt.	Phase 1		A provider has been identified for the Te Ira Tangata trial, which will have a specific focus on improving the care of Māori who have made a suicide attempt. (See page 34.)	Māori involved in this trial will receive a structured cultural assessment, plus a culturally informed intervention or treatment.
	Based on the scoping findings, develop and implement services and interventions for the longer-term care of Māori who have made a suicide attempt.	Phases 1 and 2		Evaluation of the services, and implementation of recommendations from the evaluation, will be undertaken at a later stage.	
	Evaluate the effectiveness of these services and interventions.	Phases 1 and 2			
	Based on the evaluation findings, develop a plan for implementing effective models nationally.	Phase 2			

Key:

✓ Complete

 On hold

 Under way

± Mixed results/progress

 Work is ongoing

 Not yet begun / planned for a later time

Key action area: Improving the management of suicide attempt in institutional settings

Actions	Milestones/ measures	Timeframes	Rating	Note	Whānau ora pathways
3.4 Review and, if necessary, revise and evaluate initiatives (including policies, procedures, screening and assessment tools, forms and guidelines) for managing the aftermath of a suicide attempt in key institutional settings. This action includes evaluating whether these initiatives are culturally appropriate and effective for Māori specifically.	Undertake a review of relevant guidelines, programmes and initiatives, including assessing alignment with the evidence and cultural appropriateness (this is aligned with Actions 2.3 and 2.14).	Phase 1	±	Reviews of suicide risk assessment and management are under way in various settings (eg, the Department of Corrections and Child Youth and Family).	This action includes evaluating whether these initiatives are culturally appropriate and effective for Māori specifically.
	Where necessary, implement changes to the initiatives to address any of the above matters identified in the assessment.	Phase 1	⌚		
	Evaluate the effectiveness of the initiatives.	Phase 2	⌚		

Key:

✓ Complete

👉 On hold

👉 Under way

± Mixed results/progress

🔄 Work is ongoing

⌚ Not yet begun / planned for a later time

Goal 4: Reduce access to the means of suicide

Key action area: Hanging

Actions	Milestones/ measures	Timeframes	Rating	Note	Whānau ora pathways
4.1 Review and revise institutional policies for preventing and responding to suicide attempts by hanging, to ensure they meet international evidence-based best-practice guidelines.	Undertake a review of institutional policies and procedures.	Phase 1	±	Reviews of suicide risk assessment and management are under way in various settings (eg, the Department of Corrections and Child Youth and Family).	Consideration of Māori issues will occur.
	Provide recommendations to agencies that oversee institutions.	Phase 2	⌚		

Key:

✓ Complete

👉 On hold

👉 Under way

± Mixed results/progress

🔄 Work is ongoing

⌚ Not yet begun / planned for a later time

Key action area: Vehicle exhaust gas

Actions	Milestones/measures	Timeframes	Rating	Note	Whānau ora pathways
4.2 Review the feasibility of incorporating changes into the vehicle fleet to achieve reductions in the rate of suicide attempt by vehicle exhaust gas.	Engage with relevant government agencies dealing with vehicle emission issues.	Phases 1 and 2		These actions are on hold while the Ministry of Transport awaits support for the development of a vehicle fleet action plan, which is likely to address this action. (See page 36 for more information.)	Participation by Māori will occur as deemed appropriate by Māori.
4.3 Consider the extent to which the regulation of vehicle exhaust might be changed by alignment with clean air and related policies.	Engage with relevant government agencies on 'clean air' issues and provide information about suicide prevention issues.	Phases 1 and 2			

Key:

✓ Complete

 On hold

 Under way

± Mixed results/progress

 Work is ongoing

 Not yet begun / planned for a later time

Key action area: Firearms

Actions	Milestones/ measures	Timeframes	Rating	Note	Whānau ora pathways
4.4 Continue to promote awareness of personal responsibilities of gun ownership, including secure storage of guns and ammunition.	Undertake a publicity campaign promoting secure firearm storage.	Phase 1	✓	A publicity campaign is under way. (See page 37 for more information.)	The campaign is using a variety of media to get the message to everyone (magazines, newspapers and distribution of postcards).
4.5 Strengthen monitoring checks of firearms security of licence holders during the 10-year licensing period and at change of address.	Implement a mandatory security inspection at the key points in the firearms licensing process.	Phase 2		The Arms Amendment Bill is currently before the Law and Order Select Committee. (See page 37 for more information.)	
4.6 Encourage health professionals to enquire routinely about guns in homes, and to advocate for their removal from the home where patients are depressed or suicidal.	Include messages about firearms in best practice guidelines for managing depression, common mental health problems and suicidal behaviours.	Phase 1	✓	Included in: <i>Identification of Common Mental Disorders and Management of Depression in Primary Care</i> (see page 22).	The guideline was produced by the New Zealand Guidelines Group (NZGG) with involvement from Māori consumers and health care workers.

Key:

✓ Complete

 On hold

 Under way

± Mixed results/progress

 Work is ongoing

 Not yet begun / planned for a later time

Key action area: Self-poisoning

Actions	Milestones/measures	Timeframes	Rating	Note	Whānau ora pathways
4.7 Review the feasibility of tightening regulations to reduce the risks posed by paracetamol.	Investigate making an application to the Medicines Classification Committee to tighten regulation of paracetamol.	Phase 1		Work will commence in 2009/10.	Consideration of Māori issues will occur.
4.8 Ensure that best practice guidance on the treatment of mental illness includes advice on prescribing less toxic medicines to individuals at risk of suicide.	Include such guidance in all new and updated best practice guidelines.	Phases 1 and 2		Included in: <i>Identification of Common Mental Disorders and Management of Depression in Primary Care</i> (see page 22).	The guideline was produced by the New Zealand Guidelines Group (NZGG), with involvement of Māori consumers and health care workers.
4.9 Continue existing information campaigns and institute new ones to encourage the return of unused medicines.	Develop and implement unused medicine disposal campaigns.	Phase 2		This work is planned for Phase 2.	

Key:

✓ Complete

 On hold

 Under way

± Mixed results/progress

 Work is ongoing

 Not yet begun / planned for a later time

Key action area: Jumping

Actions	Milestones/ measures	Timeframes	Rating	Note	Whānau ora pathways
4.10 Undertake data surveillance to identify jumping sites that are emerging as favoured locations for suicide by jumping.	Collect and analyse data from the coroners' database, and, where necessary, respond to emerging trends.	Phase 1		Research is anticipated to be complete by December 2009. (See page 38 for more information.)	The research will include analyses of suicide methods by ethnicity.
4.11 Scope the need for guidance on managing favoured jump sites.	Scope the need for and, if required, develop information resources for managing jump sites.	Phase 2		This work is planned for Phase 2.	

Key:

✓ Complete

 On hold

 Under way

± Mixed results/progress

 Work is ongoing

 Not yet begun / planned for a later time

Key action area: Overarching actions

Actions	Milestones/ measures	Timeframes	Rating	Note	Whānau ora pathways
4.12 Consider the feasibility of establishing a suicide mortality review committee, with one of its roles being to report regularly on the relationship of method access to suicide and suicide attempt.	Draft feasibility report. If appropriate, establish the committee.	Phase 1 Phases 1 and 2	 	The Ministry of Health is drafting this report. (See page 38 for more information.)	The committee, if established, would include Māori representation.
4.13 Promote guidance to advise family, whānau and others who are caring for people at risk of suicide to remove potential means of suicide, such as obvious ligature points, firearms and toxic substances (including unnecessary medications), from the home.	Ensure that new and updated resources contain key messages about removing means of suicide from the home.	Phases 1 and 2		Included in: <i>Identification of Common Mental Disorders and Management of Depression in Primary Care</i> (see page 22).	The guideline was produced by NZGG with involvement from Māori consumers and health care workers.

Key:

✓ Complete

 On hold

 Under way

± Mixed results/progress

 Work is ongoing

 Not yet begun / planned for a later time

Goal 5: Promote the safe reporting and portrayal of suicidal behaviour by the media

Key action area: Collaboration

Actions	Milestones/ measures	Timeframes	Rating	Note	Whānau ora pathways
5.1 Promote opportunities for exchange of ideas and information, discussion and collaboration among the media, the research community and policy makers, as well as other key stakeholders, as appropriate (eg, clinicians, consumers / tangata whaiora and Māori).	Identify existing opportunities for collaboration, and support new opportunities when required.	Phases 1 and 2		The Role of the Media in Suicide Prevention seminar series was held to promote discussion. (See page 39 for more information.)	A symposium will be held in September 2009 to encourage the exchange of ideas and information on Māori suicide prevention initiatives and research.

Key:

✓ Complete

 On hold

 Under way

± Mixed results/progress

 Work is ongoing

 Not yet begun / planned for a later time

Key action area: Guideline/protocol development, implementation and evaluation

Actions	Milestones/ measures	Timeframes	Rating	Note	Whānau ora pathways
5.2 Further develop, implement and evaluate guidelines or protocols for the reporting and portrayal of suicide in the media.	Revise and/or develop new guidance/protocols, in consultation with key stakeholders.	Phase 1		The Ministry is currently scoping this work (see page 40).	Māori media organisations will be consulted during the development of the resource.
	Develop a comprehensive implementation and dissemination plan to ensure all existing media and new people entering the industry report and portray suicide safely.	Phase 1		Development of an implementation plan will take place alongside the development of the resource.	
	Evaluate the implementation of the guidance/protocols, and monitor media reporting and portrayal of suicide.	Phase 2		This work will take place after the development of the resource.	

Key:

✓ Complete

 On hold

 Under way

± Mixed results/progress

 Work is ongoing

 Not yet begun / planned for a later time

Key action area: Education and support

Actions	Milestones/ measures	Timeframes	Rating	Note	Whānau ora pathways
5.3 Provide ongoing support, information and incentives to the media and those working with the media.	Develop a resource/ guide to assist people working with the media on issues of suicide.	Phase 1		The Ministry will discuss this action with media during the development of the above resource.	Māori media organisations will be consulted during the development of the resource.
	Investigate options for providing incentives for positive reporting and portrayal of suicide in the media.	Phase 1			
	Consider and consult on the best way to provide additional and ongoing support to the media and people working with the media.	Phase 1			Information and support will be provided to Māori media and Māori organisations that are likely to be working with the media.
	Provide information to coroners on suicide and media issues, as required.	Phase 1		The Ministry of Health contributed information about suicide prevention for a new resource for coroners.	

Actions	Milestones/ measures	Timeframes	Rating	Note	Whānau ora pathways
5.4 Encourage the inclusion of evidence and issues about media reporting of suicide in journalism training programmes.	Develop relationships with journalism training organisations.	Phase 2		Representatives from journalism training organisations attended the Role of the Media in Suicide Prevention seminar series in September 2008 (see page 39).	Relevant Māori media and Māori organisations will be involved in journalism training initiatives, as appropriate.
	Discuss options for including or strengthening media reporting of suicide in training programmes.	Phase 2			
	Develop appropriate information/resources for use as part of the training, as agreed with the training organisations.	Phase 2		The Ministry of Health is engaging with journalism training organisations during the development of the above resource.	
	Work with journalism training organisations to implement the initiatives developed above.	Phase 2 and ongoing			
	Evaluate the uptake and effectiveness of the initiatives.	Phase 2 and ongoing		This work is planned for Phase 2.	
5.5 Provide guidance about fictional portrayal of suicidal behaviour in films, television and drama. This action may involve considering specific approaches and target groups and including issues about fictional portrayal in more general resources and information.	Consider fictional media in development of new guidelines/protocols.	Phase 1		The Ministry will address this action during the development of the above resource.	Māori media organisations will be consulted during the development of the resource.
	Consider specific approaches and target groups to promote safe fictional portrayal of suicidal behaviour.	Phase 2			Appropriate Māori participation will occur in specific approaches and target groups for fictional media.
	Include fictional media in implementation and evaluation of guidelines/protocols and other initiatives.	Phase 2			

Key:

✓ Complete

 On hold

 Under way

± Mixed results/progress

 Work is ongoing

 Not yet begun / planned for a later time

Key action area: Internet

Actions	Milestones/ measures	Timeframes	Rating	Note	Whānau ora pathways
5.6 Monitor international developments to mitigate potentially harmful effects of Internet sites that encourage suicide.	Identify and maintain contact with appropriate international organisations and forums.	Phases 1 and 2		International developments are being monitored, and options for reducing harmful effects in New Zealand are being investigated (see page 41).	Consideration of Māori issues will occur.

Key:

✓ Complete

 On hold

 Under way

± Mixed results/progress

 Work is ongoing

 Not yet begun / planned for a later time

Goal 6: Support families/whānau, friends and others affected by a suicide or suicide attempt

Key action area: Services for those bereaved by suicide, those affected by suicide attempt, and community organisations needing to respond to emerging or occurring clusters

Actions	Milestones/ measures	Timeframes	Rating	Note	Whānau ora pathways
<p>6.1 Continue the development of a comprehensive Postvention Support Initiative.</p> <p>This work includes:</p> <ul style="list-style-type: none"> • developing an effective suicide bereavement service • identifying and monitoring the availability of specialised local services for those bereaved by suicide and responding to emerging needs – which will include consideration of services for specific population groups such as Māori and Pacific peoples • developing a service for identifying and responding to emerging or occurring suicide clusters • providing co-ordinated management plans to ensure communities are prepared to respond in the event of a suicide • developing appropriate support services for those affected when someone close to them makes a suicide attempt. <p>All these services must be developed and evaluated to be culturally appropriate and effective for Māori.</p>	<p>Implement the initial phase of this initiative, which is the staggered roll-out of services underpinned by a research and development model.</p>	Phase 1		<p>The Initial Response Service and the Specialist Counselling Service are available in seven DHBs. The Community Postvention Response Service is available nationally. (See page 42.)</p>	<p>This service is contracted to have a strong focus on addressing the needs of Māori, which includes providing outreach to Māori communities.</p>
	<p>Consider future service provision and development based on the results of the research and development evaluation.</p>	Phase 2		<p>Consideration of future service provision is under way.</p>	<p>Services will be evaluated to assess their appropriateness and effectiveness for Māori.</p>
	<p>Implement future service provision.</p>	Phase 2		<p>This work is planned for Phase 2.</p>	<p>Future service provision will include specific consideration of Māori needs.</p>
	<p>Provide ongoing evaluation and implement quality improvements to services.</p>	Phase 2		<p>This work is planned for Phase 2.</p>	

Actions	Milestones/ measures	Timeframes	Rating	Note	Whānau ora pathways
<p>6.2 Implement recommendations from the review of the Traumatic Incidents Response Service. This work includes:</p> <ul style="list-style-type: none"> providing a nationally consistent, evidence-based service – part of this service will be to utilise and revise resources appropriate to age and culture, including a support manual and pre-planning support workshops for schools and early childhood services developing a communications strategy to inform the sector of this service continuing to roll out the pre-planning training package to schools and early childhood services continuing training for traumatic incident staff. 	<p>Revise the Ministry of Education's traumatic incident report manual.</p>	Phase 1	✓	The revised manual is available to Ministry of Education staff.	<p>A special education manual has been collaboratively developed with Aue He ... Aitua, a special education, Ministry of Education Traumatic Incident Service for Māori-language settings to ensure culturally appropriate responses and contexts are supported.</p> <p>Resources, staff training, and pre-planning support will be evaluated for cultural appropriateness and effectiveness for Māori.</p>
	<p>Provide regional training to traumatic incident co-ordinators and their managers.</p>	Phase 1	✓	Training was completed in October 2008.	
	<p>Complete pre-planning support to schools and early childhood services in all regions.</p>	Phase 2	👉	A manual for schools and early childhood services is currently being negotiated across the education sector. When the manual is complete, traumatic incident co-ordinators will be trained in 2009, followed by school and early childhood services training from 2010 onwards. (See page 43 for more information).	
	<p>Externally evaluate the traumatic incident resources, staff training and pre-planning support to schools and early childhood services.</p>	Phases 1 and 2	🕒	Evaluation will be considered in Phase 2.	

Key:

✓ Complete

👉 On hold

👉 Under way

± Mixed results/progress

🕒 Work is ongoing

🕒 Not yet begun / planned for a later time

Key action area: Resources for those bereaved by suicide, those affected by suicide attempt, those working with the bereaved and affected, and key institutions

Actions	Milestones/ measures	Timeframes	Rating	Note	Whānau ora pathways
<p>6.3 Develop, implement and evaluate best-practice guidelines for establishing suicide support groups. These guidelines must be culturally appropriate and effective for Māori.</p>	<p>Consult with key stakeholders about the development of these guidelines.</p> <p>Develop the guidelines.</p> <p>Develop and execute an implementation plan for these guidelines.</p> <p>Evaluate the implementation, utilisation, usefulness and cultural appropriateness of these guidelines.</p>	<p>Phase 1</p> <p>Phase 1</p> <p>Phases 1 and 2</p> <p>Phases 1 and 2</p>	<p></p> <p></p> <p></p> <p></p>	<p>See page 44 for work being undertaken by CASA to support suicide support groups.</p> <p>The need for resources/ guidelines is being considered during 2009/10.</p>	<p>This is part of the Postvention Support Service, which has a focus on ensuring the service is culturally appropriate for Māori and will meet their needs.</p>
<p>6.4 Review existing information resources, guidelines and protocols on managing the aftermath of suicide or suicide attempt for:</p> <ul style="list-style-type: none"> • people who are bereaved • key personnel who have regular contact with people who are bereaved • people who are affected by a suicide attempt • key institutional settings. <p>All these resources, guidelines and protocols must be evaluated for cultural appropriateness and effectiveness for Māori.</p>	<p>Review existing key resources, guidelines and protocols and consider any quality improvements, including identifying key gaps.</p> <p>If required, develop, implement and evaluate any new or revised resources.</p>	<p>Phase 1</p> <p>Phases 1 and 2</p>	<p></p> <p></p>	<p>This work will commence in 2009/10.</p> <p>If required, this work will commence in Phase 2.</p>	<p>The resources, guidelines and protocols will be evaluated for cultural appropriateness and effectiveness for Māori.</p>

Goal 7: Expand the evidence about rates, causes and effective interventions

Key action area: Improving the quality and timeliness of suicide data

Actions	Milestones/ measures	Timeframes	Rating	Note	Whānau ora pathways
7.1 Improve the quality of suicide-related data.	<p>Develop a plan to improve the quality and consistency of national and regional suicide data.</p> <p>Scope the feasibility of establishing surveillance sites for suicide attempt data.</p> <p>Implement quality improvement recommendations.</p> <p>Monitor the impact of implementing any recommendations, including the impact on improving the quality and consistency of Māori suicide data.</p>	<p>Phase 1</p> <p>Phase 1</p> <p>Phases 1 and 2</p> <p>Phases 1 and 2</p>	<p>±</p> <p></p> <p></p> <p></p>	<p>The quality of suicide data has been greatly improved by the new coronial database described below (Action 7.2). A documented plan will commence in 2009/10.</p>	<p>This plan would include a focus on improving the quality and consistency of Māori suicide data.</p>
7.2 Address issues regarding the timeliness of suicide data.	<p>Establish the national coronial database.</p> <p>Assess whether the new coronial database has enabled access to timely and appropriate information, including information on Māori suicide.</p> <p>Develop a plan to improve the timeliness of suicide data.</p> <p>Implement recommendations.</p>	<p>Phase 1</p> <p>Phases 1 and 2</p> <p>Phase 1</p> <p>Phases 1 and 2</p>	<p>✓</p> <p>✓</p> <p></p> <p></p>	<p>The database has been established.</p> <p>The database allows searches for self-inflicted deaths and related circumstances (see page 45).</p> <p>A plan has not been developed, but timeliness has been significantly improved (on average only 147 days for a finding).</p>	<p>The ethnicity of a deceased person is identified in most cases. This allows easy access to information about Māori suicide.</p>
7.3 Scope the feasibility of establishing a suicide mortality review committee.	<p>Scope the feasibility of establishing a suicide mortality review committee.</p> <p>If appropriate, establish the committee.</p>	<p>Phase 1</p> <p>Phases 1 and 2</p>	<p></p> <p></p>	<p>The Ministry of Health is drafting this report.</p> <p>This will be considered upon completion of the report.</p>	<p>The committee, if established, would include Māori representation.</p>

Key:

✓ Complete

 On hold

 Under way

± Mixed results/progress

 Work is ongoing

 Not yet begun / planned for a later time

Key action area: Expanding the research base

Actions	Milestones/ measures	Timeframes	Rating	Note	Whānau ora pathways
7.4 Analyse existing suicide-related databases.	Monitor the further mining of suicide-related information in existing databases.	Phases 1 and 2		Further analysis of data from the Youth '07 study, Te Rau Hinengaro, the Child and Youth Mortality Review Committee database and the coronial database is under way.	This action includes identifying key gaps in existing databases for high-risk groups, including Māori, to inform potential research priorities.
	If required, investigate ways to commit further funding to ensure key areas of information in these databases are researched.	Phases 1 and 2		This includes research on high-risk groups such as youth (using the Youth '07 data) and Māori (using Te Rau Hinengaro). (See pages 46 and 23 respectively.)	
	Identify key gaps in existing databases for high-risk groups, including Māori, to inform potential research priorities.	Phases 1 and 2			
7.5 Evaluate new suicide prevention initiatives.	All actions in this Action Plan contain a commitment to evaluation from the lead agency/agencies, wherever feasible.	Phases 1 and 2		Evaluation of suicide prevention initiatives takes place where appropriate.	Evaluation of the effectiveness for Māori of suicide prevention initiatives takes place, where appropriate.
7.6 Continue to fund suicide research through the Health Research Council (HRC).	Continue to have suicide research funded within HRC's research investment.	Phases 1 and 2		See page 47 for suicide prevention research funded by HRC.	HRC is funding a number of Māori suicide research projects.
	Develop alignment between HRC, ACC and the Ministry of Health on suicide research priorities.	Phases 1 and 2		HRC is consulting with the Ministry of Health to identify priorities for a new model of investment.	Research on Māori suicide will be considered as a priority.
7.7 Fund research using the Ministry of Health's Suicide Prevention Research Fund to support the implementation of the <i>New Zealand Suicide Prevention Strategy 2006–2016</i> .	Establish, manage and administer the Suicide Prevention Research Fund.	Phases 1 and 2		See page 46 for suicide prevention research funded by the Suicide Prevention Research Fund.	Māori suicide research is a funding priority for this fund, although no Māori-specific research is currently funded.

Actions	Milestones/ measures	Timeframes	Rating	Note	Whānau ora pathways
7.8 Invest in Māori suicide research.	Develop priorities for Māori suicide research.	Phases 1 and 2		Priorities will be developed in Phase 2.	Priorities will be developed in consultation with the Ministry of Health's Māori Population Health team.
	Fund Māori suicide research priorities using a range of research methods that are appropriate to Māori.	Phases 1 and 2		HRC is funding a number of Māori suicide research projects (see page 47).	
	Continue to implement Māori workforce development strategies as outlined in <i>Kia Puāwai Te Ararau</i> .	Phases 1 and 2		See page 25 for information about Te Rau Matatini, which is undertaking this work.	

Key:

 Complete

 On hold

 Under way

 Mixed results/progress

 Work is ongoing

 Not yet begun / planned for a later time

Key action area: Disseminating research and information

Actions	Milestones/ measures	Timeframes	Rating	Note	Whānau ora pathways
7.9 Develop, implement and evaluate a suicide prevention research and information dissemination plan. This plan will specifically include meeting the needs of Māori service providers and communities.	Conduct a stocktake of current dissemination approaches and areas of need.	Phase 1		SPINZ has developed an information dissemination plan to provide evidence-based and audience-specific information.	This plan includes meeting the needs of Māori service providers and communities. SPINZ is hosting a symposium in September 2009 to encourage the exchange of ideas and information on Māori suicide prevention initiatives and research.
	Develop a suicide prevention research and information dissemination plan. This plan will consider ways to meet the needs of different audiences.	Phases 1 and 2			
	Implement the dissemination plan. This will address the needs of specific audiences, such as district health boards, Māori and Pacific communities, through developing and implementing action-focused best-practice guidelines or toolkits.	Phases 1 and 2		SPINZ has produced a newsletter and redeveloped its website. The website is organised by audience so that people can immediately find the information relevant to them.	
	Evaluate the effectiveness of the plan in providing evidence-based and safe information, and its impact on practice.	Phase 2		The effectiveness of these developments will be evaluated in Phase 2.	

Key:

 Complete

 On hold

 Under way

 Mixed results/progress

 Work is ongoing

 Not yet begun / planned for a later time

References

- Adolescent Health Research Group. 2008. *Youth '07: The health and wellbeing of secondary school students in New Zealand: Initial findings*. Auckland: University of Auckland.
- Associate Minister of Health. 2006. *The New Zealand Suicide Prevention Strategy 2006–2016*. Wellington: Ministry of Health.
- Associate Minister of Health. 2008. *The New Zealand Suicide Prevention Action Plan 2008–2012*. Wellington: Ministry of Health.
- Baxter J. 2008. *Māori Mental Health Needs Profile: A review of the evidence*. Palmerston North: Te Rau Matatini.
- Clark TC, Robinson E, Crengle S, et al. 2008. *Te Ara Whakapiki Taitamariki: Youth '07: The health and wellbeing survey of secondary school students in New Zealand: Results for Māori young people*. Auckland: University of Auckland.
- Dowell AC, Garrett S, Collings S, et al. 2009. *Evaluation of the Primary Mental Health Initiatives: Summary report 2008*. Wellington: University of Otago and Ministry of Health.
- Faleafa M, Lui D, Afaaso B, et al. 2007. *Paolo 'O o'u Paolo out e malu ai' 'It is my people that give me shelter': Embracing our Samoan communities: Suicide prevention information for people working with Samoans in Niu Sila*. Auckland: Mental Health Foundation of New Zealand.
- Fergusson D, Stanley L, Horwood LJ. 2009. Preliminary data on the efficacy of the Incredible Years Basic Parent Programme in New Zealand. *Australian and New Zealand Journal of Psychiatry* 43(1): 76–9.
- Hegerl U, Althaus D, Schmidtke A, et al. 2006. The alliance against depression: two-year evaluation of a community-based intervention to reduce suicidality. *Psychological Medicine* 36: 1225–33.
- Ihimaera L. 2008. *Whiria te Oranga: Kaumatua Workforce Strategy for Mental Health and Addiction Services*. Palmerston North: Te Rau Matatini.
- Minister of Health. 2005. *Te Tāhuhu – Improving Mental Health 2005–2015: The second New Zealand Mental Health and Addiction Plan*. Wellington: Ministry of Health.
- Minister of Health. 2006. *Te Kōkiri: The Mental Health and Addiction Action Plan 2006–2015*. Wellington: Ministry of Health.
- Minister of Health and Associate Minister of Health. 2002. *Te Korowai Oranga: Māori Health Strategy*. Wellington: Ministry of Health.
- Ministry of Health. 1999. *Suicide and the Media: The reporting and portrayal of suicide in the media: A resource*. Wellington: Ministry of Health.
- Ministry of Health. 2007a. *National Health Emergency Plan: Planning for Individual and Community Recovery in an Emergency Event: Principles for psychosocial support*. Wellington: Ministry of Health.
- Ministry of Health. 2007b. *Suicide Trends by Method: 2005–2006 data*. Unpublished report.
- Ministry of Health. 2007c. *Whānau Ora Health Impact Assessment*. Wellington: Ministry of Health.

- Ministry of Health. 2008a. *A Portrait of Health: Key results of the 2006/07 New Zealand Health Survey*. Wellington: Ministry of Health.
- Ministry of Health. 2008b. *Future Directions for Eating Disorders Services in New Zealand*. Wellington: Ministry of Health.
- Ministry of Health. 2008c. *Let's Get Real: Real skills for people working in mental health and addiction*. Wellington: Ministry of Health.
- Ministry of Health. 2008d. *Office of the Director of Mental Health: Annual Report 2007*. Wellington: Ministry of Health.
- Ministry of Health. 2008e. *Suicide Facts: Deaths and intentional self-harm hospitalisations: 2006*. Wellington: Ministry of Health.
- Ministry of Health. 2008f. *Te Puāwaiwhero: The Second Māori Mental Health and Addiction National Strategic Framework 2008–2015*. Wellington: Ministry of Health.
- Ministry of Social Development. 2008. *The Social Report 2008*. Wellington: Ministry of Social Development.
- Ministry of Transport. 2008. *The New Zealand Transport Strategy 2008*. Wellington: Ministry of Transport.
- New Zealand Guidelines Group. 2008. *Identification of Common Mental Disorders and Management of Depression in Primary Care: An evidence-based best practice guideline*. Wellington: New Zealand Guidelines Group.
- New Zealand Guidelines Group and Ministry of Health. 2003. *The Assessment and Management of People at Risk of Suicide*. Wellington: New Zealand Guidelines Group and Ministry of Health.
- Oakley Browne M, Wells JE, Scott KM (eds). 2006. *Te Rau Hinengaro: The New Zealand Mental Health Survey*. Wellington: Ministry of Health.
- Owens D, Horrocks J, House A. 2002. Fatal and non-fatal repetition of self-harm. Systematic review. *British Journal of Psychiatry* 181: 193–9.
- Pirkis J, Blood RW. 2001. *Suicide and the Media: A critical review*. Canberra: Commonwealth of Australia.
- Suaalii-Sauni T, Wheeler A, Saafi E, et al. 2009. Exploration of Pacific perspectives of Pacific models of mental health service delivery in New Zealand. *Pacific Health Dialog* 15(1): 18–27.
- Wyllie AJ, Cameron A, Howearth J. 2008. *Impacts of National Media Campaign to Counter Stigma and Discrimination Associated with Mental Illness: Survey 9: Results for campaign 4*. Unpublished Phoenix research report for Ministry of Health.